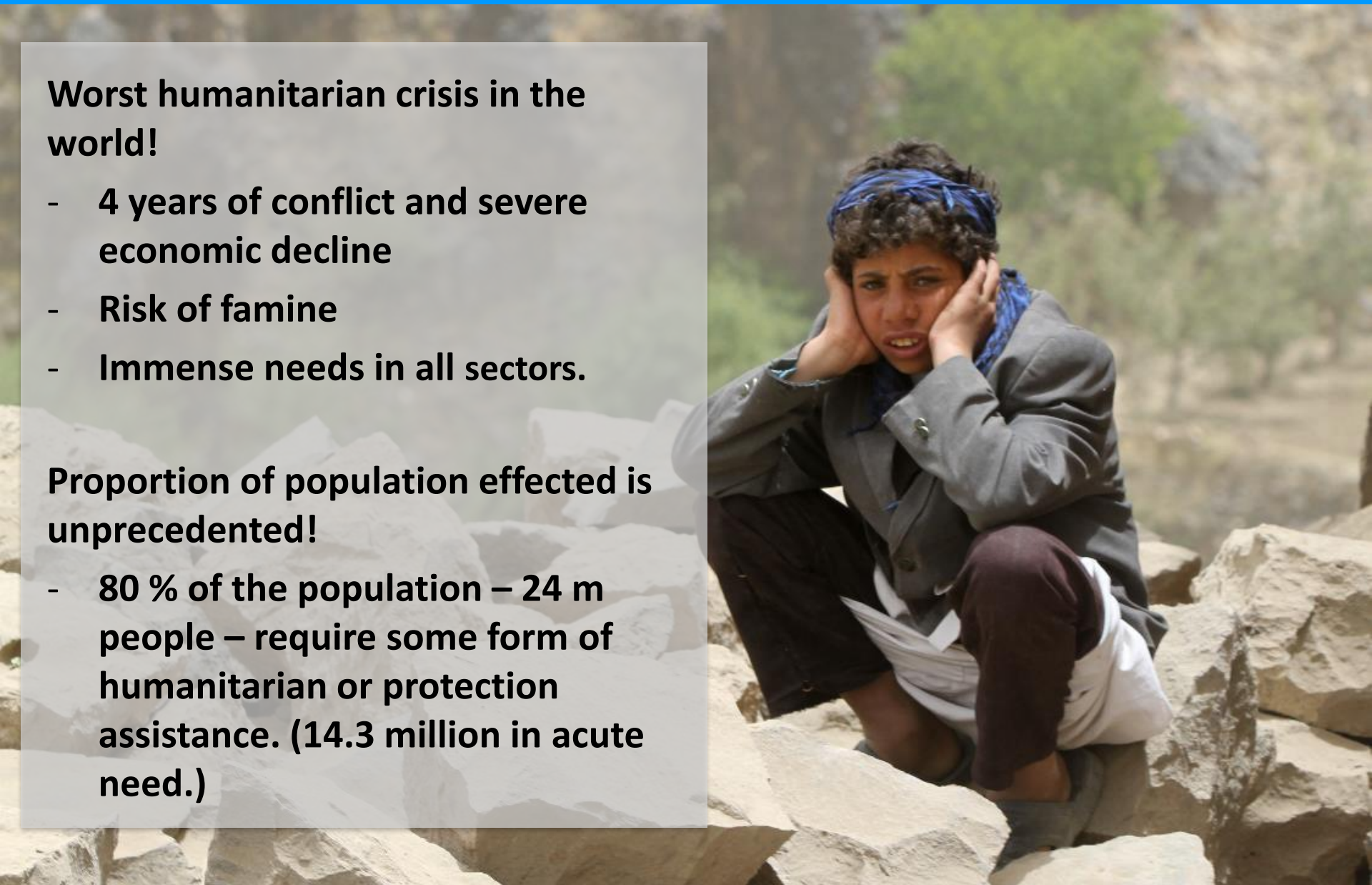
Addressing Child Health in Humanitarian settings:

Lessons learnt in Yemen

Child Health in Emergencies and Humanitarian Settings Subgroup meeting, April 30th

Situation



Worst humanitarian crisis in the world!

- **4 years of conflict and severe economic decline**
- **Risk of famine**
- **Immense needs in all sectors.**

Proportion of population effected is unprecedented!

- **80 % of the population – 24 m people – require some form of humanitarian or protection assistance. (14.3 million in acute need.)**

Health sector update

- 14 million Yemeni's lack access to health care and more than 7 million are in urgent need of health services – 49% increase from 2018.
- < 50% health facilities are fully functional.
- Continued lack of human resources (esp. specialists) equipment and medicines.
- No operational cost for over three years and no salaries for over 60% health staff for over 2 years.
- Wide-spread introduction of user-fees

Child Health Situation

- Since 2015 as per UN IMGE there are 10,000 more death of children annually – indirectly related to the war.
- Every 10 minutes once child under 5 dies most from easily preventable causes.

Key changes in child health programming since conflict escalation

Pre conflict (2012 – early 2015)

- Focus on policy and strategy level, decentralization, reaching MDG 4 & 5.
- Efforts at better integration of Health, Nutrition, WASH and C4D efforts in addressing malnutrition
- System Strengthening – HR development, M&E, Supply and logistics

Immediately after conflict escalation (March 2015 to end 2016)

- Focus on emergency response to save lives
- Revision of Plans to stop 'development activities'
- Drastic change in donors/ partnership coordination

As conflict becomes protracted (2017 till now)

- Continuation of humanitarian response
- Response to emerging challenges (cholera, Malaria, Dengue, Measles, diphtheria, Floods, Cyclones, conflict/ warzones, displacements)
- Identification of opportunities for 'development work and significant progress on some of these.

Progression of Child Health programme goals

Pre conflict (2012 – early 2015)

- Reaching MDG 4 and support MDG 1.
- Enable a child friendly policy/ health financing environment

Immedi[illegible]ely after conflict escalation (March 2015 to end 2016)

- Saving lives of mothers, newborn and children and reducing morbidity/ suffering.
- [illegible] development activities
- Preventing collapse of the health system.

As conflict becomes protracted (2017 till now)

- Support Primary Health Care including Co[illegible]mmunity based health care.
- Build Health system resilience

some of these.

Meeting the needs through expanding the scope of work

Tertiary Health Care
(THC)

Second Health Care
(SHC)

Primary Health Care
(PHC)

Household and
Community level

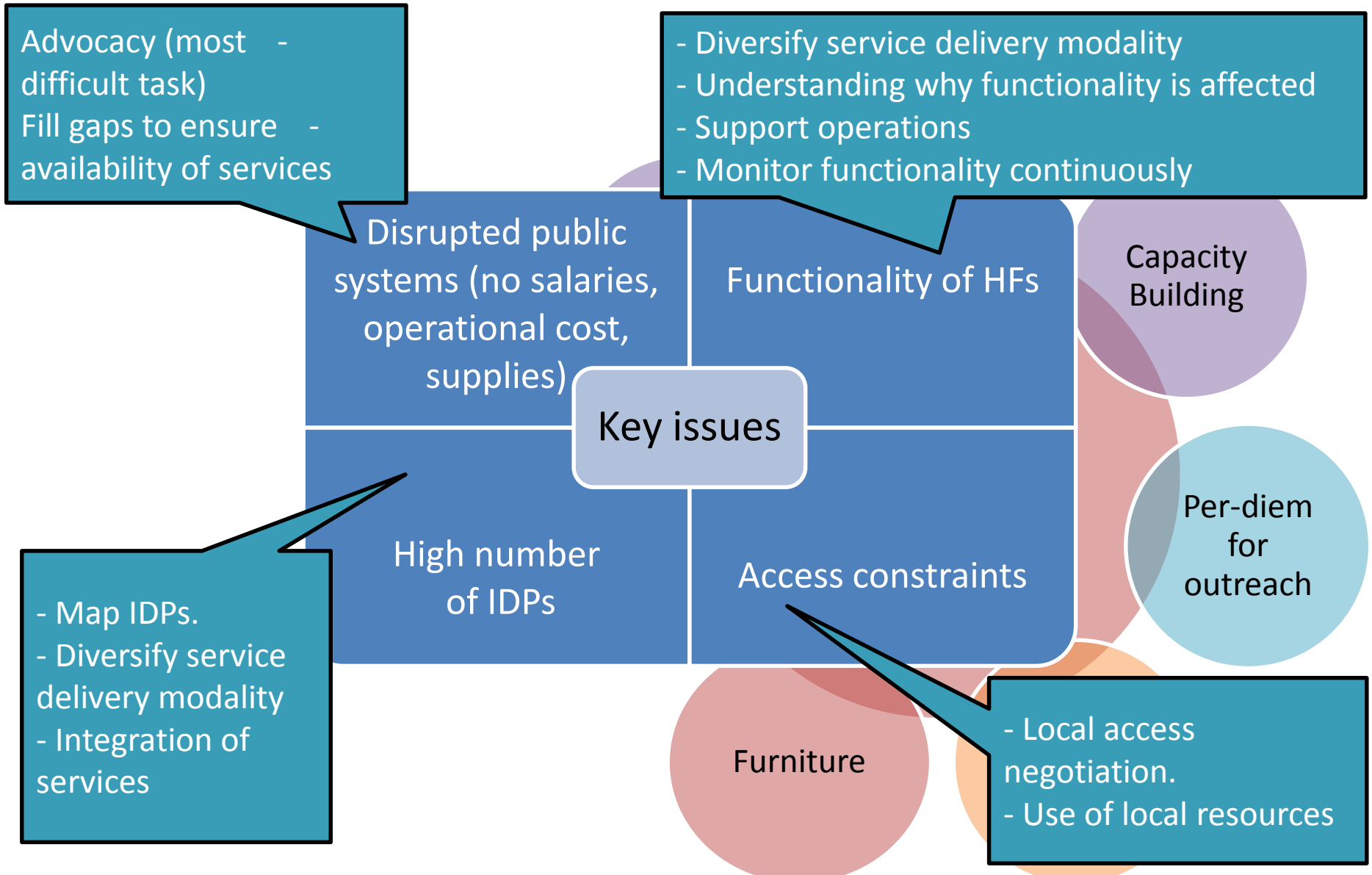
Mother, Newborn & Child Health & Nutrition

Primary Health Care

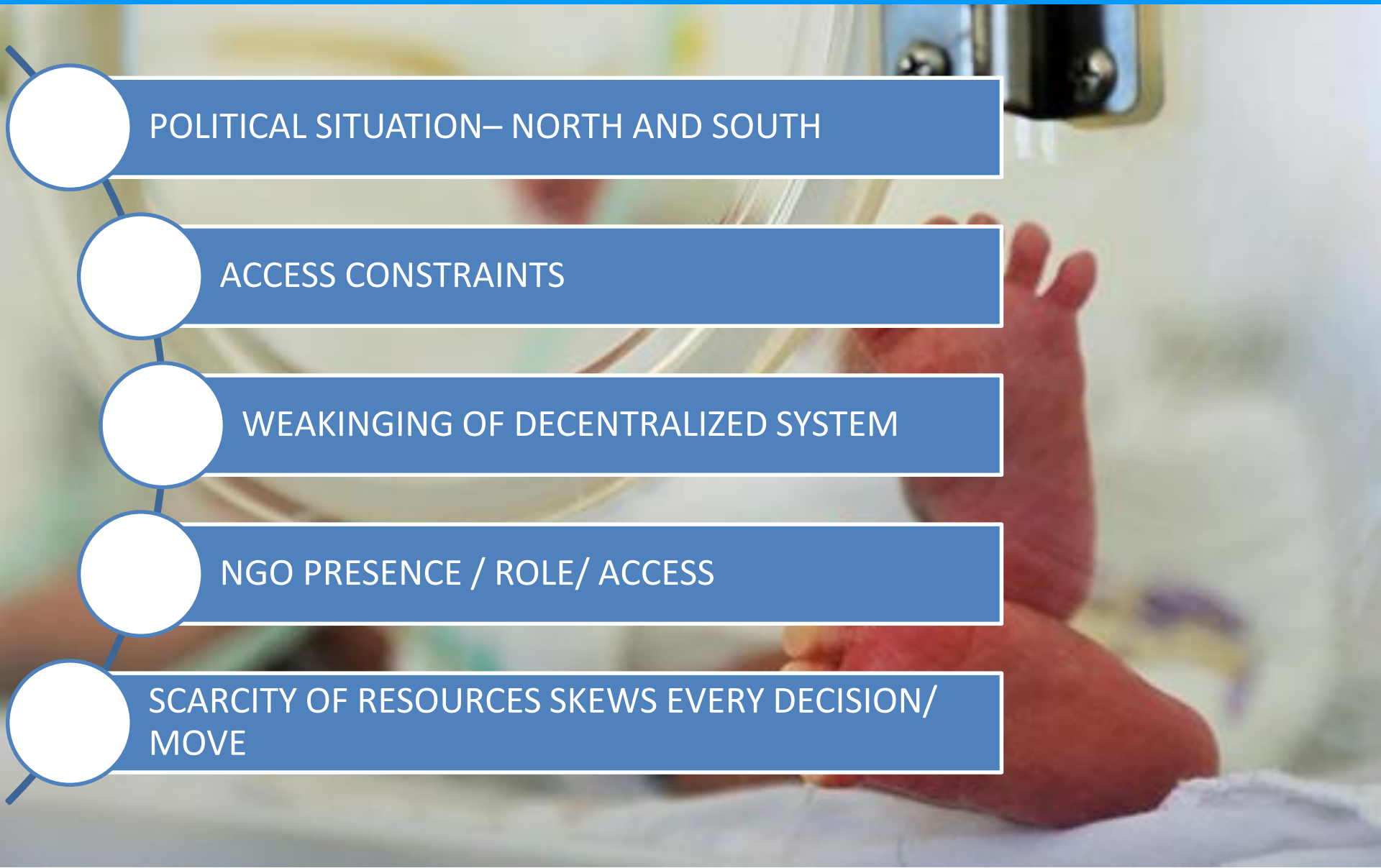
MSP (minimal service package include) :

Preventive care: Immunization of preventable communicable diseases
Curative care (OPD) including:
Mother & newborn: ANC,NC&PNC,FP & Essential Newborn Care.
Child: IMCI ,SAM screening and management, PSS.
Adolescent, Adults: Communicable diseases , Infectious diseases & NCD.
All: First Aid, Basic Lab.

Inputs- addressing the needs in the FCV context



ADDITIONAL CHALLENGES



- POLITICAL SITUATION– NORTH AND SOUTH
- ACCESS CONSTRAINTS
- WEAKINGING OF DECENTRALIZED SYSTEM
- NGO PRESENCE / ROLE/ ACCESS
- SCARCITY OF RESOURCES SKEWS EVERY DECISION/ MOVE

Lessons learnt

1. Continuum of care along the life cycle and along the service delivery levels remains important in humanitarian response in acute and protracted phases.

Continuum of care should remain a corner stone of response, advocacy and fund raising efforts

KEY SYSTEM COMPONENTS

COUNTRY

Governorate

DISTRICT

Health Unit and center

Outreach and mobile

CHW

CHV

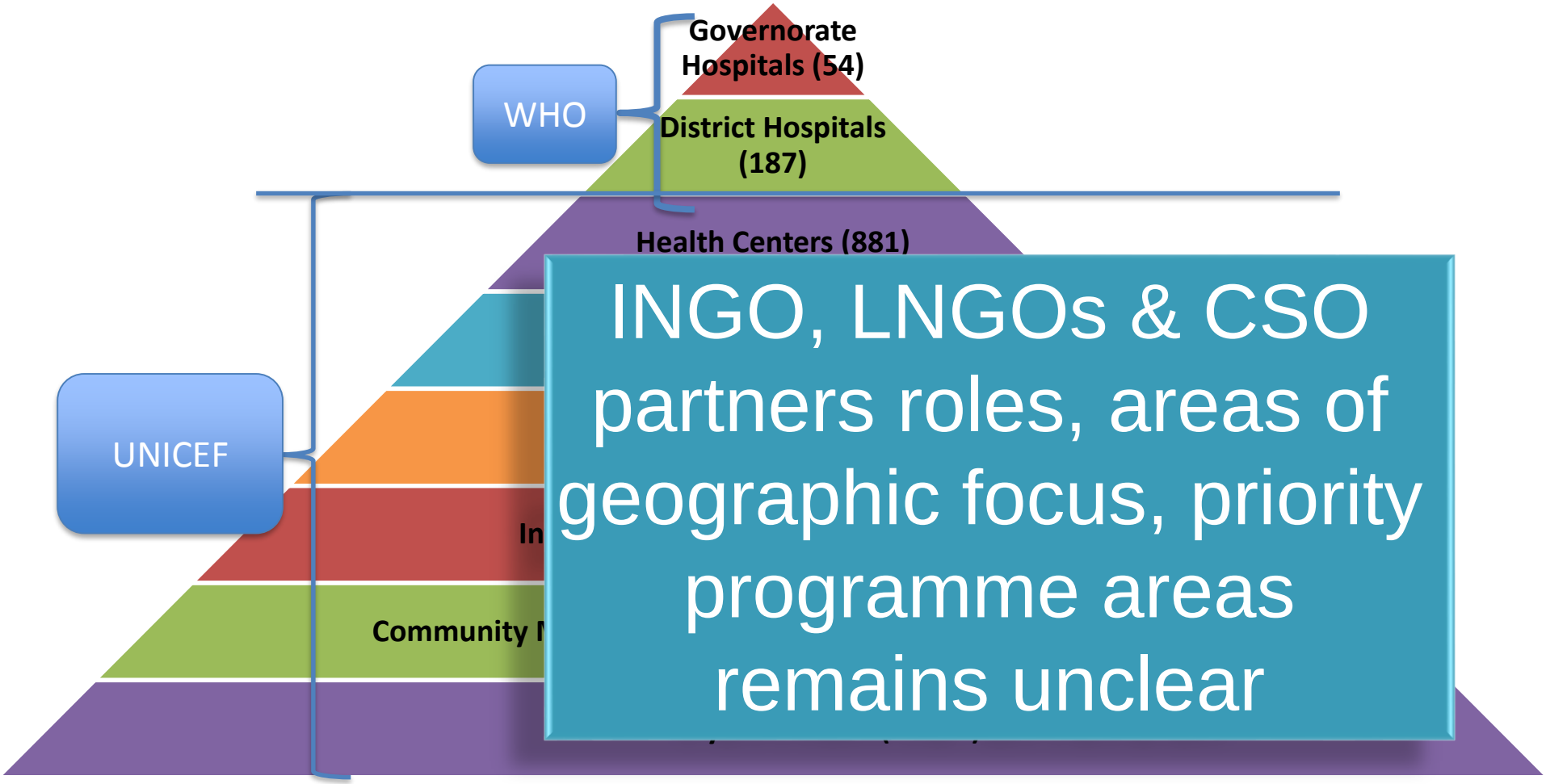
Challenges:

- Maternal and Newborn health were NOT a priority for authorities in the first three years of conflict.
- Yemen Humanitarian response plan (and therefore funding received) were mostly silent on MNH.
- Community based health care and PHC were NOT a priority. Mobile teams were not a priority; as compared to secondary care, trauma care and NCD.

Lessons learnt

1. Continuum of care along the life cycle and along the service delivery levels remains important in humanitarian response in acute and protracted phases.
2. **Clarity in partner's role is of utmost importance to ensure comprehensive response to child health needs and to addressing specific challenges such as Cholera outbreak.**

Clarity of roles and responsibilities of child health partners



Lessons learnt

1. Continuum of care along the life cycle and along the service delivery levels remains important in humanitarian response in acute and protracted phases.
2. Clarity in partner's role is of utmost importance to ensure comprehensive response to child health needs and to addressing specific challenges such as Cholera outbreak.
3. **Joint advocacy is difficult and frustrating but more powerful.**

Joint advocacy

UNICEF, WHO, Save the Children, IMC and several partners conducted very strong visibility and advocacy campaigns for child's plight in Yemen esp. for Health and Nutrition – the coordination was missing!

230,000+ Affected by Yemen's New Cholera Outbreak

By DANIEL LARISON • April 28, 2019, 1:34 PM

Yemen war a 'living hell' for children: UNICE

REUTERS Reuters • September 13, 2018

1 / 13

A woman carries a child at the malnutrition ward of al-Sabeen hospital in Sanaa

A woman carries a child at the malnutrition ward of al-Sabeen hospital in Sanaa, Yemen September 11, 2018. REUTERS/Khaled Abdullah

Lessons learnt

1. Continuum of care along the life cycle and along the service delivery levels remains important in humanitarian response in acute and protracted phases.
2. Clarity in partner's role is of utmost importance to ensure comprehensive response to child health needs and to addressing specific challenges such as Cholera outbreak.
3. Joint advocacy is difficult and frustrating but more powerful.
4. **Health Cluster must champion the MNC health**

Global / national health clusters need to champion child health response

Facts:

- Health cluster had too broad a mandate, too many players and was not well managed!
- The first 3 YHRPs were silent on newborn health! No objectives or targets and no funding!
- Children health was mainly seen as limited to immunization!
- Where mentioned, focus was on children 5 to 18 were neglected!

Things to consider:

- A sub group affiliated with Global Health Cluster and maybe national clusters as well focusing on Child health.
- Sensitization of cluster coordinators on CH
- Recommendations for national HC on objectives/ targets etc. for HRPs.
- Capacity building of partners on focusing on the child in all health programming / response.

Lessons learnt

1. Continuum of care along the life cycle and along the service delivery levels remains important in humanitarian response in acute and protracted phases.
2. Clarity in partner's role is of utmost importance to ensure comprehensive response to child health needs and to addressing specific challenges such as Cholera outbreak.
3. Joint advocacy is difficult and frustrating but more powerful.
4. Health Cluster must champion the MNC health
5. **Need for better data on child health situation.**

Need for better data on child health situation

- Other than estimates done by UNICEF and SAVE - not much data on child health.

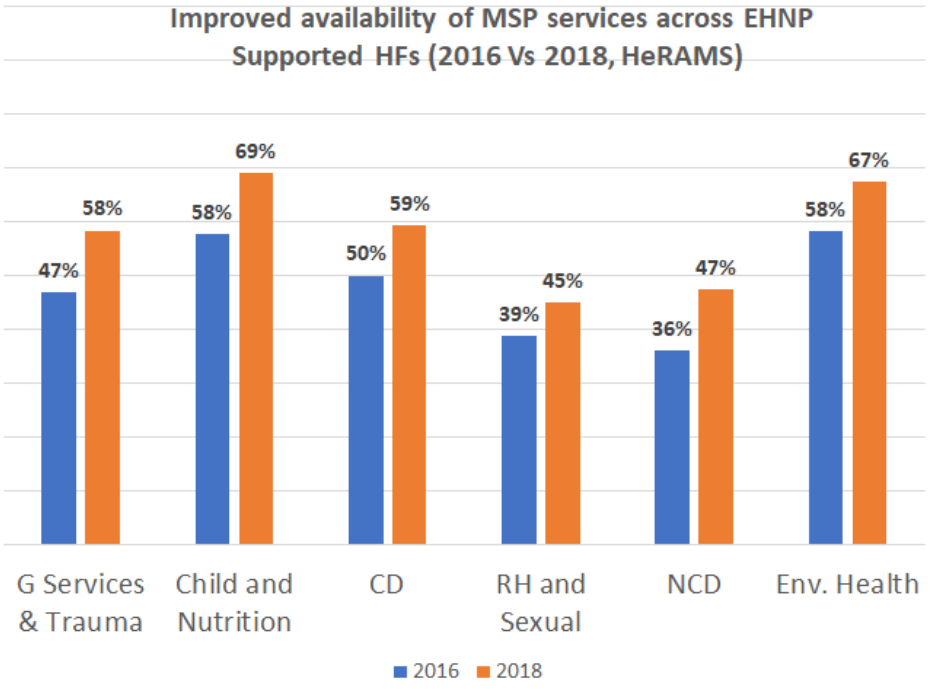
- Other than SMART survey, not many assessments or survey's focused on child health.

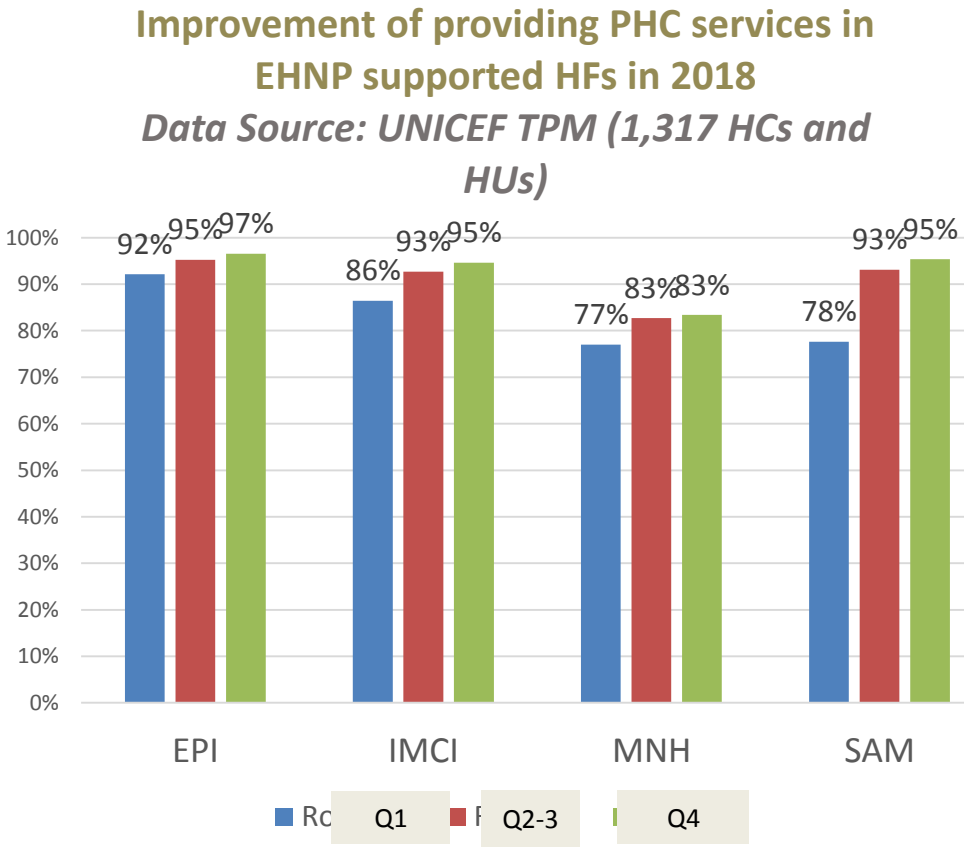
- Health Cluster did not lead on assessments and an assessments working group was not established until end 2018.

- Program data remains weak but TPM data is reliable.

Improved availability of services

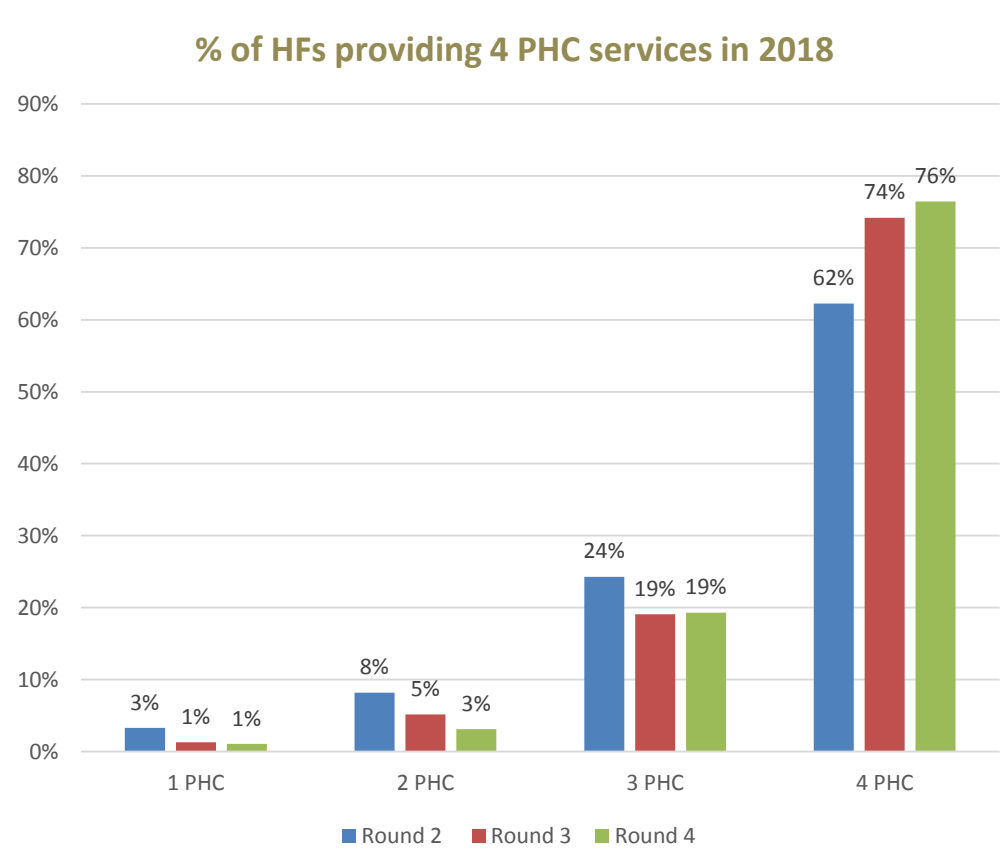
Multiple data sources are being used-
HeRAMS is replacing SARA in normal setup with an intensive desk review conducted nationwide. TPM is project specific data collection but with actual physical visits





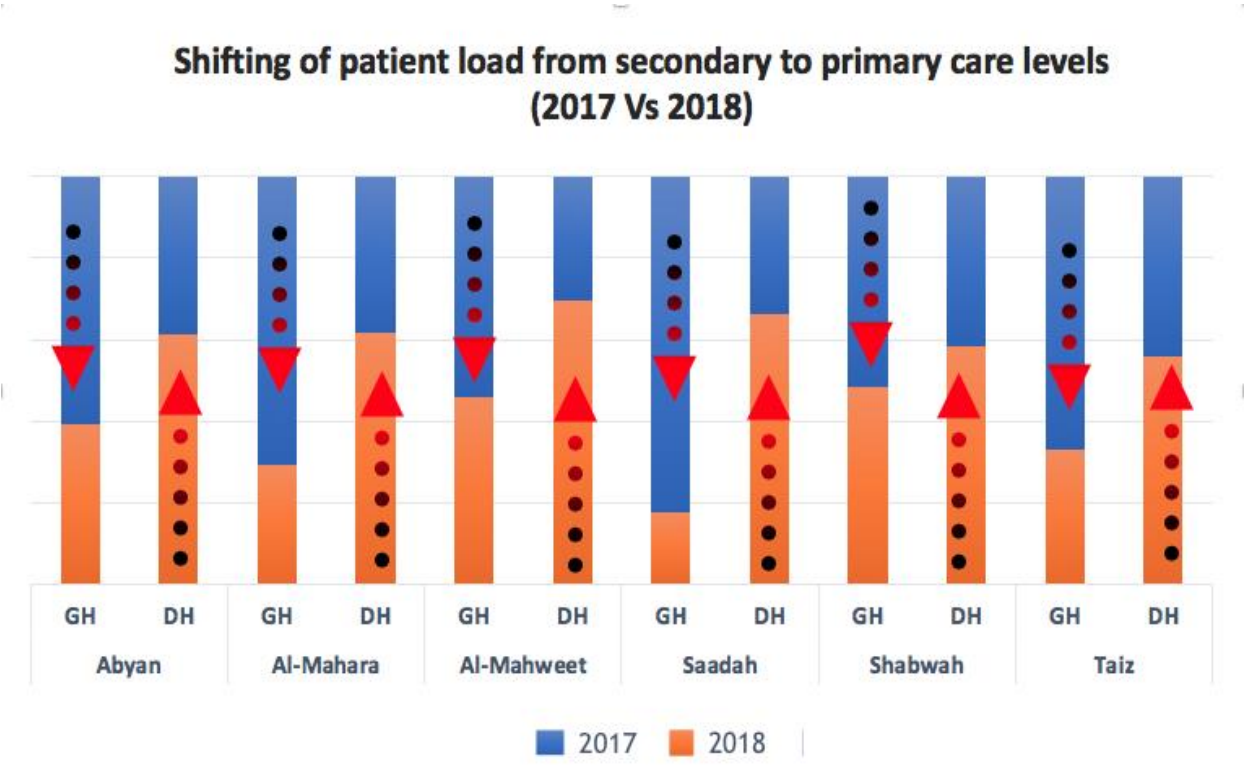
Availability of integrated PHC services

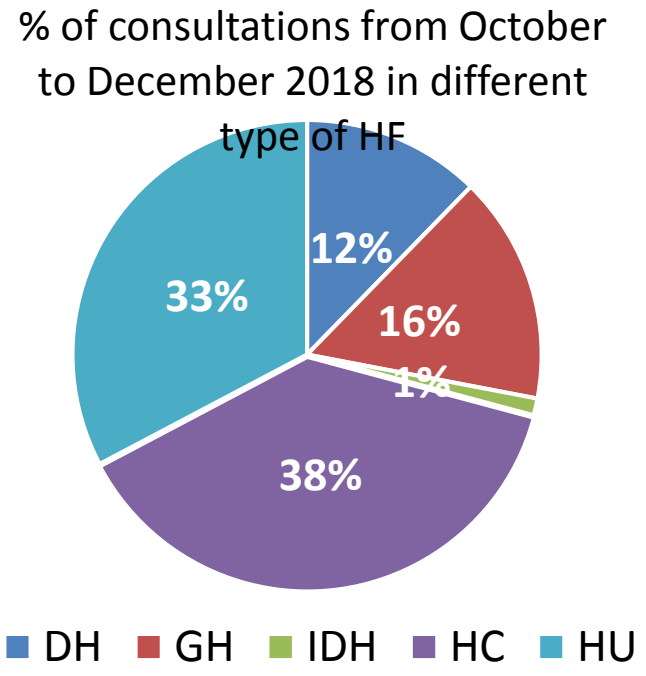
Data Source: UNICEF TPM Data – 1,317 HCs and HUs



Service utilization

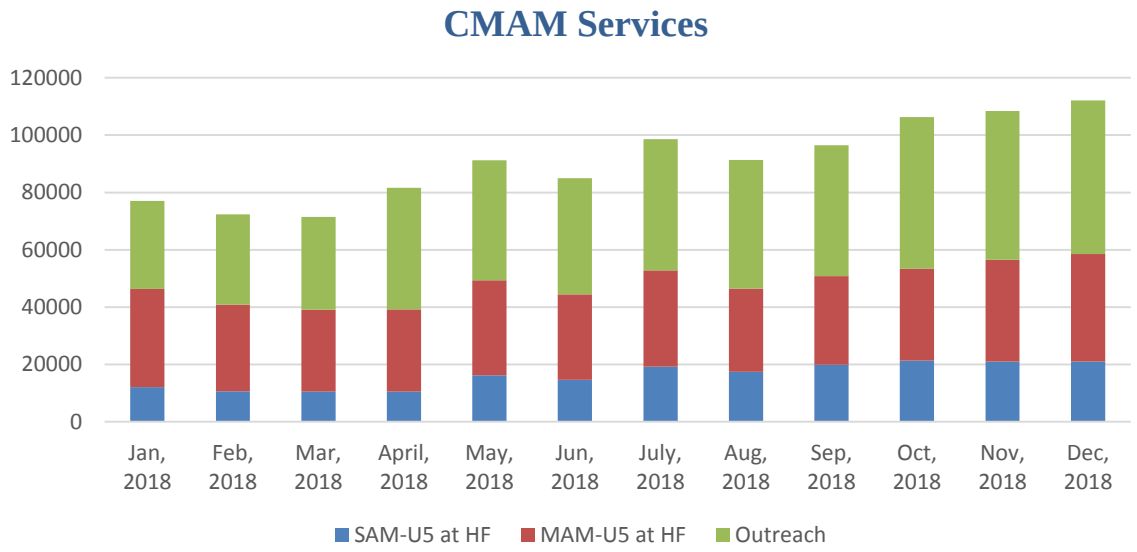
Overall service utilization has not only improved but also the pattern of care is normalizing where more patients are being seen at the PHC level, and patients are visiting secondary care only for appropriate cases

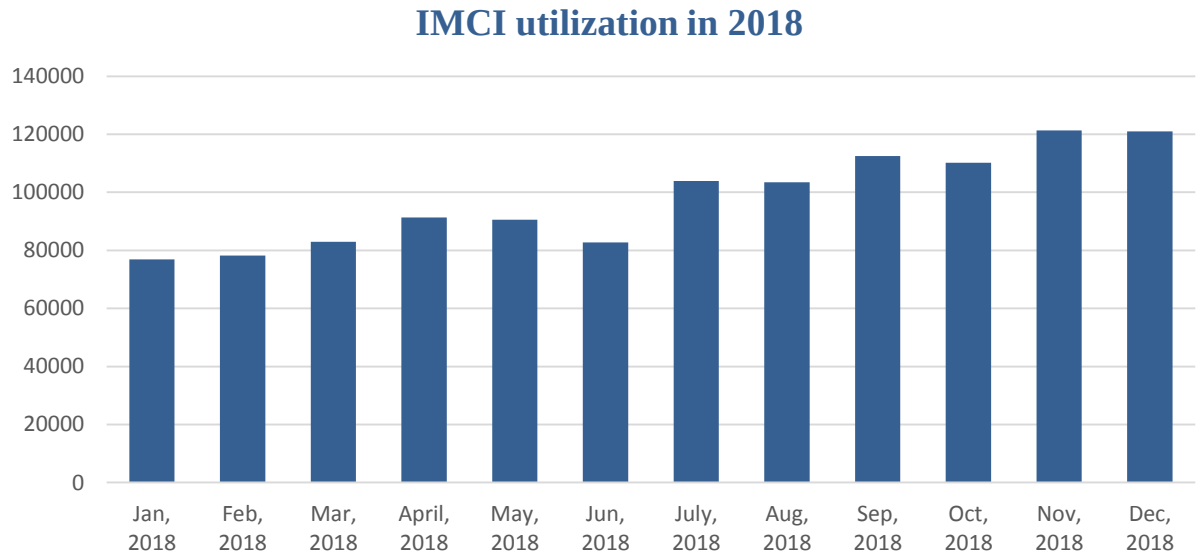




Service utilization at the PHC level

Data Source: UNICEF TPM Data – 1,317 HCs and HUs

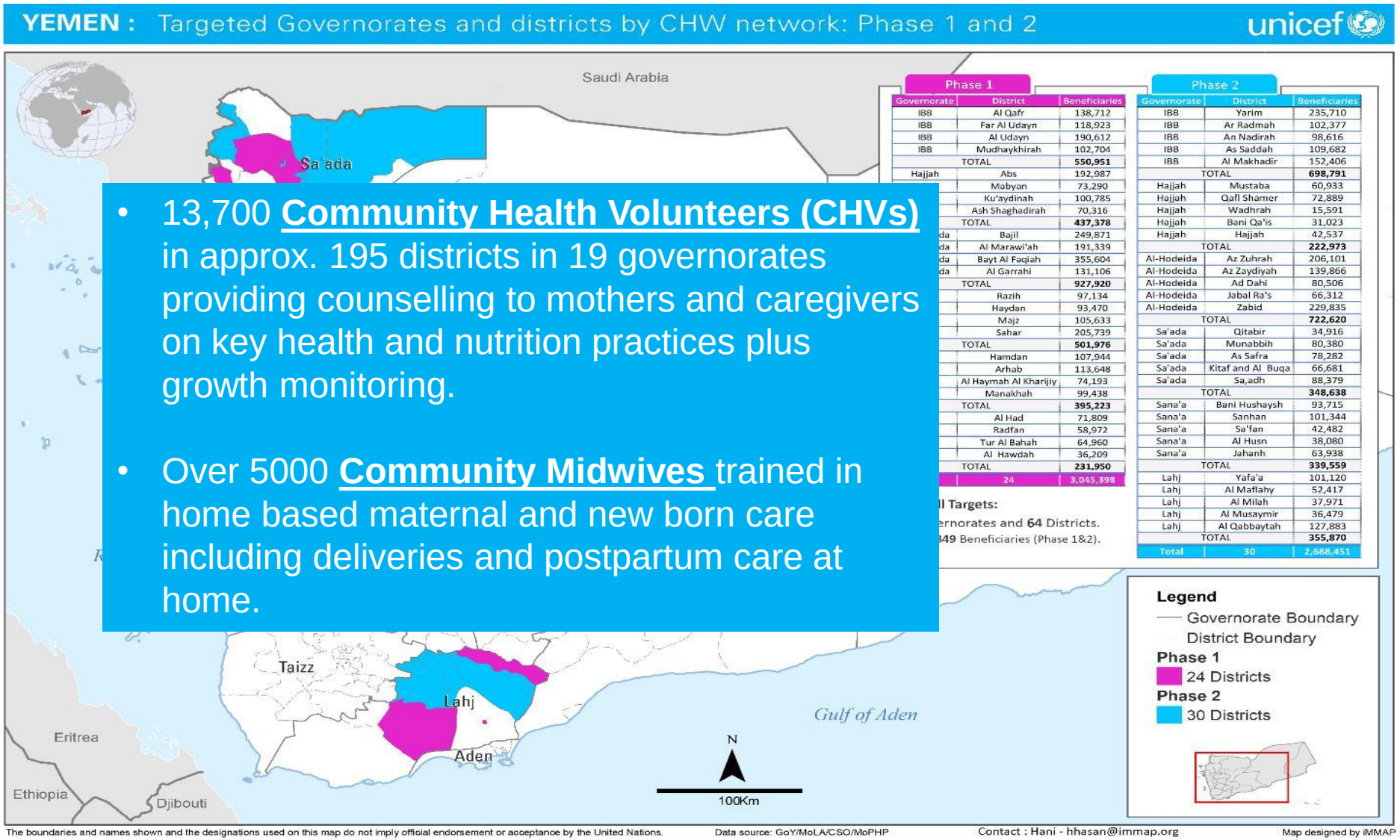




Lessons learnt

1. Continuum of care along the life cycle and along the service delivery levels remains important in humanitarian response in acute and protracted phases.
2. Clarity in partner's role is of utmost importance to ensure comprehensive response to child health needs and to addressing specific challenges such as Cholera outbreak.
3. Joint advocacy is difficult and frustrating but more powerful.
4. Health Cluster must champion the MNC health
5. Need for better data on child health situation.
6. **Humanitarian situations may present opportunities for work with longer term implications on health sector.**

Household and community level: CHV, CHWs and CMWs in targeted governorates



Phase 1

Governorate	District	Beneficiaries
IBB	Al Qafr	138,712
IBB	Far Al Udayn	118,923
IBB	Al Udayn	190,612
IBB	Mudhaykhirah	102,704
	TOTAL	**550,951**
Hajjah	Abs	192,987
	Mabyan	73,290
	Ku'aydinah	100,785
	Ash Shaghadirah	70,316
	TOTAL	**437,378**
da	Bajil	249,871
da	Al Marawi'ah	191,339
da	Bayt Al Faqiah	355,604
da	Al Garrahi	131,106
	TOTAL	**927,920**
	Razih	97,134
	Haydan	93,470
	Majz	105,633
	Sahar	205,739
	TOTAL	**501,976**
	Hamdan	107,944
	Arhab	113,648
	Al Haymah Al Kharijiy	74,193
	Manakhah	99,438
	TOTAL	**395,223**
	Al Had	71,809
	Radfan	58,972
	Tur Al Bahah	64,960
	Al Hawdah	36,209
	TOTAL	**231,950**
	24	3,045,398

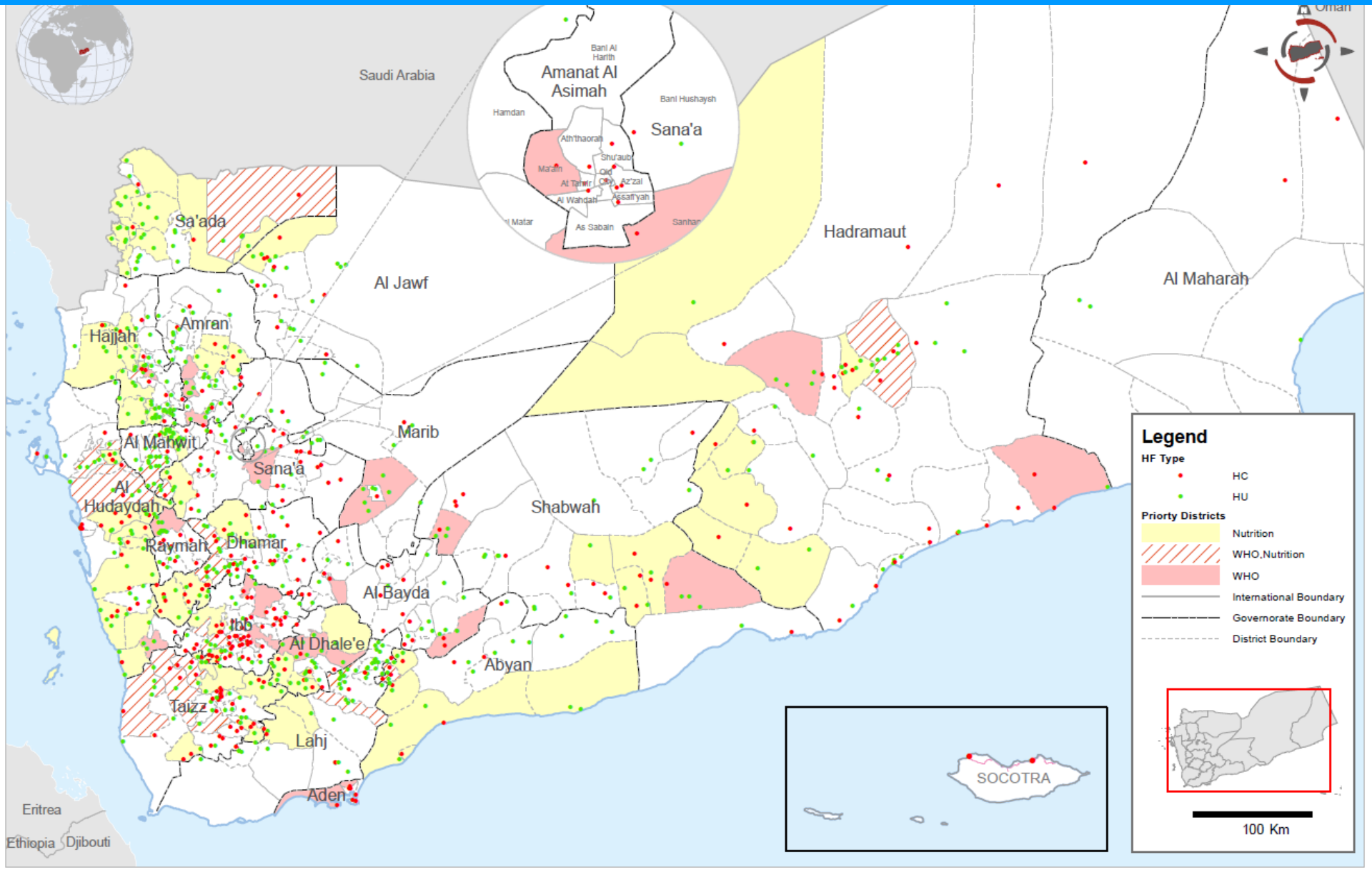
Phase 2

Governorate	District	Beneficiaries
IBB	Yarim	235,710
IBB	Ar Radmah	102,377
IBB	An Nadirah	98,616
IBB	As Saddah	109,682
IBB	Al Makhadir	152,406
	TOTAL	**698,791**
Hajjah	Mustaba	60,933
Hajjah	Qafl Shamer	72,889
Hajjah	Wadhrah	15,591
Hajjah	Bani Qa'is	31,023
Hajjah	Hajjah	42,537
	TOTAL	**222,973**
Al-Hodeida	Az Zuhrah	206,101
Al-Hodeida	Az Zaydiyah	139,866
Al-Hodeida	Ad Dahi	80,506
Al-Hodeida	Jabal Ra's	66,312
Al-Hodeida	Zabid	229,835
	TOTAL	**722,620**
Sa'ada	Qitabir	34,916
Sa'ada	Munabbih	80,380
Sa'ada	As Safra	78,282
Sa'ada	Kitaf and Al Buqa	66,681
Sa'ada	Sa,adh	88,379
	TOTAL	**348,638**
Sana'a	Bani Hushaysh	93,715
Sana'a	Sanhan	101,344
Sana'a	Sa'fan	42,482
Sana'a	Al Husn	38,080
Sana'a	Jahanh	63,938
	TOTAL	**339,559**
Lahj	Yafa'a	101,120
Lahj	Al Maflahy	52,417
Lahj	Al Milah	37,971
Lahj	Al Musaymir	36,479
Lahj	Al Qabbaytah	127,883
	TOTAL	**355,870**
Total	30	2,688,451

ll Targets:
ernorates and **64** Districts.
349 Beneficiaries (Phase 1&2).

- 13,700 **Community Health Volunteers (CHVs)** in approx. 195 districts in 19 governorates providing counselling to mothers and caregivers on key health and nutrition practices plus growth monitoring.
- Over 5000 **Community Midwives** trained in home based maternal and new born care including deliveries and postpartum care at home.

Over 1700 health facilities being fully supported



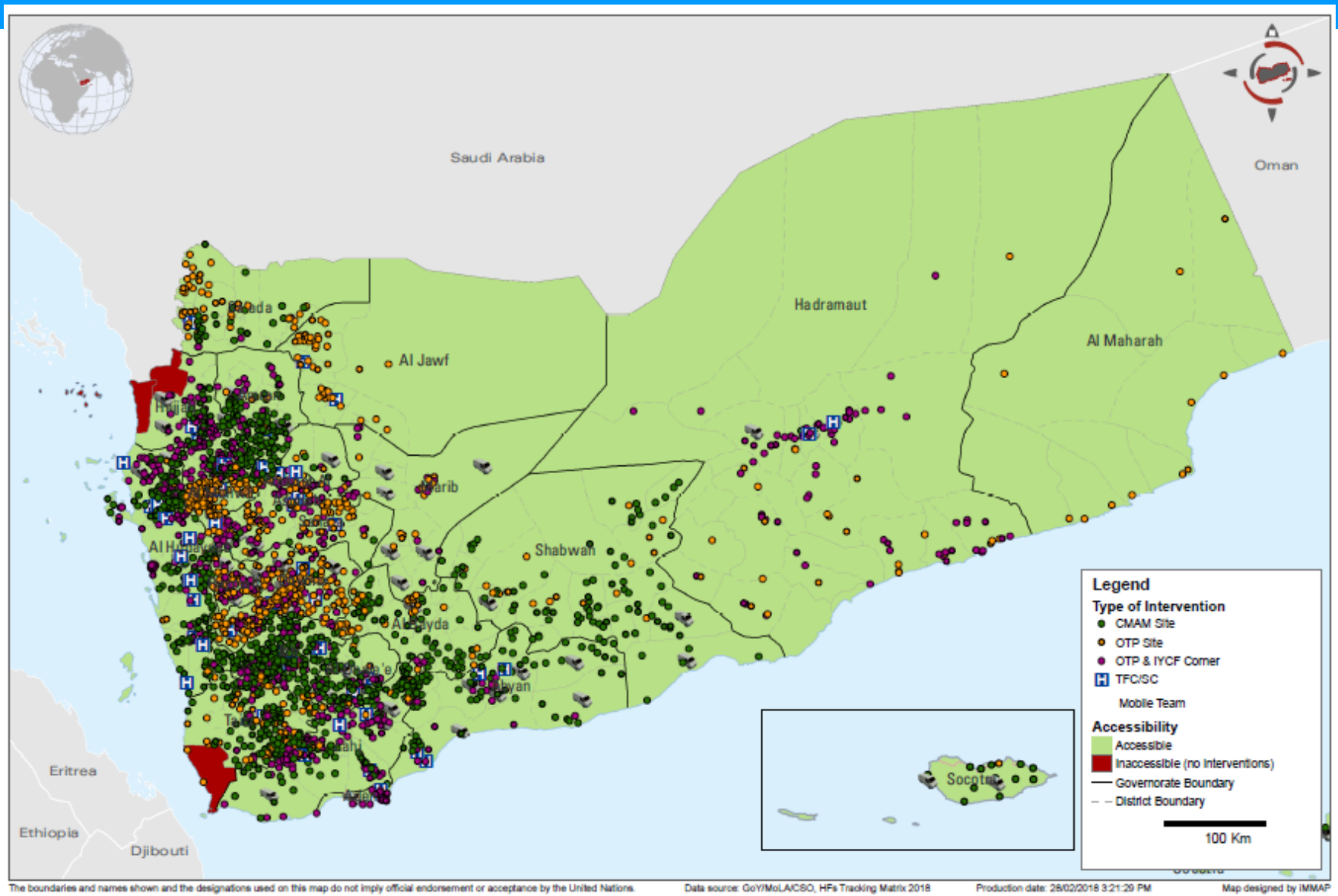
Data source:GoY/MoLA/CSO/ YEHNP Project

Production date: 8/22/2017 10:35:33 PM

Map designed by iMMAP

And over 3300 Health facilities partially supported!

Map of OTPs supported across the country



Multi-sectoral interventions to maximize results

Lessons learnt

1. Continuum of care along the life cycle and along the service delivery levels remains important in humanitarian response in acute and protracted phases.
2. Clarity in partner's role is of utmost importance to ensure comprehensive response to child health needs and to addressing specific challenges such as Cholera outbreak.
3. Joint advocacy is difficult and frustrating but more powerful, builds donor confidence and improves coordination.
4. Health Cluster must champion the MNC health.
5. Need for better data on child health situation.
6. Humanitarian situations may present opportunities for work with longer term implications on health sector.

THANK YOU!

ANY QUESTIONS?