Addressing women's, children's and adolescents' health in conflict settings in the Middle East and neighbouring countries:

A focus on leadership, governance, human resources and financing mechanisms

Contents

Acknowledgements

Problem statement

Weak health system governance, leadership and coordination, along with insufficient health workforce and financing mechanisms, have hindered access to quality essential health care services for women, children and adolescents in conflict-affected contexts. Universal health coverage and many of the Sustainable Development Goal (SDG) targets can only be achieved if urgent attention is paid to conflict-affected settings worldwide and to the health needs of women, children and adolescents (WCA) residing in them, including those who have been forcibly displaced.

Background

The World Health Organization's (WHO) Eastern Mediterranean Region (EMR) is a diverse region comprising 21-member states and occupied Palestinian territory (including East Jerusalem). It accounts for approximately 745 million people *(1)*. Spanning from Middle East and North Africa to Pakistan in Southern Asia to Somalia in Eastern and Southern Africa, this expanded regional classification contains some of the richest and poorest countries in the world *(2)*. Nine EMR countries[1] are listed in the World Bank's 2023 list of fragile and conflict-affected countries *(3)*. Six countries[2] experienced violent conflicts in 2021 and many other countries in this region have also experienced some form of crisis in the past few decades *(4)*. Since 2014 there have been more than 100,000 conflict-related deaths per year in this region *(2)*. Almost two-thirds of all refugees worldwide originate from countries in the EMR *(5)*.

War and conflict have continued to have a detrimental impact on the health and well-being of WCA in WHO's EMR. The region experiences some of the highest rates of maternal and child mortality, and the lowest levels of health coverage in the world. Reductions in maternal, newborn and child mortality have also been slower in conflict-affected countries compared to the rest of the region.

By working collectively, the global community can make a real difference. Each stakeholder has a critical role to play in ensuring women, children and adolescents in fragile and conflict-affected settings receive the care they need and are not forgotten in the journey to achieve universal health coverage and the SDGs.

In response to this need, PMNCH has been at the forefront with key partners driving coordinated and evidence-based advocacy calling for equity, and for the improved health and well-being of WCA in humanitarian and fragile settings.

This includes conflict-affected contexts. In January 2021, PMNCH supported the release of the BRANCH (Bridging Research & Action in Conflict Settings for the Health of Women & Children) Consortium Lancet Series on Women's and Children's Health in conflict settings. The evidence from this series emphasized that much still 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 WCA health and well-being in conflict settings.

To further enhance advocacy and action for improved WCA in conflict settings, the BRANCH Consortium and PMNCH have collaborated with the American University of Beirut's Knowledge 2 Policy Centre (K2P), to host a series of regional multi-stakeholder virtual workshops, including in EMR to promote multi-stakeholder policy dialogue and uptake of new and critical evidence. The workshops thus brought together stakeholders with a view to strengthen dialogue amongst stakeholder groups working on issues across the continuum of care. The aim was to foster responsive evidence-informed policy, financing and action for WCA health and well-being in conflict-affected contexts. The workshop in EMR brought together 50 stakeholders with varying expertise from governments, academic and research institutions, non-governmental organizations, adolescent and youth organizations, UN agencies, donor organizations, and health care professional associations. Participants were representatives from eight different EMR countries that include Lebanon, Jordan, Syria, Yemen, Afghanistan, Somalia, Egypt, and Pakistan. The outcomes of this dialogue and findings of a literature review led by the K2P Centre have informed the development of this report to support evidence-based advocacy efforts and action for more responsive policy around WCA health and well-being in conflict-affected contexts in EMR.

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1. The nine countries are: Afghanistan, Iraq, Lebanon, Libya, occupied Palestinian territories, Somalia, Sudan, Syria and Yemen.
2. Afghanistan, occupied Palestinian territory, Somalia, Sudan, Syria and Yemen.

Methods

This policy report was developed using a scoping review of existing systematic reviews and local primary studies by the American University of Beirut (AUB). To formulate the size of the problem and underlying factors, a search was conducted on UN, INGO and government websites. Peer-reviewed articles were also selected if they discussed evidence related to WCA health and well-being in the EMR region. WHO's regional classification has been used for the purpose of this report.

For the policy options, a search strategy was developed to search the following databases such as **PubMed, Medline, Health Systems Evidence, and Google Scholar** to identify relevant **systematic reviews**. Keywords pertaining to women, children, adolescents, humanitarian and fragile settings, governance, human resources, and financing were used to develop the search strategy. A total of 1684 articles were screened for their title and abstracts. Relevant studies were then included in the policy report options if they were conducted in low- and middle-income countries, humanitarian and fragile contexts, and addressed the efficacy of governance, financing and human resource interventions.

The screening resulted in a total of 22 relevant systematic reviews (See **Figure 1**). Additional studies were identified and included from the BRANCH Consortium policy briefs and based on the literature shared with us from the litmus testing interviews. Data was extracted on an Excel sheet which identified the themes related to **governance, human resources and financing**. The options were then formulated based on the **recurring themes** extracted from the studies. Implementation barriers and facilitators at the system, organization, institutional and individual levels were also identified from systematic reviews.

Following the finalization of the scoping review, a draft outline of the policy report was developed by the Knowledge to Policy (K2P) Center at the American University of Beirut (AUB). This draft served as the basis for litmus testing on approach and content of the Policy Report. K2P Center purposively reached out to 20 global stakeholders across PMNCH Constituencies (Non-Governmental Organizations (NGO), Donors and Foundations (D&F), United Nations Agencies (UNA), Partner Governments (PG), Adolescents and Youth (A&Y), Academic, Research and Training Institutes (ART). This step involved representation across the Middle East countries (Lebanon, Syria, Somalia, Afghanistan, Egypt, Yemen), Spain (AECID), Switzerland and the United Kingdom. Ten stakeholders across various constituencies (NGO, D&F, UNA, PG, A&Y, ART) with expertise and experience in WCAH conflict settings and the Middle East provided inputs and comments on the policy report (See **Figure 2**). Feedback from the litmus testing suggested that the report should include a sub-focus on Afghanistan given the acute crisis, the need for applying a gender lens, including information on gender-based violence (GBV) and highlight the need for improved focus on coordination and alignment, including the humanitarian-development nexus. Feedback from stakeholders has been consolidated by K2P to develop this updated policy report.

Figure 1

1,684 screening of abstracts and titles

1,662 excluded after screening of abstract and title (inclusion criteria not met)

22 full text systematic reviews included

l-text articles selected 22 full text systematic reviewed articles assessed for eligibility

Figure 2

Stakeholders across PMNCH constituencies contacted to develop the policy report							
Academic, Research & Training Institutes	Healthcare Professional Associations	Donors & Foundations	Adolescents & Youth	Non-Governmental Organizations	Partner Governments	United Nations Agencies	Civil society Organizations

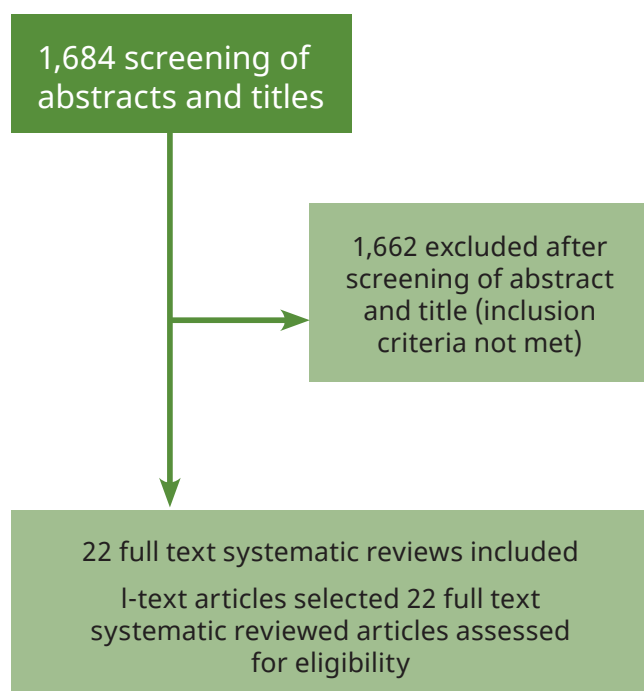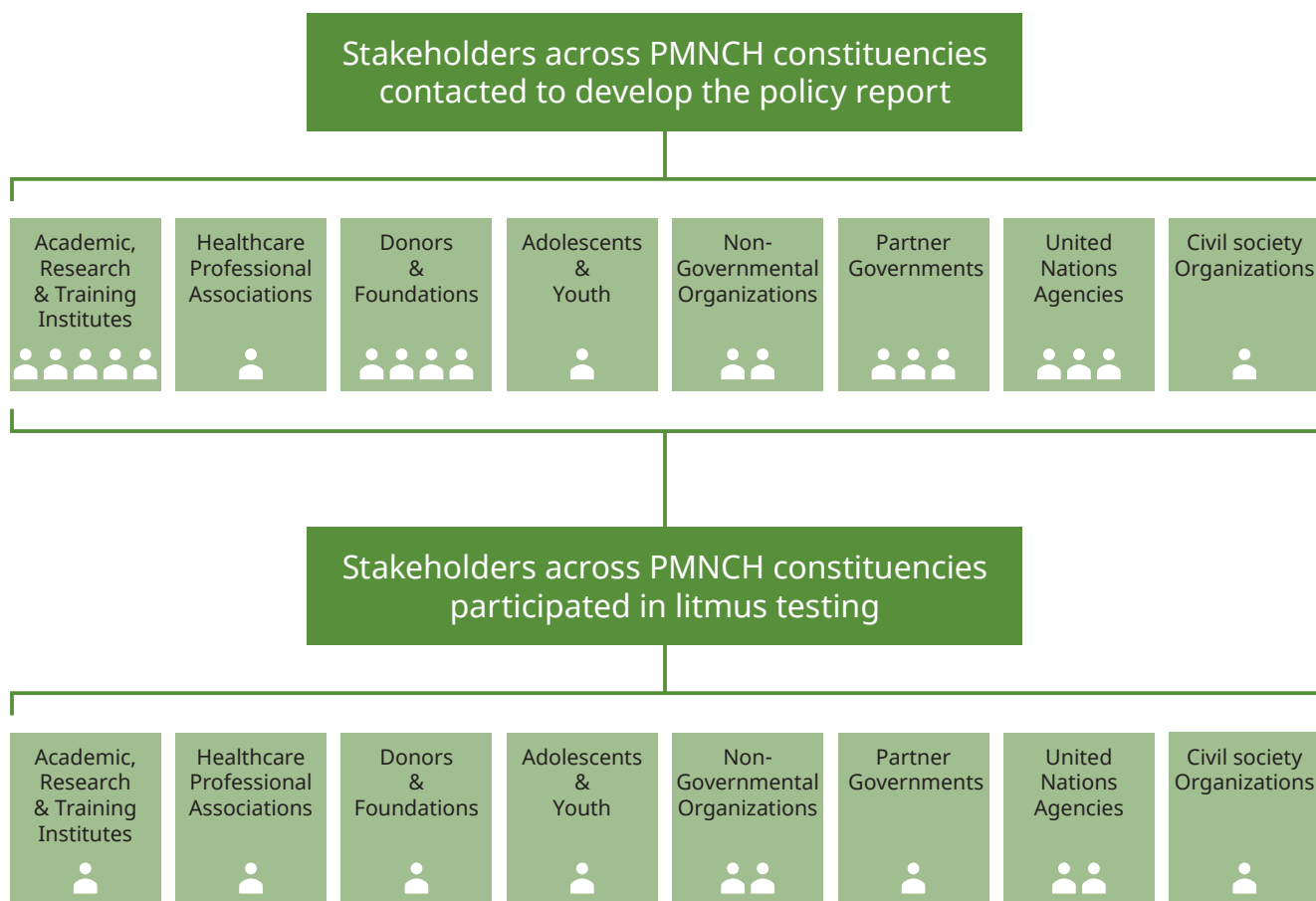| Stakeholders across PMNCH constituencies participated in litmus testing							
Academic, Research & Training Institutes	Healthcare Professional Associations	Donors & Foundations	Adolescents & Youth	Non-Governmental Organizations	Partner Governments	United Nations Agencies	Civil society Organizations

The effects of conflict on women's, children's and adolescents' health

Maternal and child health

Conflicts in the WHO EMR have significantly impacted WCAH and well-being. Maternal mortality rates in conflict-affected countries in the region such as Somalia and Afghanistan are amongst the highest in the world (**Table 1**). Similarly, rates of under-five and neonatal mortality are considerably higher in EMR countries affected by conflict (**Table 2**). Afghanistan, Pakistan and Somalia recorded stillbirth rates of more than 25 deaths per 1000 births in 2021, some of the world's highest rates *(6)*.

Whilst overall maternal and child mortality rates have fallen in the region over recent decades, gains have been far slower in conflict-affected countries.

For example, in Iraq, infant mortality rates only decreased from 24 deaths per 1000 live births in 2015 to 21 deaths per 1000 live births in 2020 *(7,8)*. A similar trend was also seen in the neonatal mortality rate which decreased from 16 deaths per 1000 live births in 2015 to 14 deaths per 1000 live births in 2020 *(6)*. The lack of routine national data collection and statistics in many conflict-affected countries is contributing to gaps in timely and reliable data.

Child, adolescent and youth health and well-being

In the EMR, adolescents and youth represent more than 25% of the population *(11)*. Conflict and insecurity have both immediate and long-term impacts on their health and well-being *(11)*. The adolescent mortality rate in EMR is the second highest after WHO's Africa Region *(12)*. According to the most recent estimates available (2019), while communicable, maternal, perinatal and nutritional conditions and injuries cause a higher proportion of death amongst adolescents, the Middle East and North Africa was uniquely characterized by having collective violence as the leading cause of death *(13)*. For instance, in 2022, UNICEF reported that since the conflict escalated in Yemen nearly seven years ago, the UN has verified that more than 10 200 children have been killed or injured. The actual number is likely much higher *(14)*.

Table 1: Maternal mortality ratios, 2020 *(9)*

WHO EMR country	Maternal mortality ratio (deaths per 100 000 live births)
Somalia	621
Afghanistan	620
Sudan	270
Djibouti	234
Yemen	183
Pakistan	154

Table 2: Under-five and neonatal mortality rates, 2021 *(10)*.

EMR country	Under-five mortality rate (deaths per 1000 live births)	Neonatal mortality rate (deaths per 1000 live births)
Somalia	112	36
Pakistan	63	39
Yemen	62	28
Afghanistan	56	34
Sudan	55	27
Djibouti	54	30

Adolescents and youth living in conflict settings are at a higher risk of suffering from mental health disorders *(15)*. One study showed that the suicide ideation prevalence among Palestinian middle school students residing in the occupied Palestinian territory was 25.6% *(16)*. In contrast, Palestinian middle school students residing in other EMR countries such as Jordan, United Arab Emirates and Kuwait had lower prevalence of suicide ideation *(16)*. Other studies, looking at the burden of mental disorders in the EMR also show that approximately 37.4% of Iraqi school children and 22.2% of Afghani school children suffer from mental health disorders *(17)*. Furthermore, Save the Children reports that almost one in five of all recorded suicide attempts and deaths in north-west Syria are among children, with a total of 246 suicides and 1748 attempts recorded in just the last three months of 2020 *(18)*.

Adolescent girls are at an increased risk of gender-based violence in humanitarian settings because of the intersectionality of their age and gender coupled with the additional and exacerbated risk factors relevant to emergencies *(19)*. Research conducted with Syrian refugee girls residing in Egypt showed that disruptions in education, and livelihood insecurity resulting from displacement, also increases girls' vulnerability to early marriage *(20)*. In Yemen, studies have estimated that approximately one in five displaced girls between the ages of 10-19 were married; compared to one in eight girls in the host community *(21)*. Similarly, in Iraq, the prevalence of child marriage was highest among the internally displaced population compared to refugees and host communities *(21)*.

Impact of the COVID-19 pandemic on women's, children's and adolescents' health

The COVID-19 pandemic has impacted the availability of health care services globally, especially for marginalized and vulnerable groups in conflict settings. Reduced access to sexual and reproductive health services and pandemic restrictions worsened WCAH outcomes. The pandemic also resulted in a global increase in the prevalence of gender-based violence *(22)*. The EMR had the second highest prevalence of violence against women globally, reaching 37.7% during the pandemic *(23)*. Cases of intimate partner violence increased by 50%-60% in the EMR *(22)*. In Somalia, studies showed an increase in female genital mutilation *(24)*. It is also speculated that the pandemic would increase the risk of child marriage and adolescent fertility in countries across the EMR *(25)*.

System-level barriers to improving women's, children's and adolescents' health in EMR

Governance and leadership barriers

Armed conflict and the political unrest have deteriorated many health systems in the EMR. In addition to infrastructural damage to health facilities, armed conflicts and wars have contributed to poor health governance structures which affect health care delivery. In Somalia, for example, the conflict and civil war have led to a dysfunctional public health care system and proliferation of unregulated private sector providers of health and nutrition services *(37,38)*. In Yemen, war has led to the formation of separate health authorities in different parts of the country. Poor coordination amongst these authorities has weakened the health sector. Weak coordination among different actors (i.e., private sector, public sector and NGOs) and political interference in the health sector has also affected the delivery of health services in Afghanistan, Pakistan and Somalia *(37,39)*. During conflict, the strong presence of the humanitarian sector often leads to the creation of parallel health governance systems. This introduces additional coordination challenges. For example, in Syria, the presence of multiple coordinating bodies implemented by humanitarian actors and the government negatively impacted coordination *(40)* (see **Box 1**). Misalignment between donor and population priorities is also a contributing factor to poor coordination and often results in the duplication of efforts *(41-43)*. There is an urgent need for strong leadership and governance in the EMR to improve the health of women, children, and adolescents.

There is increasing evidence that the inclusion of women in leadership positions increases gender equality, improves health outcomes, and strengthens the durability of peace. Furthermore, it has been argued that rebuilding health services can play an essential role in promoting social cohesion in a nation's post-conflict recovery stage. Strengthening health systems in conflict settings through women's leadership may therefore support the dismantling of entrenched gender-blind social institutions *(44)*.

Policies to address gender inequality and lack of female representation in leadership roles are insufficient across EMR, contributing to poorer WCAH in the region. Countries such as Yemen and Iraq, for example, continue to lack policies which prevent female genital mutilation, putting women and girls at risk *(45)*. Similarly, while women have contributed significantly to the health system throughout the Syrian conflict, they've remained invisible in leadership roles. The COVID-19 pandemic has further reinforced gender barriers and inequalities. The COVID-19 taskforce in north-west Syria, for example, has one woman and almost 30 men at its helm *(46)*. These persistent inequities hinder progress in countries towards strengthening governance systems *(45)*.

Delivery barriers

Conflict and political instability have jeopardized health care delivery in conflict-affected countries in the EMR. Some of the main challenges faced in these countries include poor infrastructure, inadequate response to population needs, reliance on NGOs to deliver services and the shortage of health care workers and health care centres. The destruction of health facilities and transport infrastructure in Afghanistan, Pakistan and Yemen, for example, has rendered health care services inaccessible for people, especially those residing in rural areas *(39,43,47)*. The situation in Yemen is particularly critical, with reports from 2022 suggesting that more than 20.1 million people (out of a total population of 30.5 million) currently lack access to basic health care and only 51% of health facilities across the country still function *(48)*.

Poor programme design is another challenge for many conflict-affected countries where services do not reflect the health needs of the population. In Somalia, for example, the prioritization of key interventions is often assigned by donors and mainly respond to immediate needs rather than strengthening health care services to address all current and future health challenges of a population *(37)*. Similarly, in Afghanistan, health programmes have failed to address important areas including communicable diseases, mental health and injuries that contribute largely to the burden of disease in the country *(39)*.

Box 1:

Women's, children's and adolescents' health in conflict settings: The case of Syria

The Syrian conflict started in March 2011 when a popular uprising in the south of the country was met by a security response that resulted in further unrest and escalation within the country *(26)*. Prior to the crisis, Syria was classified as a middle-income country with a robust national health system, a growing private sector and little reliance on civil society organizations. National commitment contributed to nearly 30 years of progress in health indicators; with Syria achieving 85% and 68% of its Millennium Development Goals (MDGs) 4 and 5 targets respectively. The situation in Syria has raised concerns regarding health system resilience and the lack of emergency preparedness in a wider region that has been particularly prone to conflict *(27)*.

Since 2011, the protracted crisis, political destabilization, targeting and destruction of healthcare facilities, attacks on health workers, and an exodus of well-trained health professionals have led to the partial collapse and fragmentation of the healthcare system *(26)*. Out of more than 1380 reported attacks since the start of the conflict, Physicians for Human Rights has documented and verified 601 attacks on at least 350 health facilities *(28)*. At its peak in 2017, an attack was recorded every 36 hours *(27)*. The killings of over 942 medical staff have been recorded since the start of the conflict, as well as systematic detention and torture of health workers *(29,30)*. Since the beginning of the civil war in Syria, it has accounted for 25% of all recorded killings of health workers in conflict areas globally (February 2011-November 2022) *(31)*.

More than 65% of households interviewed by the International Rescue Committee in north-eastern Syria since the start of 2021 reported that they faced difficulties accessing health care *(32)*. One study found that 59% of female participants were apprehensive and afraid of seeking health care for themselves and their children *(28)*.

Research from the BRANCH Consortium suggests that the partial breakdown of the healthcare system and weak coordination of humanitarian responses led to gaps in service delivery and coverage along the WCAH continuum of care including an increased risk of infectious disease outbreaks and challenges in accessing reproductive, maternal and child health interventions *(27,29)*. There is some evidence to suggest that limited access to antenatal health services and the de-prioritization of family planning and adolescent health by health administrators have contributed to increases in both maternal and infant mortality rates *(27,38,33)*. According to some humanitarian agencies, fewer pregnant women receive care during pregnancy and the number of infants born with deformities has increased *(28)*. Polio, which was thought to have been eradicated in Syria, has made a resurgence *(34)*. The COVID-19 pandemic has introduced additional barriers to care in an already overstretched health system *(19)*. Reports indicate that women and girls also had limited access to COVID-19 care *(28)*.

Health system functionality, accessibility and governance varies across this particularly heterogeneous setting *(27)*. The conflict fragmented territories across different governing authorities, resulting in a complex coordination and implementation structure known as the whole of Syria approach *(35)*. A unique multi-hub response was also established to improve coordination of humanitarian responses and strengthen the provision of WCAH and nutrition interventions. Despite challenges regarding fluctuations in border crossings, the adopted remote management strategy has permitted humanitarian agencies to expand their reach and serve populations in need of healthcare in often inaccessible areas *(35)*.

To help overcome barriers to care, civil society organizations such as Hand in Hand for Syria and the Syrian American Medical Society are training community health workers (CHWs) to fill the gaps left by health workers who fled the country. Skills-shifting and training programmes are helping to equip Syrian health workers with urgently needed surgical and intensive care skills. Digital health technologies are also being used to increase the capacity of health workers and reach underserved communities *(36)*.

Another factor affecting service delivery in conflict-affected settings in EMR is the high dependence and reliance on NGOs in the delivery of health care with minimal-to-no provision from the government. This is the case in Somalia and Afghanistan as well as in areas of Syria not controlled by the government.

A shortage and unequal distribution of health workers limits the accessibility of health services in the EMR. The negative impacts of these health workforce shortages are amplified in conflict settings where access and security concerns have severely limited availability of qualified and specialized health workers *(49,50)*. Many countries across the region are characterized by the uneven distribution of health workers across urban and rural areas *(51)*. In Sudan, for example, more than 70% of health professionals work in the capital, which is home to only 30% of the population *(51)*. 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 *(50)*. In Yemen, lack of incentives to retain members of the health workforce resulted in high health facility staff turnover and the health cluster estimated in August 2021 that more than half of deliveries occurred under risky conditions without a skilled caregiver *(50,52)*.

Security is a major factor for health worker recruitment and retention *(51)*. Attacks on healthcare are a common feature for the region. In 2021, while the number of violent incidents against health care in Syria and Yemen declined, explosive weapons continued to be used in attacks on hospitals *(52)*. In Sudan, health workers have been targeted and arrested following coups *(52)*. Despite global commitments and international law, health care in conflict-affected countries, including in EMR needs to be better protected *(53)*. Greater efforts are required to uphold and support the implementation of these global commitments and international law to protect health care providers and facilities in humanitarian contexts *(53)*. Greater investments, national policies and locally led efforts are also needed to strengthen systems that prioritize quality of care and the training, recruitment, retention, safety and security of health workers. Greater representation of nurses, midwives and other frontline health workers is also needed in senior decision-making positions *(54)*.

Finance barriers

Due to limited governmental budgets, conflict-affected countries in the EMR primarily depend on international donors to fund health programmes *(55)*. Recent evidence in Pakistan, Somalia, Sudan, Syria and Yemen shows that the reliance of many NGO health providers on external assistance means that health programmes are often determined by donor priorities rather than the needs of communities *(56)*. In Afghanistan and other countries, dependence on short-term and unpredictable aid also negatively affects the sustained availability of essential WCAH services *(37,39)* (see **Box 2**)*. For example, a case study on Somalia, funding is often earmarked to address urgent needs with inadequate budgets to address the longer-term needs of women, newborns, children and adolescents or to address systemic barriers to health *(37)*. Similarly, evidence from Syria suggests that donors sometimes determined where and how to execute strategies which often limited the effectiveness of WCAH interventions *(35)*. In the case of Yemen, while the humanitarian response plan was one of the better funded worldwide, financing has primarily been short-term with major donors drastically decreasing their funding since 2020 *(58)*. Across conflict-affected parts of EMR, programmes for family planning and gender-based violence are routinely underfunded *(37)*.

Box 2:

Donor dependence: The case of Afghanistan

In August 2021, the Taliban seized control of the Afghanistan government. Consequently, assets of the Afghan Central Bank were suspended, and donor funding was discontinued *(59)*. Due to the withdrawal of funds, the Sehatmandi programme, one of the country's largest health care delivery systems has been on the brink of collapse and only 17% of clinics were said to be functional *(60)*. Access to primary health care services, medications and medical equipment became more challenging *(60)*. More than half of the population, 24.4 million people, need humanitarian assistance, including 12.9 million children. Multiple disease outbreaks (measles, acute watery diarrhoea, dengue, COVID-19) are ongoing *(61)*.

Even prior to the new government, 75% of the people in need of humanitarian assistance were women, girls and children. The withdrawal of donor funds and the new governance have further impacted their access to essential services *(62,63)*. Women can only seek reproductive health care services from female health workers, further restricting health care accessibility *(64)*. According to Afghanistan's UN Resident Coordinator report from March 2022, 95% of Afghans are not getting enough to eat, with that number rising to almost 100% in female- headed households *(65)*. Recent data also suggests that 4.7 million children and pregnant and lactating women are at risk of acute malnutrition *(60)*, with more than one in two children under-five facing acute malnutrition and risk of death *(66)*. Moreover, 3.5 million children have dropped out of school, 75% of which are girls *(67)*.

To respond to this crisis, UN agencies have appealed for US$4.44bn to implement Afghanistan's humanitarian response plan. As part of this HRP, $378m and $287.4m are required by the health and nutrition clusters. Yet, only $171.9m (45%) and $203.4m (76%) have been secured till date *(68)*.

Additionally, PMNCH also issued a call *(69)*, on behalf of its 1200 member organizations, upon the global community to commit to the urgent and unwavering protection of women, children and adolescents by:

- Increasing financing for humanitarian assistance, including through emergency pooled funds to those in need and vulnerable to violence and exploitation;

- Exploring the possibilities to maintain development assistance through new funding channels to safeguard the health gains of the last decade;

- Immediately reinstating COVID-19 response and recovery plans;

- Strengthening global coalitions, including those with the private sector, to advocate at the highest possible level for the people of Afghanistan;

- Providing protection and resources to health professionals and aid workers, including access to essential medicines, vaccines, health commodities, equipment, and medical supplies;

- Implementing a gender-specific approach to all health policy and programming.

Policy options to address the barriers

To improve WCAH in conflict settings in the EMR region, interventions at the level of governance and leadership, human resources and financing need to be implemented.

Option 1:

Strengthen system-wide multi-sectoral collaboration among actors to improve health outcomes for women, children and adolescents in conflict settings in the EMR

Multi-sectoral collaboration refers to the deliberate efforts undertaken by various actors and sectors to achieve a specific outcome or policy goal *(70)*. Several systematic reviews report that inter-sectoral coordination and closer coordination among different health actors can result in improvements in service delivery and better health outcomes. Coordination between actors also increases accountability and enhances the flow of information and resources *(67,71-73)*.

Engaging stakeholders in decision-making and service delivery processes is also shown to have a positive impact on policy implementation, health worker performance and maternal health outcomes *(74-76)*. System-level integration strategies can also improve cost-efficiency across sectors *(77)*.

Category of finding	OPTION 1
Benefits	Two systematic reviews found that a multi-disciplinary approach to addressing child sexual abuse led to a decrease in depression, anxiety and posttraumatic stress, as well as a decrease in the number of substantiated child sexual abuse cases. It also improved accountability, case tracking and increased persecution of child sexual abusers *(78,79)*.
	One systematic review found that inter-sectoral linkages in mental health service delivery improved service efficiency and improved interagency communication *(77)*.
	One systematic review reported that the establishment of a unit by the Ministry of Public Health in Afghanistan to monitor service delivery and coordinate with other departments, plus the establishment of a public health directorate in each province to enhance coordination with NGOs, improved implementation of basic primary health service programmes and coverage of maternal health services *(73)*.
	Three systematic reviews found that engaging community members and CHWs in health service delivery and decision-making processes lead to better intervention delivery, improved clinical and social outcomes (i.e., decreased maternal and infant mortality), sustainability of the programme or policy and improved policy implementation *(41-43)*.
Potential harms	One systematic review reported that poor coordination among stakeholders resulted in the loss of information about child sexual abuse cases, poor accountability and deprioritization among decision makers *(78)*.
	One systematic review found that integration strategies implemented through earmarked funding did not lead to better client outcomes *(77)*.
Costs	One systematic review found that system level integration strategies are associated with improved cost efficiency across sectors *(77)*.
Uncertainties	One Cochrane review found that collaboration between local health and local government agencies had variable impact on health outcomes *(80)*.
	One systematic review concluded that financing integration efforts may not result in better integration at the local and macro-levels *(77)*.

Option 2:

Improve the provision of health services delivery through decentralization

Decentralization in the provision of health care services involves the delegation of power, resources, functions and responsibility for service delivery from the central government level to the local community or municipality level *(81,82)*. When local government authorities have been largely autonomous to make policy and operational decisions in line with the country's laws, improvements were reported in the efficiency of health resource management and enhanced resource allocations, accountability and priority setting *(81)*.

NGO financial stability has been found to be greater in countries with a decentralized political structure *(83)*. Municipalities with high administrative decentralization had fewer postnatal deaths than those that did not *(82)*. Despite the mentioned benefits, evidence remains uncertain on the impact of decentralization on health care system performance *(81,84)*. Some studies have suggested that the delegation of fiscal decisions to local governments can have harmful effects on local health spending *(82)*.

Category of finding	OPTION 2
Benefits	One systematic review concluded that decentralization improved efficiency in resource management in the health care sector and enhanced resource allocations, accountability and priority setting *(81)*.
	One systematic review also showed that decentralized political structures have a positive impact on NGOs' financial stability *(83)*.
Potential harms	One systematic review reported that transferring power of fiscal decisions to local governments had harmful effects on local health spending *(82)*.
Costs	The cost of decentralization was not reported in the literature.
Uncertainties	Two systematic reviews reported uncertainties concerning the impact of decentralization on health care system performance *(81,84)*.

Option 3:

Empower the health care workforce to improve outcomes for women, children and adolescents in conflict settings

Option 3.1. Strengthen the capacity of human resources in conflict settings in the EMR

Several systematic reviews showcase the benefits of education and training to strengthen the capacity of health workers in conflict-affected settings, including in countries in the EMR *(85-89)*. For example, peer-led training and support for lower-level health care providers such as traditional birth attendants lead to improved sexual and reproductive health outcomes and decreases in perinatal and neonatal mortality rates *(87)*.

In Somalia, training midwives in Emergency Obstetric care (EmOC) has enhanced the health outcomes of patients and reduced hospital-based mortality at first-level referral hospitals *(86)*. EmOC training in Pakistan also improved the knowledge and confidence of health care providers to recognize and manage emergency cases, make decisions, and record data *(86,89)*. However, evidence from approaches to recruit and retain midwives in other fragile and conflict-affected settings concluded that the evidence is uncertain in the capabilities of village midwives to detect, manage, and refer pregnancy and postpartum complications *(44)*.

Category of finding	OPTION 3.1
Benefits	One systematic review concluded that interventions that included training of lower-level health care providers and peer-led education and counselling have led to improved sexual and reproductive health outcomes *(90)*.
	One systematic review reported a decrease in perinatal and neonatal mortality rates in low and middle-income countries due to incorporating training and supporting traditional birth attendants (TBAs) as a means of expanding health coverage and quality *(91)*.
	EmOC training in Pakistan also improved the knowledge and confidence of health care providers to recognize and manage emergency cases, make decisions, and record data *(92,93)*.
Potential harms	No harms were reported in the literature.
Costs	The cost of such interventions were not reported in the literature.
Uncertainties	One systematic review conducted to examine community midwives' approaches from recruitment to retention in fragile and conflict-affected setting concluded that the evidence is uncertain in the capabilities of village midwives to detect, manage and refer postpartum or during pregnancy complications *(94)*.

Option 3.2. Widen the scope of practice of human resources in conflict-affected settings in the EMR: task-shifting and task-sharing

The benefits of task shifting and expanding health workers' scope of work to improve WCAH in conflict-affected settings have been widely reported *(37,92,95,96)*. For example, in Somalia, task shifting has been seen as a successful method for managing health worker shortages *(37)*. Task shifting in resource-limited settings is also associated with decreased neonatal and perinatal mortality rates *(95,96)*. Evidence from conflict-affected settings outside of EMR has shown that antenatal counselling by lay nurse aides improves maternal knowledge among women in prenatal care compared to those counselled by nursing midwives *(97)*. One systematic review across several countries including Afghanistan, Iraq, Yemen, and occupied Palestinian territories highlighted that involving more than one female traditional birth attendant and CHWs increased the usage of EmOC *(87)*.

Similarly, evidence suggests that Pakistan's Lady Health Workers Program has played 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 also enable more women to join the health workforce *(98)*.

However, some studies suggest that task shifting can create tensions between health workforce cadres where some professionals viewed changes in roles as a threat to the standard of care provided. Additionally, task shifting can overload nurses and other lower cadres *(85)*. Based on evidence from systematic reviews the WHO has published further guidance on the support systems required for successful task-shifting *(99)*.

Category of finding	OPTION 3.2
Benefits	One case study concluded that task shifting is a successful method of managing health workers shortages *(37)*.
	One systematic review and one policy brief showed that task shifting in resource-limited settings was associated with decreased neonatal and perinatal mortality rates *(95,96)*.
	One systematic review across Afghanistan, Iraq, Yemen, occupied Palestinian territory highlighted that involving more than one female traditional birth attendant and CHW in the community increased the usage of EmOC *(87)*.
	One case study from Pakistan suggests that task shifting can play 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 *(50)*.
Potential harms	One systematic review reported that task shifting can create tensions between health workforce cadres and overload some cadres such as nurses *(85)*.
Costs	The cost of interventions was not reported in the literature.
Uncertainties	No uncertainties were reported in the literature.

Option 3.3. Implement recruitment and retention policies for human resources in conflict-affected settings in the EMR

Offering good salaries and other benefits has been shown to be important for attracting midwives to work in humanitarian and fragile settings and to retain them *(37,80).* However, many governments are unable to compete with the salaries offered by international NGOs and continue to face challenges recruiting a healthy workforce *(37).*

Recruiting staff that live in the area where services are provided improves their retention over the longer term and builds stronger trust among women, adolescents and their communities *(37).* Additionally, findings from Somalia highlight the intrinsic motivation that many health workers have to serve their local community and how important this factor is for staff retention even when salaries are low and irregular *(50).*

Category of finding	OPTION 3.3
Benefits	One systematic review showed that good salaries and other benefits are important to attract and retain midwives in humanitarian and fragile settings *(93).*
	One systematic review across low and middle-income countries including Pakistan highlighted the importance of individual motivation when recruiting CHWs for WCAH. Recruitment of CHWs relies heavily on the individual sense of social responsibility and altruism and individual desire for job satisfaction (e.g. career advancement). At the retention stage, community recognition and training match individual social responsibility and altruism and job satisfaction as the most often mentioned motivating factors for CHWs *(50).*
	One case study conducted in Somalia showed higher staff retention among staff living close to where services are provided *(37).*
Potential harms	One case study showed that salaries offered by international NGOs is making it hard for the government to recruit a healthy workforce *(37).*
Costs	The cost of interventions was not reported in the literature.
Uncertainties	No uncertainties were reported in the literature.

Option 4:

Introduce financing schemes to improve WCAH outcomes and service delivery in the EMR

Option 4.1. Utilize supply-side financing schemes to improve health outcomes and service delivery

Supply-side financing schemes are among the strategies employed in conflict-affected settings to motivate behaviour change among health service providers and improve health outcomes *(86)*. Pay-for-performance schemes (P4P) have been shown to improve quality of care, for example by increasing the availability of skilled staff, decreasing out-of-pocket expenditure, increasing women's knowledge of prenatal drug usage, and improving physicians' knowledge of treating children under five for pneumonia and diarrhoea *(73, 87, 88,92)*. Despite reported benefits, reliable evidence on the impacts of P4P schemes is weak *(89)*. Some schemes have shown variable impact on service delivery and physician practice *(87)*. Additionally, one systematic review stated that performance pay may also lead to the de-prioritization of health indicators that are not included in the scheme *(88)*. The schemes also come at a cost. In Egypt, for example, incentives accounted for 275% times the base salary of a primary health care facility physician *(87)*.

Category of finding	OPTION 4.1
Benefits	One systematic review found that pay for performance schemes increased the availability of skilled staff, decreased out of pocket expenditure, increased the women's knowledge of prenatal drug usage, and improved the physicians' knowledge of treating children under-five *(73)*.
	Three systematic reviews showed that pay for performance schemes improved quality of care *(73,88,90)*.
	One systematic review found that pay for performance increased institutional deliveries in fragile contexts *(92)*.
Potential harms	One systematic review showed that pay for performance schemes changed patient perceived availability of drugs and decreased vaccine availability *(73)*.
Costs	One systematic review stated that incentives were variable across countries that used pay for performance schemes. In Egypt, incentives accounted for 275% times the base salary of a primary health care facility physician *(87)*.
Uncertainties	One systematic review found that pay for performance had variable impacts on physician practice *(73)*.
	One systematic review concluded that the impact of pay for performance on service delivery is unclear due to the poor quality of evidence *(93)*.
	One systematic review stated that pay for performance may lead to the de-prioritization of health indicators that are not included in the scheme *(91)*.

Option 4.2. Provide demand-side financing schemes to improve sexual, reproductive and maternal health outcomes

Demand-side financing, or the use of individual financial incentives, is another strategy used to increase the uptake of specific health services *(86)*. User fee removal and conditional cash transfers in low and middle-income countries, for example, have been shown to increase demand for facility-based deliveries and reduce the risk of maternal deaths *(91)*. Similarly, voucher schemes can increase the likelihood of facility-based delivery and postnatal care *(92,98)*. The subsidization of health care services in humanitarian settings increases the use of contraceptives among refugees *(90)*. More research is required on the impact of demand-side financing on quality of care *(92)*.

Category of finding	OPTION 4.2
Benefits	One descriptive review found that user fee removal and conditional cash transfers increased demand for facility-based deliveries in low and middle-income countries *(91)*.
	One systematic review found that vouchers increased the likelihood of facility-based delivery and accessibility of antenatal care services. *(92)*
	One study in Pakistan found that use of voucher booklets significantly increased women's usage of at least three ANC visits, delivery in a health facility, and utilization of postnatal care *(98)*.
	One systematic review reported that the subsidization of health care services in humanitarian settings increased the use of contraceptives among refugees *(90)*.
Potential harms	No harms were reported in the literature.
Costs	The costs of these interventions were not reported in the literature.
Uncertainties	One systematic review stated that the evidence on the impact of financial incentives on the quality of care was inconclusive *(92)*.

Additional considerations for implementing the options

Implementation considerations and counterstrategies

Interpretation of WCAH outcomes in conflict settings are particularly context-dependent given the myriad of complex factors that constitute conflict and their interactions. Additionally, the dynamic nature of modern conflict and context dependent barriers pose significant challenges to delivering WCAH services in the EMR.

However, key stakeholders have developed some novel solutions to bring lifesaving WCAH services closer to populations using innovative modes of delivery. These counter-strategies, when evaluated, can inform current implementation challenges to modern armed conflicts. The following implementation considerations (barriers and counterstrategies) were thus identified in the literature reviewed, at the system, organizational and individual level.

Level	Barriers	Counter-strategies
System	The presence of parallel systems (i.e., humanitarian system and government) could result in power imbalances which hinders effective multi-sectoral coordination *(44)*.	Introduce multiple coordination strategies to clarify the roles and responsibilities of each actor *(44)*. Outline basic criteria around overall governance of service delivery and ensure there is no duplication of efforts *(44)*.
	The absence of effective governance and accountability mechanisms that enable responsiveness to local needs and hinders the effectiveness of health system decentralization *(81,82)*.	Improve local accountability mechanisms *(81)*. Promote community responsibility, ownership and participation to strengthen governance systems *(81)*.
	Decentralized health boards and local governments often have limited agency over financing and human resources *(81)*.	Promote community responsibility, ownership and participation to strengthen governance systems *(81)*.
Organizational	Inadequate availability and unequal distribution of health workers hamper the delivery of WCAH services *(100,101)*.	Recruit staff connected to the area in which the services are to be provided, provide competitive salaries and introduce task shifting to overcome health workforce challenges *(33)*. Engage community leaders and leaders of the host communities to support remaining human resources *(100)*. Train CHWs and volunteers to conduct screening and awareness raising activities *(100)*.
Individual	Insecurity due to ongoing conflicts deter community members, especially women, from seeking health services *(89,102)*.	Utilize community members and volunteers to conduct screening and awareness raising activities *(100)*.
	In certain cases, women lack autonomy in making the decision to seek health services. *(103)*.	Increase employment opportunities for women to increase autonomy and financial independence *(103)*. Raise awareness among community gatekeepers to address cultural factors hindering the accessibility of health services *(104)*.

Conclusion

This report has explored various barriers at a health system, organization and individual level associated with delivering quality and equitable health services to WCA in conflict settings in EMR. At a health system level these include parallel and decentralized systems with poor governance and accountability. At an organization level there is often a lack of even distribution of health workers to deliver services effectively. Similarly, at an individual level the ongoing insecurity limits access to and from services. As such, women often lack the autonomy to seek health services by virtue of their gender.

A whole-of government Is required to establish policies that focus on improving access to health services through decentralising health services and introduction of innovative financing mechanisms that reduce out of pocket expenditure.

In addition, focus must be taken to strengthen the health workforce to improve outcomes for WCA's in conflict settings. Effective and efficient implementation of these policies requires a system-wide multi-sectoral collaboration among all key actors. Finally, more contextualized research is needed as it pertains to WCA in conflict settings to understand the various issues being faced which can be utilized to highlight gaps and advocate for the implementation of policies, programmes and country level strategies to support the availability and accessibility of a high-quality SRMNCAH services for WCA.

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