Addressing Child Health in Humanitarian settings: Lessons learnt in Yemen
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

- 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.'
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Progression of Child Health programme goals
- Reaching MDG 4 and support MDG 1.
- Enable a child friendly policy/health financing environment.

- Saving lives of mothers, newborn and children and reducing morbidity/suffering.
- Preventing collapse of the health system.

- Support Primary Health Care including Community based health care.
- Build Health system resilience some of these.
Meeting the needs through expanding the scope of work

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

Advocacy (most difficult task)
Fill gaps to ensure availability of services

Disrupted public systems (no salaries, operational cost, supplies)

Functionality of HFs
- Diversify service delivery modality
- Understanding why functionality is affected
- Support operations
- Monitor functionality continuously

Key issues
- Local access negotiation.
- Use of local resources

High number of IDPs

Access constraints
- Map IDPs.
- Diversify service delivery modality
- Integration of services

Capacity Building

Per-diem for outreach

Furniture
Additional Challenges

1. Political Situation – North and South
2. Access Constraints
3. Weaking of Decentralized System
4. NGO Presence / Role / Access
5. 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 cornerstone of response, advocacy and fund raising efforts.

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

INGO, LNGOs & CSO partners roles, areas of geographic focus, priority programme areas remains unclear
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3. Joint advocacy is difficult and frustrating but more powerful.
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!
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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.
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- 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.
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.

Improved availability of services

Improvement of providing PHC services in EHNPs supported HFs in 2018

Data Source: UNICEF TPM (1,317 HCs and HUs)
Availability of integrated PHC services

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

% of HFs providing 4 PHC services in 2018

- Round 2: 3% 8% 24% 62%
- Round 3: 1% 5% 19% 74%
- Round 4: 1% 3% 19% 76%

1 PHC 2 PHC 3 PHC 4 PHC
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.

% of consultations from October to December 2018 in different type of HF:
- 33%
- 38%
- 16%
- 12%
- 1%

Shifting of patient load from secondary to primary care levels (2017 Vs 2018)

GH
- Abyan
- Al-Mahara
- Al-Mahweet
- Saadah
- Shabwah
- Taiz
Service utilization at the PHC level

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

CMAM Services

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IMCI utilization in 2018

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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

- **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
And over 3300 Health facilities partially supported!

Map of OTPs supported across the country
Multi-sectoral interventions to maximize results

- Health and Nutrition
- Water, hygiene and sanitation
- Communication for development
- Emergency response (ex-Cholera)
- Child protection (victims assistance, Psycho social support)
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THANK YOU!