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

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

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 focuses on the need for more evidence-based guidance on identifying and implementing priority WCH interventions in conflict settings.

The accompanying brief (Summary Brief 3 - Women's and Children's Health in Conflict Settings: Prioritizing and Packaging Health Interventions - Deciding What to Deliver, When and How) proposes a decision-making framework for identifying priority WCH interventions in a given conflict setting.

This brief is intended for programmatic decision-makers such as Ministry of Health or other government staff, local NGOs, international humanitarian agencies, UN agencies, and other key humanitarian actors, including donors, concerned with improving the humanitarian health response for conflict-affected women, newborns, children, and adolescents.

Introduction

Several new and recently updated resources that are available in the public domain address different aspects of selecting and implementing interventions for women and children within humanitarian settings in general,[1-8] but **conflict-specific guidance is very limited.**[9] Given the unique challenges of conflict settings (such as the insecurity that often characterizes such settings, with increased risks for those providing and seeking care, mass population displacement, severely disrupted health systems and excessively scarce system inputs), **there is a need for specific guidance on addressing WCH needs in conflict settings particularly.**[10]

The Evidence and Guidance Gaps

A recent review of existing guidance documents found very little guidance focused on identifying and implementing health and nutrition sector interventions for women, children and adolescents in the context of conflict specifically.[9] Existing guidance, even operational guidance, rarely differentiates between conflict situations and other humanitarian crises such as natural disasters and epidemics, with insufficient adaptation and translation of global recommendations into practical actions relevant for conflict contexts.[9]

While broader humanitarian guidance that is relevant for women, newborns, children or adolescents in conflict settings is publicly available in such topic areas as nutrition, infectious diseases, sexual and reproductive health (SRH), gender-based violence and mental health, there are still important gaps in these areas as well as others. A range of humanitarian health actors active in the planning and provision of services for conflict-affected populations recently highlighted the need for conflict-specific guidance in particular aspects of SRH such as the provision and procurement of emergency contraception and safe abortion care, as well as in the areas of newborn care, early child development, mental health, health among children aged 5-9 years, adolescent health beyond SRH, and non-communicable diseases.[9]

The lack of guidance on selecting and delivering priority WCH interventions in conflict settings reflects the limited evidence available in the literature, both in terms of quantity and quality.[11] **The existing literature includes significant evidence gaps with respect to the effectiveness of, and effective delivery strategies for, interventions targeted to conflict-affected women, newborns, children and adolescents.**[12-18]

Most publications in the literature report on intervention delivery to refugee women and children living in camps, with relatively few reporting on delivery to refugees in non-camp settings or to internally displaced populations. Across all displacement settings, including camp-based settings where intervention delivery may be easier, there is limited reporting of the delivery of interventions targeting newborns or adolescents, or of interventions addressing such high burden needs as abortion care, pneumonia treatment, or NCDs. There are also few reports in the literature of community-based platforms for intervention delivery, with most publications reporting on intervention delivery at the facility level by skilled health personnel. Estimates of intervention coverage or of intervention effectiveness are rarely reported.

Some of these gaps in the literature are likely attributable to the challenges of collecting data and information in conflict settings and the many constraints on humanitarian health responders' capacities and time. Other gaps in the literature may reflect actual intervention gaps in the field.

In the absence of sufficiently contextualized guidance for conflict settings, decision-making in such settings is driven by a wide range of factors, including a tendency to continue existing programming irrespective of changing needs, donor priorities, and political and policy influences that affect decision-making, all of which can **lead to a set of selected interventions that do not comprehensively meet the actual needs of the population in a particular setting and/or cannot be effectively delivered in that setting.**

A set of recent case studies across ten conflict-affected countries was conducted by the BRANCH Consortium. The case studies investigated how decision-making was made within the humanitarian health response on addressing WCH needs in the absence or disregard of data and information on needs, lack of evidence on what works and guidance on what to prioritize, how to prioritize and how to implement priorities in these settings. Their findings underscored the need for more conflict-specific guidance.[19]

The What, Where, and How of Implementing WCH Interventions: A Look Across 10 Countries
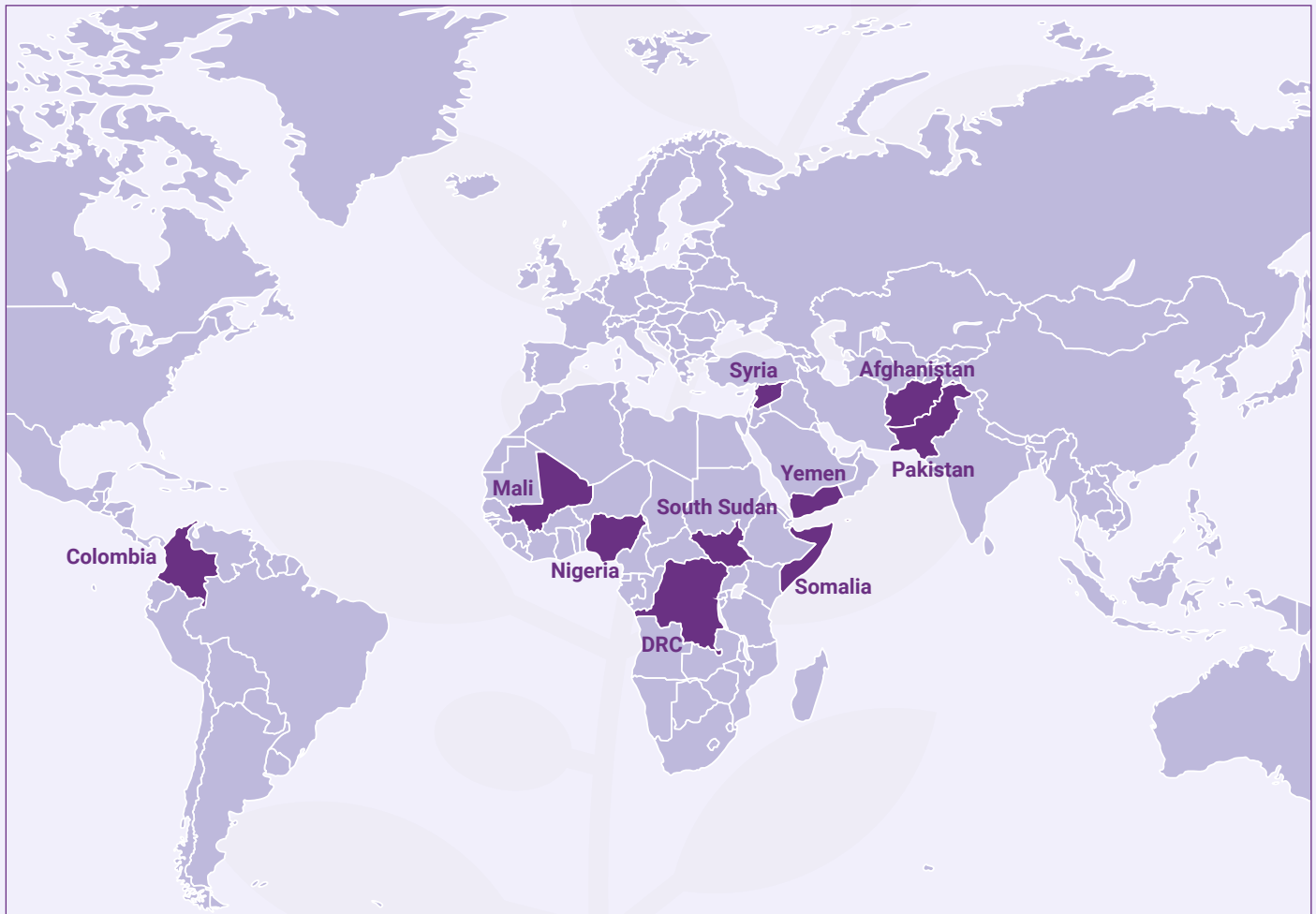
Despite large variations in contexts and decision-making processes, it was found that antenatal care, emergency obstetric and newborn care (EmONC), immunisation, treatment of common childhood illnesses, infant and young child feeding (IYCF) and malnutrition treatment and screening had been prioritised for implementation in all ten conflict settings studied.

On the other hand, **there were many interventions neglected in most countries despite the need**. For example, most reproductive, newborn and adolescent health services were not reported as being delivered in the ten conflict settings, and interventions to address stillbirths were absent. The provision of contraception was also not a primary focus of the implementing stakeholders, particularly in countries where religious and cultural practices affected the acceptability of such services such as in Afghanistan, Mali, Nigeria, Pakistan, Somalia and Yemen. Policy and political environments also influenced the provision of contraception, e.g., in Colombia, family planning interventions were mainly restricted to urban areas, excluding access among rural populations, and DRC continued to enforce a

law prohibiting the sale and use of contraceptive methods for young people and adolescents.

Adolescent health was another area that was apparently neglected, with the majority of the case studies reporting no evidence of implementation of adolescent-focused interventions, with the exception of limited reproductive health programming for adolescents in DRC and Somalia led by international humanitarian organisations.

In other instances, **international donors were influencing the what, where, and how of implementing WCH interventions**. In Afghanistan and Pakistan, for example, there was a specific focus on polio campaigns which had been prioritised due to funding opportunities rather than relative need.[19]

These practical country cases highlight reported gaps in service prioritization and the need for clear guidance on what interventions to implement, to which populations and how.

Syria:
Need for Prioritization and Information on Needs to Inform Prioritization

As the crisis progressed and needs intensified in Syria, the shift in service prioritization from local actors to international humanitarian actors influenced the types of interventions delivered and their coverage. Delays in family planning services also occurred due to certain donors refusing to fund such services, and governing authorities restricting service delivery in certain geographic areas. Weak public facilities that either slowed down in the pace of services, stopped services, changed locations or suffered from a lack of local healthcare staff led to the further disruption of establishing family planning, among other, services.

Programs and services that were not prioritized or funded pre-conflict continued to be neglected during the conflict, despite continuing need. A re-assessment of service needs during the conflict would have been beneficial, specifically including interventions around family planning programs and adolescent-specific services.[20]

Yemen:
Meeting Basic Needs

In the context of conflict in Yemen, **current priorities were generally described as "meeting basic needs" and "keeping basic services functioning", with such interventions taking precedence over longer term investments in health system strengthening.**

In those urban centres that were away from the frontlines of the conflict, there was more consistent attention to a broader range of women's and children's health needs (e.g., obstetric, maternal and newborn care). However, family planning was neglected as it was not seen by the government and decision-makers as a priority or urgent need in comparison to disease outbreaks, for example. Furthermore, adolescent health programming was not mentioned by study respondents, and most were unaware of any programs or health services specifically for adolescents.[21]

Pakistan:
Influence of Partners and Funding Agencies

There was no uniform, formal mechanism for government prioritization of health and nutrition services for women and children in conflict areas in Pakistan. Most of the decisions were made at the center (Islamabad), and after devolution of powers in 2011 at the provincial capital, these **decisions were majorly influenced by development partners and funding agencies.** Prioritization of interventions was done through needs assessments (e.g., collection of baseline data) and desk-based literature reviews, however **response strategies were formed at the centre with little or no involvement of stakeholders at the peripheral level.**[22]

Afghanistan:
Government-driven Prioritization

The priority of health service delivery in Afghanistan has been on those health and nutrition services for women and children that were offered through the Ministry of Public Health's Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS), developed to improve health services, with a focus on maternal and child health. However, the **BPHS and EPHS have not fully and comprehensively met the health needs of the Afghan population.** There was less or no priority given to important areas including non-communicable diseases, mental health, and injuries which share the major burden of disease. **The specific focus has also been on the primary healthcare model, mainly addressing basic health needs, and this has affected tertiary and specialized quality care.**[23]

Across the ten country cases, instead of being driven primarily by assessed local needs and feasibility of implementation, decisions were often "the fruit of a negotiation process between the international organisations and the national authorities, but also between the humanitarian organisations themselves."[19] Donors also often influence, and at times set, intervention priorities, including the *what*, *where* **and** *how*. **A key driver of effective intervention implementation remains access to the right resources, including financial resources from international donors and expertise from national and international organisations.**[19]

Conclusions and Next Steps

There is an apparent global need to systematically develop, disseminate and evaluate additional guidance for addressing WCH needs in conflict settings, including guidance on determining what interventions to prioritize and how to implement them. In addition to requiring better data on the burden of morbidity and mortality among population subgroups in different conflict contexts, the development of better guidance also requires a better understanding of the effectiveness of different strategies for identifying and then implementing the most appropriate interventions in different conflict contexts. This would require **further work to strengthen the evidence base through improved data collection and analysis and more operational research and evaluation, particularly on implementation and scale-up strategies in different conflict contexts**. Additionally, testing and evaluation of models for community engagement in humanitarian health programming for women, newborns, children and adolescents, along with locally driven processes, would also be useful to informing guidance.[24]

In the meantime, **as a preliminary step toward filling the guidance gap around WCH, the BRANCH Consortium proposes a conflict-specific decision-making framework to systematically guide intervention prioritization in different conflict contexts.**[10] (*See Summary Brief 3 - Women's and Children's Health in Conflict Settings: Prioritizing and Packaging Health Interventions - Deciding What to Deliver, When and How.*)

Explicitly taking into account local burden and risks, the range of potential interventions to address local burden and risks, and the feasibility of delivering those interventions in the local context, such a framework would help to empower decision-makers (such as governments and local and international humanitarian agencies) in conflict settings to better navigate and adapt the broader humanitarian guidance in specific contexts, especially in the face of donor influence.[10] The application of such a framework could also make decision-makers more accountable for what ultimately gets delivered, promoting explicit justification for decisions that are made and executed in a given setting.[24]

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:

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 need for more evidence-based guidance on identifying and implementing priority WCH interventions in conflict settings, please refer to this BRANCH paper.