

## Lancet Series on women's and children's health in conflict settings



A new four-part Series published in *The Lancet* in January, 2021, draws upon recent scholarship from the Bridging Research & Action in Conflict Settings for Health of Women & Children (BRANCH) Consortium, an international research enterprise aimed at improving evidence and guidance for effective action on women's, newborns', children's, and adolescents' (hereafter women's and children's) health and nutrition in the context of armed conflict. The Consortium aimed to complement the previous work of operational and academic colleagues in the field, including work examining the debilitating effects of conflict on public health systems and outcomes,<sup>1,2</sup> including among women and children;<sup>3-5</sup> the low quality and quantity of available evidence on public health intervention effectiveness in crisis settings;<sup>6</sup> and the insufficiency of available data and guidance for monitoring, evaluating, and informing humanitarian health activities.<sup>7,8</sup> Building on such previous work, the Series aims to improve understanding of and address the special requirements of providing sexual, reproductive, maternal, newborn, child, and adolescent health, and nutrition services in conflict settings. The papers aim to provide empirical and analytical insights into the nature and dynamics of women's and children's health and nutrition in diverse conflict contexts and propose some immediate next steps to help fill evidence and guidance gaps as well as longer-term action to better promote and support more effective humanitarian health response for women and children affected by conflict.

In the first Series paper,<sup>9</sup> Paul Wise and colleagues examine the contemporary political and security challenges that define areas affected by armed conflict and drastically impact the realities of humanitarian action on the ground. The changing nature of war, including more protracted and more urbanised warfare involving less conventional combatants and methods, increases risks for women and children needing and trying to seek care, as well for the local and international humanitarian health-care workers trying to provide it. Complex command and control structures of proxy wars that bring to bear the sophisticated intelligence and cyber capabilities of regional and global powers, and

the global proliferation and fragmentation of armed non-state actors with evolving identities, interests, and patterns of violence, all combine to complicate the negotiation of access to and protection of women's and children's health and nutrition services and undermine accountability for violations of international humanitarian law. Additionally, progress in medical and public health practice is generating new opportunities but also new burdens for humanitarian practice, creating imperatives to provide a wider range of services and closer to the front lines.

Crafting effective responses to the changing nature of war will require rapid adaptation and enhanced ability to identify local governance structures and specific governance capacities that permit the delivery of high priority women's and children's health services in specific contexts. Technical imperatives for more advanced and comprehensive service provision will require innovations in delivery systems and in protections for humanitarian workers and facilities. New approaches to coordinating humanitarian and development strategies will also prove useful, particularly when close relationships with a host government would challenge humanitarian neutrality and independence.

In the second paper of the Series,<sup>10</sup> Eran Bendavid and colleagues use international statistical databases to estimate that conflict had displaced almost 36 million children and about 16 million women as refugees, asylum seekers, or internally displaced people by 2017. From geospatial analyses, 368 million children and 265 million women are estimated in 2017 to be living within 50 km of armed conflict, increasing their risk of morbidity and mortality from direct violence as well as the indirect effects of conflict resulting from the destruction of the essentials of life and deterioration of local conditions. More intense and more chronic conflicts are shown to lead to greater mortality. These indirect effects of conflict on women and children far exceed the direct effects, across all populations, of violence. Women of reproductive age living near high-intensity conflicts have three times higher mortality than do women in peaceful settings, and more than 10 million deaths in children younger than 5 years

between 1995 and 2015 globally can be directly and indirectly attributed to conflict.

There are many ways in which health and nutrition can be affected by conflict, but systematic evidence is sparse. Existing evidence links conflict to malnutrition, physical injuries, acute and infectious diseases, poor mental health, and poor sexual and reproductive health. However, aside from malnutrition, the evidence is typically limited to local contexts and is of low-to-moderate quality. Data on adolescents are almost non-existent. Clearer information on the indirect health effects of armed conflicts, including their duration and extent, would aid the design and implementation of essential interventions for mitigating the harms of armed conflicts.

In the third Series paper,<sup>11</sup> Neha Singh and colleagues report findings on the prioritisation and delivery of sexual, reproductive, maternal, newborn, child, and adolescent health, and nutrition interventions from mixed methods case studies of the humanitarian health response in ten conflict-affected countries: Afghanistan, Colombia, Democratic Republic of the Congo, Mali, Nigeria, Pakistan, Somalia, South Sudan, Syria, and Yemen.

Despite large variations in contexts and decision making processes, antenatal care, basic and comprehensive emergency obstetric and newborn care, immunisations, treatment of common childhood illnesses, infant and young child feeding, as well as malnutrition screening and treatment appeared to be considered priorities for intervention across all ten conflict settings. Conversely, the delivery of many life-saving and other essential services and interventions went unreported across settings, including the delivery of the majority of reproductive, newborn, and adolescent health services, as well as interventions to address stillbirths.

The authors report that predefined packages of priority interventions are not commonly agreed upon and implemented in conflict settings. Instead, the priorities of international donors appear to remain the primary drivers of what, where, and how health and nutrition interventions for women and children affected by conflict are implemented. They also report that the comprehensiveness and quality of data remain limited in conflict settings. The interpretation of health and nutrition outcomes is particularly context-dependent given the myriad of complex factors that constitute conflict, and their interactions. Moreover, the

dynamic nature of modern conflict and the expanding role of armed non-state actors in large geographical areas pose new challenges to delivering health and nutrition services to women and children and assessing outcomes. Nonetheless, the humanitarian system is creative and pluralistic and has developed some novel solutions to bring life-saving services closer to populations, including the packaging of interventions and the use of more flexible modes of delivery such as mobile clinics and community-based care. If and when rigorously evaluated, these novel solutions could represent concrete responses to current implementation challenges in modern conflict contexts.

In the fourth paper of the Series,<sup>12</sup> Michelle Gaffey and colleagues address the importance of accounting for context when determining intervention priorities for women and children affected by conflict. Although guidance on promoting women's and children's health and nutrition in humanitarian crises does exist, it is not sufficiently contextualised for optimal use in conflict settings. As a preliminary step towards filling the guidance gap, a conflict-specific framework is proposed to help decision makers focused on the health and nutrition of women and children affected by conflicts to prioritise interventions that would address the major causes of mortality and morbidity among women and children in their particular settings and that could also be feasibly delivered in those settings. Assessing local needs, identifying relevant interventions from among those already recommended for humanitarian settings or universally, and determining the local, contextual feasibility of delivery for each candidate intervention are key steps in the framework.

The authors then illustrate what a framework-guided selection of priority interventions might look like in three hypothetical conflict contexts that differ in terms of levels of insecurity and patterns of population displacement. In conflict epicentres, where violence is acute and ongoing, risks to the personal safety of both care seekers and care providers imply that a small set of medically urgent, life-saving interventions should be prioritised in this context. In insecure areas, where the threat of violence might be imminent but the population is not presently exposed to active conflict, a wider range of community, facility, and hospital-based interventions should be prioritised; given insecurity and risks, however, the sequencing of higher and lower

priority interventions for immediate and subsequent implementation is recommended. Where displaced populations are settled in stable camps or integrated among host communities, there are generally fewer constraints on service delivery and a full, comprehensive package of relevant interventions should be prioritised, targeting those in greatest need. By outlining this proposed decision-making framework, the authors aim to catalyse its further iteration and eventual field-testing by local, national, and international organisations and agencies involved in humanitarian health response for women and children affected by conflict.

In a Comment linked to this Series,<sup>13</sup> Zulfiqar Bhutta and members of the BRANCH Consortium steering committee outline some ways forward for the humanitarian health community to do better for women and children in the context of armed conflict. Several key areas for action are highlighted, beginning with a call to rapidly progress the systematic development, collation, and dissemination of operational and other guidance for health and nutrition sector interventions for women and children that takes sufficient account of contextual challenges in conflict settings and translates broader recommendations into pragmatic local solutions, underpinned by evidence. Examples of areas in which such guidance is urgently needed include task shifting and the use of community-based health workers to implement evidence-informed interventions in conflict-affected settings with broken health systems, and meaningful engagement with communities to ensure buy in and uptake of interventions delivered through such platforms.

Bhutta and colleagues echo and amplify long-standing calls for better, readily available, actionable data and information in conflict settings, which would require substantial investment in methodological and technological adaptation and innovation to improve data collection and analysis. They also echo previous calls for reform of the prevailing architecture of the humanitarian health sector, and advocate for greater engagement of local partners on the ground to enhance

operational flexibility and reach, and also to strengthen local mitigating responses to conflict. To help steer these and other efforts to improve health and nutrition action for women and children affected by conflict, the authors recommend the convening of an independent, international technical advisory group. Finally, Bhutta and colleagues maintain that the global health community has a special responsibility to elevate global attention to the suffering, vulnerability, and capacities of populations affected by conflict and displacement, and give voice to those communities in need and to do so immediately, especially given the challenges posed by COVID-19 in conflict settings and among displaced populations.

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