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

Strategic, Adaptable and Multisectoral Leadership, Governance and Coordination

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, this brief focuses on the **barriers and facilitators to delivering effective health services to women, newborns, children, and adolescents in conflict, specifically in relation to the role and functionality of leadership, governance and coordination when delivering services**.

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 of 2021 to further discuss the current needs around the role and functionality of leadership, governance, and coordination, among other key issues.

To access these additional resources, please check-in periodically on the BRANCH website[1], 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

Leadership governance and coordination are important factors to ensure essential health services are readily available, easily accessible and delivered in a timely manner 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.[3-7]

A *lack of synergy and collaboration* between NGOs was reported across the 10 countries that were researched by BRANCH - Afghanistan, Columbia, Democratic Republic of the Congo (DRC), Mali, Nigeria, Pakistan, Somalia, South Sudan, Syria, and Yemen - especially where field interventions for women, newborns, children, and adolescents in conflict settings were concerned.[8-19] In many cases, several NGOs offered the same services to the same population at the same time. This finding highlights a clear and obvious *communication gap* between different actors on the ground, which has led often to an overlap in programmes, services, and funds, calling on all humanitarian stakeholders to act on this issue.[8,9]

SYRIA:
Multiple Cooperation Strategies

In Syria the humanitarian sector adopted a system of coordination where four main regional hubs existed. Within these hubs, UN agencies collaborated with various governing bodies in areas under different control groups (e.g., Syrian MoH or Health Directorates established by local health networks). The presence of different coordinating hubs was reported to cause difficulties in having a harmonized approach to service prioritization and delivery, and aligned standards across the hubs, partly due to the distinct approaches of the NGO/UN-led system versus the existing national system.[10]

MALI:
Siloed Approach to Service Delivery

In Mali initial humanitarian response activities were reported to be poorly coordinated and organizations (mainly NGOs) were working in isolation resulting in the duplication of WCH services. Collaboration between humanitarian actors was also perceived to be insufficient, with a need for more synergy.[11]

AFGHANISTAN:
Ongoing Communication

In Afghanistan, though there were coordination mechanisms in place at the central and provincial levels, these were not fully utilized as the committees did not regularly meet and there were no proper follow ups to monitor progress. The lack of coordination and communication not only affected delivery of WCH services, but at times led to duplication of efforts.[12]

There is a *constant adaptation* that is needed in relation to response measures due to the unpredictable and uncertain situations in conflict settings. Several countries that were examined reported the need to frequently adapt their WCH interventions due to the escalation of insecurity in some parts of the country, the constant changes of the conflict (e.g. nature, scale, movement of troops, nature and intention of belligerents) and the cost of delivering WCH services in hard-to-reach locations (e.g., South Sudan, Somalia, Afghanistan and DRC).[12-15] However, in some instances, the constant adaptation resulted in an even greater *discord between humanitarian actors* due to an inability to plan ahead, often slowing response and delivery of WCH services (e.g., Yemen, Colombia).[16,17]

SOUTH SUDAN:
Ever-Changing Needs and Supplies

In parts of South Sudan, air delivery is the only means to resupply health facilities. However, the dynamic context within the country made planning out the supply needs of the communities difficult to assess. Costing WCH interventions also became difficult since the current cost of the supplies could not be equated to the previous cost assumptions since the context would entirely change, in addition to inflation.[13]

Power imbalances between national and international humanitarian actors is another source of tension leading to skewed coordination and poor governance around the delivery of WCH services. In some cases, the decision-making power is with the local government, in other cases it lies with the international organizations, and other times it is a shared role.

With unequal power also comes unequal access to resources between international and national actors leading to even greater tension between who has access to funds, who decides on what programming and services are provided and how they are delivered, etc (e.g., Pakistan, Nigeria).[18,19]

There is no doubt that most national authorities and humanitarian agencies have a common vision of providing care to the most vulnerable. However, the timeline, budget and scale of these services largely vary between international humanitarian agencies targeting special geographical areas and national authorities managing the local space.

POLICY IMPLICATIONS

The changing nature of conflict and "rules of engagement" impact leadership, governance and especially coordination of efforts.[21] In any conflict, there are numerous humanitarian actors on the field responding to the needs of the population. The way in which these players work together and/or cover various areas and health services is crucial to ensuring the delivery of these (WCH) services are provided to those in need in conflict settings.

The way in which various humanitarian and national actors work together or synergistically on the delivery of WCH services in conflict settings can be complex. Based on the BRANCH Consortium's key research findings and recommendations, several policy asks have been suggested for various humanitarian actors to facilitate this ongoing tension and improve leadership, governance and coordination for bettering women's, newborns', children's, and adolescents' health in conflict settings.[8-19,21]

1. Strategic planning and governance

Minimal and strategic governance among key actors would enable complementary roles in response and WCH service delivery, while also providing flexibility to work around changing needs in conflict settings.

What may be needed for effective (WCH) service delivery in conflict settings is not a complete, "whole governance" capacity, but perhaps a "*strategic governance*" whereby minimal governance conditions are identified and upheld when delivering interventions and services.[21,22] In other words, basic criteria and needs around overall governance can be outlined and agreed upon by all actors in relation to (WCH) service delivery, ensuring there is no overlap of efforts and that *roles are complementary*.

Furthermore, concentrating the responsibility for response coordination among fewer, effective operational actors would also complement this notion, realizing that coordination and oversight of the humanitarian health response in countries ultimately lies with governments.[21]

The inclusion of local priorities is also imperative. To ensure better collaboration and coordination, decisions should be aligned with identified local and regional priorities at all levels (e.g., communities, healthcare institutions, donors, governments, local and international organizations, academics, researchers, etc.).

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, more so in conflict settings. In some instances, the protracted nature of war and the politicisation of aid have fractured the community's trust in health service providers and in some cases local leaders (e.g., Afghanistan, DRC, Pakistan).[12,15,18] For example, the use of polio vaccinators to identify and target Osama Bin Laden in Pakistan has created long-lasting resistance and reluctance from communities regarding public health campaigns in both Pakistan and Afghanistan.[12,18]

Response strategies and national clusters or other coordination mechanisms must be firmly non-partisan, based on humanitarian principles, and ideally led by the UN or other international actors.[21,22]

Agencies leading global humanitarian responses, NGOs, academics working in conflict settings, and representatives from affected communities could also convene an independent technical advisory group to establish a decision-making framework for the selection of interventions for women, newborns, children and adolescents in conflict settings, to promote the strengthening of data collection and analysis efforts in those settings, and to help develop common sets of indicators for humanitarian health action (see panel). The same group could assist in developing implementation research priorities to help fill key gaps in operational and implementation guidance on the health of women, newborns, children and adolescents in conflict settings.[21]

2. Multisectoral coordination

Coordination across multiple sectors is important to ensure the full range of WCH services are offered in an efficient manner, including meeting the actual and changing needs of the population in conflict settings.

It is recommended that coordination across a range of sectors takes place to ensure the full range of essential WCH services are available.[2,8]

In Mali, collaboration between different types of humanitarian actors was vital to ensuring WCH service delivery. Local organizations or community members were subcontracted to deliver services when there were security concerns, but also as a means to gain local contextual insights. Coordination, and often the sharing of resources, was key to improving efficiency and delivering the full range of needed WCH services.[11]

Often the ***de-centralisation of operations*** by ***contracting local organisations*** helps balance power between various levels of humanitarian actors, also enabling a platform for local voices to speak and be heard. Encouraging greater engagement of local NGOs and civil society partners on the ground can also lead to potentially enhancing operational flexibility and reach and strengthening local mitigating responses to conflict.[21] There are many examples of civil society acting as positive agents for change by openly discouraging bad practices and encouraging good practices (e.g., DRC).[15,23] In the case of WCH, the voices and perspectives of women, newborns, children and adolescents is key.[2] Furthermore, engaging more women in leadership and decision-making positions is also imperative.[5] A political analysis on the power balance between the various warring parties and humanitarian actors needs to be done to better understand these dynamics and how best to engage them.[22]

In particular, ***stronger coordination between NGOs*** in the provision of WCH services and interventions is recommended as they are the main providers of health services and interventions to the population - particularly women, newborns, children, and adolescents - in many conflict settings.[8]

In some cases, it was found that the coordination between several actors led to improved data collection (e.g., Syria), as well as unconventional data collection (e.g., the use of e-health, telephones, and informants to collect key information).[10]

Still, much needs to be done by a range of actors, to fill research and guidance gaps, to improve national, regional and international response coordination, and to ultimately improve the health, nutrition, and well-being of conflict-affected women, newborns, children, and adolescents. "A critical area of unfinished business includes the need for ***improved implementation guidance for action*** to protect and fulfil the health and nutrition needs for women and children, informed by better, ***more granular data*** and by ***more operational research*** focused on identified priorities."[21]

The availability of data to better understand and map out the roles and responsibilities of various stakeholders and key humanitarian players in the region, along with the reality of these relationships, could also lead to a more accurate or realistic understanding of the roles and responsibilities of each key humanitarian player, along with better alignment of priorities and leading to more efficient service provision for WCH in conflict settings.[21]

3. Multiple Collaboration and Cooperation Strategies and Building an Adaptive Response

Multiple cooperation strategies (that emphasize the role of local organizations) would allow for diverse actors to work together and complementarily adjust their roles and respond over the course of the conflict, while addressing WCH needs in conflict settings. Agile management mechanisms would ensure that responses and services can effectively adapt to the ever-changing context and (health) needs of women, newborns, children, and adolescents in conflict and in post-conflict recovery.

Cooperation between different humanitarian actors and local authorities (including governments) often takes on a variety of forms, changing over the course of the conflict. In some cases *multiple cooperation strategies* are needed. In Syria, different cooperation strategies and roles were used by the same actor at the same time or at different points in time. For example, humanitarian actors sometimes worked alongside local NGOs in service provision efforts, while the same humanitarian actors also monitored the NGOs activities through telephone calls and regular visits.[10]

It is important for all humanitarian actors and stakeholders to understand each other's roles and how to better work together, while also being fluid and agile in their roles and responsibilities to ensure the services being provided meet the needs of the community. For example, in addition to their other roles around monitoring, evaluating and overseeing programs and services, governments and international organizations could work with local, community-based organizations to provide WCH services to hard-to-reach areas and improve accessibility. NGOs could work with governments and international organizations to ensure alignment of service provision, in addition to carrying out the service delivery. More collaboration amongst humanitarian actors will allow for a clearer understanding of who is doing what and where, ensuring there is minimal duplication of efforts, and provide an opportunity for stakeholders to play different roles depending on their skills and competencies and the needs of the women, newborns, children, and adolescents in conflict settings.

This concept can also be applied to the response that is provided. Humanitarian actors reported having to anticipate and make constant adaptations to rapidly respond to often unpredictable situations in conflict settings.[8] Examples of these adaptations include using mobile clinics in Afghanistan to access hard-to-reach populations either due to conflict and/or terrain, and donors making emergency funds available in South Sudan to pre-stock medical supplies to be able to rapidly

respond to outbreaks (e.g., cholera) or sudden escalations in violence.[12,13]

These modes of operations are based on *agile management mechanisms*, which are most often not present in public service and create tensions in the mode of operation between mainstream health services and humanitarian services.[8] By working together in more fluid and adaptable roles, such innovative strategies can be better adopted to meet the needs of the women, newborns, children, and adolescents.

Even so, more "functional, participatory, and agile response coordination mechanisms at global, regional, and especially national levels", along with enhanced resources for overall humanitarian health response and post-conflict recovery, with an emphasis on WCH, is needed. Of course, there is also the more fundamental challenge of preventing armed conflict and protecting women, newborns, children, and adolescents that is needed by all actors.[21]

CONCLUSIONS

Coordination of humanitarian players is key, and so is the delineation of leadership and governance roles where it concerns prioritizing and delivering WCH services in conflict settings.

At the global level, the UN cluster system plays a key role in addressing gaps in programmatic services and increasing the effectiveness of humanitarian response through building partnerships and synergies among key humanitarian actors and stakeholders. The **Inter-Agency Standing Committee (IASC)** is the highest-level humanitarian coordination forum of the UN system. At the country level, coordination of the humanitarian health response is ultimately the responsibility of the government.[21]

Coordination mechanisms are becoming increasingly complex, more so in conflict settings, with a growing need for further clarity, particularly on the roles of international and national NGOs.[21,22] **The BRANCH Consortium offers several recommendations for NGOs, IOs, donors and governments to work together in synergy and harmony, with overall guidance and consideration of these suggestions for the UN cluster system.** For instance, establishing a framework for identifying context-specific packages of essential (health) interventions across the continuum of care, as well as delivery and scale-up strategies for WCH.

However, the availability of data around roles and responsibilities and the reality of these relationships would lead to a better understanding.[21]

Data collection and research would also be useful to strengthen analysis efforts, facilitate the development of common indicator sets for monitoring and evaluating effectiveness of programs and services, identify key areas for operational research, evaluate intervention and implementation effectiveness through a systematic research prioritisation exercise, as well as identify research priorities to focus on the needs, delivery strategies, and implementing platforms that engage affected populations, local actors, and delivery channels as much as possible, among others.

This data and research could inform decision-making tools and priorities, better align coordination efforts, and strengthen the linkage between researchers and policymakers to ensure the development of research that can be utilized by policymakers and key stakeholders.[21,24]

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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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