

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



Comprehensive, Sustainable and Needs-Based Health Financing

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 health financing.**

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 health financing, 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

Health financing is an important aspect to consider when ensuring essential health services are delivered to populations in need within a conflict setting, over the course of the conflict and beyond. Sustainability of programs that are also adaptive is imperative. 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.³⁻⁶

Across the 10 countries that were researched - Afghanistan, Columbia, Democratic Republic of the Congo (DRC), Mali, Nigeria, Pakistan, Somalia, South Sudan, Syria, and Yemen - most NGOs reported have a high degree of **dependency on donor funds**, putting them in a situation where many WCH programmes and services are determined by the donors, many of whom are external to the conflict and/or the geographical location of the country, in some cases causing them to be far **removed from the actual needs of the community seeking services**.^{3,4,7-16}

SYRIA: Funding Sexual and Reproductive Health Programmes and Services

In Syria (and Colombia), it was reported that donors sometimes determined where and how to execute strategies which often limited the effectiveness of WCH interventions.^{7,8}

In relation to Sexual and Reproductive Health (SRH), limited funding was noted as a barrier mainly due to competing needs during conflict and the lack of attention that is often given to adolescent health, among other reasons. For example, family planning programming was commonly reported as an underfunded program with insufficient resources and capacity to continue these efforts during conflict.^{7,8} Gender-Based Violence (GBV) and unwanted pregnancies was also reported as being higher in conflict settings, yet funding and support for these types of programs was not always provided in the package of WCH services in such conflict settings.⁷

Furthermore, there are often numerous donors providing financial aid to a region each with **differing interests**, making it even more challenging for service providers and other humanitarian actors to provide coherent WCH services that meet the needs of the population (e.g., Somalia, Afghanistan).^{9,10}

SOMALIA: Short-term versus Long-term Needs

In Somalia, while funds were provided to address the urgent emerging needs of the population, there was a lack of funding and investment given towards addressing the longer-term concerns of the population – in particular, the long-term needs of women, newborns, children, and adolescents. The prioritization of key (WCH) interventions was often mandated by a donors' priorities, which focused on providing immediate humanitarian assistance rather than development.⁹

AFGHANISTAN: Diversified Funds and Inconsistent Programming

In Afghanistan, major funds were received from a range of donors; however, these available funds were insufficient to tackle the health needs of the population and created a major barrier in the successful implementation of WCH programs. Different donors also resulted in different program interests and incoherent services that could be offered to WCH in conflict settings. At times, the funds were also diverted to towards war and security efforts in light of the fragile context of the country.¹⁰

Budget allocation also took place at the central level which had a lack of capacity resulting in delays in the release of funds, inadequate distribution of funds (between the districts and the health facilities), and improper utilization of funds which all posed as major barriers to the successful implementation of WCH programs.¹⁰

The levels and conditions tied to the various funds varied greatly between the contexts researched. **Unresponsive funding mechanisms, political interference in services, competition to get access to funding, and delays in the release of funds contributed to gaps in funding, and more often gaps in service delivery.**³ **Corruption** among governments in some countries also affected how donors distributed funds and to whom, with most of the funds housed within international organizations as a result.³

Infrastructure and operational costs (i.e., the expenses that must be met to implement activities for a project or organization) are important costs to consider when providing effective (WCH) service delivery. However, as reported in several countries, donors were reluctant to invest in these costs (e.g., Pakistan, South Sudan).^{11,12}

**DRC:
(Under-) Utilization of Services**

In the DRC, free health care promoted by international humanitarian actors clashed with the user fee policy of the MoH. This often led to some services being utilized, with many others being under-utilized. The expectations of the communities accessing these services was also creating confusion and mistrust.¹³

Without sufficient funding for all programmatic costs, programs run the risk of not being able to provide a full range of services and/or providing poor service quality. Additionally, multi-year programs which address the root causes of insecurity and better respond to population needs during protracted crises also lack funding due to *reluctant donors*.

**NIGERIA:
Insufficient Financial Resources**

In Nigeria, insufficient financial resources led to certain planned WCH interventions being compromised, and instead the use of an excessively limited “triage” or “prioritization” of the most urgent needs was conducted. The availability of funds, or lack thereof, was reported as one of the most important factors that impeded needs-based decision-making, negatively influencing decisions in the area of how to prioritize the most urgent and critical and lifesaving WCH interventions, and often impeding WCH programming.¹⁴

The cost of (WCH) service provision in conflict settings is often more challenging, with services that were otherwise provided often disrupted and additional services needed. In some cases, funds that were allocated for one type of service were often channelled into another service for various reasons, *disrupting the flow of service delivery*, (e.g., Pakistan, Yemen, Mali).^{11,15-17}

**PAKISTAN:
Disconnect in Decision-Making and
Programming Needs**

In Pakistan, most of the decisions around WCH programming were made at the center hub (Islamabad) and these decisions were majorly influenced by development partners and the funding agencies, with no needs-assessment (baseline data) conducted, and little or no involvement of stakeholders, including local NGOs.

Gaps in capacity at various levels of the government also impeded the efficient utilization of funds and at times funds were enough but underutilized. The specific WCH programs that were in place and operated and funded by various agencies also usually lacked a funding sustainability mechanism and often programs terminated abruptly when funding from the donor subsided.¹¹

POLICY IMPLICATIONS

The role of donors and the provision of financial aid to determine the WCH services needed in a given population, as well as to enable the delivery of select health services to populations in conflict settings is a crucial one. Without this monetary aid, WCH programmes and services would be drastically minimized, and the delivery of health services would be even more challenging. There is a growing need for services for women, newborns, children and adolescents in conflict settings, and a clear need for enhanced funding for action in such settings.^{3,5} There are also multiple challenges in financing the humanitarian health response - who funds what services to whom, where does this money go and who is ultimately accountable.³

Based on the BRANCH Consortium's key research findings and recommendations, several policy asks have been suggested for various humanitarian actors to consider when providing financial aid for WCH services and delivery of services in conflict settings, which also lead to varying models of health financing provision to be considered.^{3,5,7-16,18}

1. Comprehensive financing of programs and packages of services

All operational and programmatic costs (direct and indirect) are needed to ensure that a comprehensive set of WCH programs and services can be delivered.

It is important for donors to ensure that full spectrum of essential WCH services (in particular SRH services) are provided to women, newborns, children, and adolescents in conflict settings by designating funds for such programming and services to continue, or even expanding such services.

It would also be beneficial for donors to **consider the total cost of providing services and interventions to WCH in conflict settings (both direct and indirect costs)**,^{3,18} as operational and infrastructure costs and the like are also important to secure when implementing programs in conflict settings. Without sufficient funding for all programmatic costs, programmes run the risk of not providing a comprehensive set of services or closing due to insufficient costs to run the program.

Funding for immediate needs and long-term (post-conflict) needs also needs to be taken into consideration.

2. Sustainable financing

Multi-year, unmarked and diversified funds would help ensure continuity of WCH programs, as well as programming that fits the ever-changing needs of populations in conflict and post-conflict settings.

The use of **multi-year programs** would ensure consistent programming over the course of ongoing conflict and prevent gaps in service delivery for WCH.^{3,19} **Unmarked funds** would also enable programmes to fill in gaps in programming and service delivery that often emerge due to the ongoing shifting WCH needs during conflict. In the case of Somalia, the use of emergency pooled funds greatly helped channel funds into specific WCH program and service needs that arose due to the changing landscape of the conflict.⁹ This can mitigate the challenge that often arises when different donors have different program interests and the level of diversified services become difficult to fully implement.

It is recommended that **funds from different donors be sought, to ensure the continuity of WCH programs** in conflict settings in the event that funding is pulled, or the release of funds is delayed, with funds allocated to local partners to ensure funds are dispersed and utilized where needed and when needed and reducing any gaps in service delivery.^{3,5}

The use of other UN organizations was another strategy that helped diversify the use of funds when the need arose, as was the case in Yemen.¹⁵ It was also noted that **UN agencies were better able to rapidly mobilize funds** when needed, serving as another advantage.

3. Needs-based financing

Placing funds at the local level has been shown to lead to more services and programs that are directly in line with the needs of women, newborns, children, and adolescents, better flow of WCH service delivery, more funds to be given to direct services in conflict settings, and less corruption.

The further **localisation of humanitarian response** (i.e., placing the core decision-making on implementation of programs and services at the local level) is now established as a key normative principle of humanitarian action by the Grand Bargain initiative, now with more than 60 donor, UN agency, NGO, and Red Cross Red Crescent Movement signatories.^{5,2} The agreement was initially made between a range of donor governments and humanitarian organizations at the 2016 World Humanitarian Summit to improve the efficiency and effectiveness of humanitarian aid. This initiative is supported, along with the implementation

and regular monitoring of a more localized health response.

Besides localizing response, ensuring funds are placed at the local level is also effective.²⁰ Corruption and political interference in service and program provision is a valid concern, however funding that is given directly to the local organizations providing WCH services in conflict settings allows for better flow of service delivery with more funds channelled into direct services, alignment of funding with the actual needs of women, newborns, children and adolescents, and better collaboration among key local stakeholders providing services and resources.⁵

CONCLUSIONS

In the world of health financing, there are many other factors to consider in addition to the amounts being given - who gets the funds, how those funds are allocated, if the funds are earmarked or pooled, and who has access to the funds are all important points for consideration. Understanding the competition to get access to funding is also important. Together, these factors also not only impact the types of (WCH) services that are being delivered, but how these services are delivered to the population.

Several solutions or facilitators to ease these barriers have been suggested with recommendations given for NGOs, IOs, donors and governments around health financing and service provision.

For instance, ensuring financing for a comprehensive package of services, including both direct and indirect programmatic and operational costs, for immediate and long-term (post-conflict) needs. Sustainable financing, along with unmarked, multi-year and diversified funds to ensure continuity and consistency of WCH programs and services in ever-changing conflict and post-conflict settings. Seeking funds from different donors, especially considering gaps in funding is a commonly identified problem across regions and contexts. As well as localizing the humanitarian response (i.e., giving funding directly to the local organizations providing WCH services in conflict settings).³

Innovative humanitarian health financing would also lead to expanding the types of donors and create new financing mechanisms for (WCH) programs and services.¹⁹

Generating more accurate, readily available, and actionable information around funds and allocation of funds and resources for WCH in conflict settings, along with substantial investment in methodological and technological innovations for rigorous data collection and analysis in these settings would be a useful next step to help inform policies around financing WCH in conflict settings and provide needed direction as to the funding needs of various conflict contexts.⁵

Ultimately, **health financing is a collective effort** and is not just the sole responsibility of the donor to provide funds, but also of the recipients to properly manage the funds.

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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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