

## Child Health in Emergencies and Humanitarian Settings Subgroup meeting, April 30<sup>th</sup>

### Attendees:

Nate Miller – UNICEF  
Fouzia Shafique – UNICEF  
Jerome Pfaffmann – UNICEF  
Elevanie Nyankesha – UNICEF  
Miriam Awadallah – UNICEF USA  
Nureyan Zunong – Save the Children  
Ryan Toney – Save the Children  
Alfonso Rosales – World Vision  
Adugna Kebede – World Vision  
Kathleen Myer – USAID/OFDA  
Smita Kumar – USAID  
Wendy Dymont – Medair  
Naoko Kozuki – IRC  
Salim Sohani – Canadian Red Cross  
Mary Thompson – Canadian Red Cross  
Karl Blanchet – LSHTM

1) Provide an update on the Global Health Cluster discussions related to child health during public health emergencies and in humanitarian crises and implications for the CHEHS subgroup. (Jerome Pfaffmann, UNICEF)

- Some of this group was at the GHC meeting a few weeks ago.
- Child Health in Humanitarian Action Presentation
  - Do we need, as part of the GHC, a mechanism to strengthen/improve child health programming in emergencies?
  - Discussed the importance of child health in emergencies and even beyond humanitarian emergencies
  - Humanitarian Response review
    - WHO-led GHC Humanitarian Response Plans (HRP) (all health)
    - UNICEF's Humanitarian Action for Children (HAC) Appeals (all child-related programming)
    - Overall findings: child health insufficiently represented
  - Programmatic child health definition is evolving, from survival to thrive
  - While there is a gap in guidance, there are many publications on the way.
  - However, one key element of the discussion was that guidance is not the solution – it alone will not solve any problem.
  - Not everyone is looped into the Child Health Task force, even within our own organizations.
- Do we need as part of the GHC, a mechanism to strengthen/improve child health programming in emergencies? Three takeaways:
  1. There is an intuitive understanding from the wider humanitarian sphere that child health is under-prioritized.

2. Better coordination and harmonization is needed to support programming and cluster mechanisms.
  3. We are already overwhelmed with meetings, and we don't want to create new working groups made of the same people. How can we better use existing groups? Two potential existing groups for this work include this group and the IAWG for reproductive health.
    - So, do we as a group want to engage further with the GHC? What activities would this group engage in to support the GHC workplan?
    - It is important to note that this ask is not coming with extra resources or a funding proposal
- It was obvious that most partners who work in child health at that meeting felt that there is need for championing child health, through some kind of mechanism to ensure it remains on the global and country levels. There also needs to be further guidance on how countries can address child health in humanitarian settings
  - **Ask:** Do we want to take this on as an unfunded task, but could lead to funding, and could affect global and country level guidance?
    - UNICEF is interested in having a group at the global level feeding into the GHC regarding child health issues. If this group is not interested, other partners including UNICEF, Save, and other may look into this.
    - From Save perspective, there needs to be some sort of leadership role in place for child health. However, when this sub-group started last year, we were not able to develop a work plan with the participants involved at that time. Perhaps more official email correspondence may be better to gauge interest
    - Q: Is the plan to use an already developed tool and integrate it to be more child friendly, or is it to create a new instrument?
      - The plan is to use this group as a group of technical experts for child health in emergencies – not necessarily a tool, per se.
      - Similar to the IAWG for reproductive health. If a tool is required, we could consider developing one, based on need.
    - USAID is also interested, but encourages communicating offline. This topic also fits into future architecture for USAID with the imminent release of the new MCSP solicitation
    - MedAir: Depends on the time and effort involved, but supports what has been discussed so far.
  - **ACTION:** Next step is to think more in detail of exactly what the “ask” is, reach out via email to members of this group, and allow members to speak to their organizations about this. We should also identify what resources we can target for this, and how it may affect funding, policy, and programs.

2) A presentation on efforts to address child health needs in Yemen between 2015 and 2019: Challenges in prioritizing child health and related funding needs, achievements, and lessons learned. (Fouzia Shafique, UNICEF)

Addressing Child Health in Humanitarian Settings: Lessons Learnt in Yemen

- Yemen is spoken of as the worst humanitarian crisis in the world. 80% of the population require some form of humanitarian or protection assistance
- Within health sector, 14M lack access to health care, and less than 50% of health facilities are fully functional (based on revised HeRAMS done 3 months ago)
- Child health situation: since 2015, there are 10,000 more deaths of children annually, indirectly related to the war
- Key changes in child health programming since conflict escalation:
  - Pre-conflict:
    - 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:
    - Focus on emergency response to save lives, revision of plans to stop “development activities”
    - Drastic change in donors/partnership coordination
      - Lessons learned: even when there is sudden onset of emergency, the disappearance of development partners means it takes much longer to re-introduce these activities. These partnerships and coordination mechanisms should remain in place when emergency begins
  - As conflict becomes protracted (2017-now):
    - Continuation of humanitarian response
    - Response to emerging challenges (cholera, malaria, dengue, measles, floods, conflicts, displacement, etc.)
    - Identification of opportunities for development work and significant progress on some of these
- There is pressure on all partners to expand their role. For UNICEF:
  - MNCH: Tertiary Care, Secondary Health Care, Primary Health Care, Household and community level
  - PHC: Minimum Service Package (MSP) will include specific guidance for preventative and curative care, and include mother and newborn, child, adolescent, and adult-focused interventions
- Key challenges:
  - High number of IDPs
  - Disrupted public systems, e.g., salaries
  - Functionality of HFs
  - Access constraints
- Lessons learnt
  - Continuum of care along the life cycle and along the service delivery levels remains a cornerstone of response, advocacy, and fundraising efforts. Mother and newborn health were not a priority for authorities in the first three years of the conflict.

- Yemen humanitarian response plan was mostly silent on MNH
    - Community based health care and PHC were also not a priority
  - Clarity in partners' role is of utmost importance to ensure comprehensive response to child health needs and to addressing specific challenges such as cholera outbreak.
    - It took about 18 months for WHO and UNICEF to determine who was supporting which levels of the health system.
    - INGO, LNGO, and CSO partners roles, areas of geographic focus, and priority programme areas remains unclear
  - Joint advocacy is difficult and frustrating, but far more powerful
    - UNICEF, WHO, Save the Children, IMC and several partners conducted very strong visibility and advocacy campaigns for child plight in Yemen, especially around health and nutrition, but the coordination component was missing.
  - GHC must champion MNC health
    - A subgroup affiliated with GHC and maybe national clusters focusing on child health would be helpful here.
    - Sensitization of cluster coordinators on child health
    - Recommendations for national HC on objectives/targets etc. for HRPs
    - Build capacity of partners to focus on child health in all health programming/response.
  - There is need for better data on child health situation
    - Other than estimates done by UNICEF and Save the Children, not much data exists on child health
    - Other than SMART survey, not many assessments or surveys focused on child health
    - GHC did not lead on assessments and an assessment working group was not established until 2018
    - Program data remains weak, but TPM data is reliable
  - Humanitarian situations may present opportunities for work with longer term implications on the health sector
- Questions
  - How important are INGOs in provision of services? How much has to go through the government?
    - The role of NGOs is contentious. When the conflict started, most evacuated, and while some returned shortly, many returned much later. The Yemen government is not interested in working with these INGOs, because they are concerned they may leave again if the conflict worsens. A second issue is because there are no financial resources available from Ministry of Finance, most the work being done is through external donors. Therefore, many local authorities see resources that are given to NGOs as resources that could have been given to them. For example, why are mobile health teams not being run by the relevant district health teams?

- On suggestion is for NGOs to take a step back on the implementation front, but increase coordination and capacity building with government health systems.
    - Around 30% of response is currently done by NGOs, and the remaining through health authorities
  - Why are there so many more volunteers (13,000) than CHWs? Are CHWs doing integrated community case management in the field?
    - Community Health Volunteer program is seven years old, and predates the conflict. They are not service providers, and they are not paid. It was easier to get the ministry to accept their presence and deployment because there is no plan for them to become employees or to receive salaries. Once per month they come to the health facility to pick up supplies and report on activities, and only receive a small per diem
    - CHWs were meant to be service providers, do immunizations and community case management. They are paid. The government did not want to introduce a new cadre of paid health workers, particularly post-conflict, as they haven't been able to pay their current health workers for two years.
      - EU started supporting the CHWs and the health facilities they were linked to.
  - In the areas where the government has no control, or armed opposition has control, sometimes NGOs have the upper hand in service delivery, such as in Afghanistan. Do similar situations exist in Yemen?
    - In Yemen, other than a small area in the eastern part of the country that is scarcely populated, most parts of the country are controlled by the internationally recognized government in the south, or the Houthis government in the north.
    - Health facilities exist and health care workers are showing up if they get paid. We do not want to come out of the war with the public health system in shambles. If they have the capacity and the only thing missing is finances that is the preferred method of service delivery
    - In terms of NGOs delivering services in areas where there is no gov't presence, that wouldn't work. However, NGOs can assist in coordination, capacity building, and other quality-related work.
- Will meet again in about 3 months. Still awaiting clarity on funding for the child health task force. I encourage everyone to make this a more interactive group. Please reach out to co-chairs to share results of studies or interesting programs. We encourage everyone to take ownership of this group.