Group Assignment – Module 3: Respond - How to plan and enact a coordinated set of activities addressing the identified child and adolescent health priorities

Preparation

16. Revise chapter three of the operational guide on child and adolescent health in humanitarian settings (page 45-79), https://applications.emro.who.int/docs/9789290228172-eng.pdf

Other suggested reading

- The Sphere handbook: humanitarian charter and minimum standards in humanitarian response. Geneva: Sphere Association; 2018.
- Sphere. Resources: training materials in multiple languages. Sphere Association, c2018. Available from: https://spherestandards.org/resources/?category=training-pack&lang=all&years=all&postTag=all&pag%20es=1

Instructions

17. **Group discussion:** In most groups all participants are working in the same country which they will use for the assignment. If this is not the case, another country will be selected for the group to focus on.
    - **Write up:** Research, compile and write up your answers into this Word template first and then make a PowerPoint presentation based on the template ⚔️💣⚔️💣⚔️⚔️🏺 provided.p
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      👨👨‍🦱👨‍🦲👨‍🦳 Ensure that every member of the group contributes to the write-up by assigning tasks accordingly. Appoint someone to present during the webinar on 28th February.
    - Please ensure **proper citation of all references** used. Include these citations in the provided box at the end of your submission.
    - Please **ensure your answers fit within the 5-page limit** of this Word document. Concise responses are appreciated.
- **Presentation:** Please fill out the PowerPoint template provided. Complete or adapt the texts marked in yellow on each slide. Keep your slides concise, and **ensure you do not exceed the provided 13-slide limit.**

18. **Final output**: Your final output should consist of a completed Word document and PowerPoint presentation. Submit your final group assignment to the course email and post it in the Main Group of the course.
19. **Deadline to hand in word document and PowerPoint slides: 25 February**

Potential references for answering the questions

20. Reliefweb, click on the country you are using in the assignment: https://reliefweb.int/countries
21. WHO EMRO's page on child and adolescent health: https://www.emro.who.int/entity/child-adolescent-health/home.html
22. UNICEF's adolescent health dashboards: https://data.unicef.org/resources/adolescent-health-dashboards-country-profiles/

Group assignment

Each group will pick a country, preferably where the majority of the group is currently working. Consider the unique challenges presented by the humanitarian situation in the selected country.

Your task is to address the questions provided below in alignment with Chapter 3 of the Operational Guide on Child and Adolescent Health in Humanitarian Settings. Focus on experiences in the selected country that are relevant to child and adolescent health within a humanitarian response context.

Please choose one specific experience related to child and adolescent health in the selected country, which your group will analyze throughout this exercise.

Questions – country of choice

1.

The case of Somalia highlights an analysis of acute food insecurity and acute malnutrition from the IPC (integrated framework for food security classification). During the period from March to June 2023, it is estimated that a significant number of people are acutely food insecure and malnourished. The specific figures for Somalia are not provided in your question, but it is worth noting that Somalia has faced recurring food crises and high levels of malnutrition in the past.

In Somalia, acute food insecurity and malnutrition disproportionately affect vulnerable populations, particularly in rural areas. Food-insecure households are prevalent, with a substantial proportion of the rural population facing high levels of acute food insecurity. This situation is often characterized by inadequate quantity and quality of children's dietary intake, limited dietary diversity, and low meal frequency. Contributing factors include the poor quality of food intake, inadequate infant and young child feeding practices (such as breastfeeding and complementary feeding), high prevalence of childhood illnesses, poor hygiene conditions, and limited access to safe drinking water.

Additionally, Somalia faces various challenges that exacerbate the food security and malnutrition situation. These challenges include low immunization coverage, limited access to vitamin A supplementation, conflicts in neighboring countries that affect the population and

lead to the arrival of refugees, rising food prices, dependence on markets and imports due to low local food production, limited social protection programs and employment opportunities, the effects of drought and climate change, and the prevalence of illnesses and shocks faced by households.

Addressing acute food insecurity and malnutrition in Somalia requires a comprehensive approach. This includes interventions aimed at improving food availability, promoting sustainable agriculture and livelihoods, enhancing access to safe drinking water and sanitation, strengthening healthcare services and nutrition programs, improving infant and young child feeding practices, implementing social protection programs, and addressing the underlying causes of vulnerability, such as conflicts and climate change. Close collaboration between the government, humanitarian organizations, and international partners is crucial to effectively respond to the situation and mitigate the impact of food insecurity and malnutrition on the population.

2. Briefly describe the situation. Briefly review the 'Key Actions' in chapter 3 ('Respond') of the operational guide on child and adolescent health in humanitarian settings (page 45-79). Think about how these 'Key Actions' apply to your team's chosen experience. Consider dividing the technical sections of Section 3.2 between the group, rather than trying to cover everything. What were the priorities that you identified in the situation?

In Somalia, addressing child and adolescent health requires establishing service delivery structures, deciding on an essential services package, and strengthening the healthcare workforce. Here's how these actions can be adapted for Somalia:

1. Establish Service Delivery Structures: It is essential to set up appropriate and accessible health facilities and referral systems for children and adolescents in Somalia. This includes ensuring that these facilities meet quality and safety standards and promoting community engagement and participation. The Harmonized Health Facility Assessment (HHFA) tool by WHO can be utilized to assess and improve the functionality of health facilities in Somalia, replacing the previous tool known as SARA.

2. Decide on an Essential Services Package: Somalia needs to identify and implement a priority set of interventions for child and adolescent health based on the assessment of needs, available resources, and capacity. A comprehensive guide can be developed that covers 10 technical areas of child and adolescent health, including acute and chronic conditions, child protection, nutrition, mental health, and sexual and reproductive health.

- Acute Conditions: Guidelines such as the Sphere Health Standards and the newborn health in humanitarian settings field guide can be utilized to ensure appropriate care for acute conditions in children and newborns.

- Chronic Conditions: Special attention should be given to addressing respiratory, cardiac, and nutritional chronic conditions in children and adolescents in Somalia.

3. Disease Outbreaks and Immunization: Enhancing immunization coverage is crucial in preventing disease outbreaks. Monitoring the percentage of infants who receive the recommended vaccines, such as the third dose of DTP-containing vaccine, can be done in collaboration with UNICEF and other partners to assess and improve immunization coverage in Somalia.

4. Nutrition and Food Security: Given the high prevalence of malnutrition in Somalia, addressing nutrition and food security is of utmost importance. Implementing programs that promote proper nutrition, including breastfeeding and complementary feeding, and improving access to nutritious food are key interventions.

5. Child Development and Education: Supporting child development and ensuring access to quality education are critical for the well-being of children and adolescents in Somalia. Implementing programs that prioritize early childhood development, promote inclusive education, and provide psychosocial support can contribute to their overall health and well-being.

6. Sexual and Reproductive Health: Adolescent sexual and reproductive health should be addressed through comprehensive programs that provide information, services, and support related to reproductive health, family planning, and prevention of sexually transmitted infections.

7. Water, Sanitation, and Hygiene (WASH): Ensuring access to clean water, sanitation facilities, and good hygiene practices is essential for child and adolescent health. Integrating WASH interventions into health programs can contribute to preventing diseases and improving overall well-being.

8. Strengthen the Healthcare Workforce: Recruiting, training, supervising, and supporting health workers is crucial to deliver effective child and adolescent health services in Somalia. Emphasis should be placed on providing specialized training in pediatric and adolescent care, as well as ensuring their continuous professional development.

It's important to note that the specific strategies and interventions may vary based on the local context and priorities in Somalia. Collaboration between the government, healthcare providers, humanitarian organizations, and international partners is critical to implementing these actions and improving child and adolescent health outcomes in Somalia.

To apply these critical actions to your team's chosen experience, you should consider the following questions:

- What are your context's main challenges and gaps in delivering child and adolescent health services?
- What are the existing service delivery structures, and how can they be improved or expanded to reach more children and adolescents, especially the most vulnerable and marginalized?
- What are the most essential and feasible interventions for child and adolescent health in your context, and how can they be integrated and delivered across different levels of care and sectors?
- What are the current and projected needs and availability of health workers, medicines and supplies for child and adolescent health, and how can they be addressed and monitored?
- What are the sources and mechanisms of financing for child and adolescent health, and how can they be secured and managed effectively and efficiently?

3. Identify the key stakeholders and assess their roles and influences in addressing child and adolescent health priorities during the humanitarian crisis. Be as specific as possible and consider both senior and more junior people. It's important to recognize that effective champions can be found at various levels, including both senior and junior professionals, who are motivated and committed to driving initiatives forward. Please consider the full range of agencies and organizations involved. (You might refer to chapter 1 of the operational guide on child and adolescent health in humanitarian settings, page 20 for additional insights)

Key stakeholders/Principales parties prenantes	**Their roles**
1. Government Authorities and Ministries: ● Ministry of Health: Responsible for overall health policy development, coordination, and implementation. ● Ministry of Education: Plays a role in promoting access to education and ensuring the integration of health and education services. ● Ministry of Women and Human Rights: Focuses on issues related to	1. Government Authorities and Ministries: ○ Senior Government Officials: They provide strategic leadership, policy direction, and resource allocation for child and adolescent health programs. ○ Junior Government Officials: They support the implementation of policies and programs, coordinate

gender equality, child protection, and the rights of women and children.

2. **International Organizations:**

- United Nations Children's Fund (UNICEF): Provides technical assistance, funding, and advocacy for child and adolescent health programs in collaboration with the government.
- World Health Organization (WHO): Offers technical expertise, guidance, and support in developing health policies, guidelines, and interventions.
- United Nations Population Fund (UNFPA): Focuses on sexual and reproductive health and rights, including addressing adolescent reproductive health needs.
- International NGOs: Organizations such as Save the Children, World Vision, and Médecins Sans Frontières (Doctors Without Borders) contribute resources, expertise, and program implementation in child and adolescent health.

3. **Local NGOs and Civil Society Organizations:**

- Local NGOs: These organizations often have a deep understanding of the local context and can provide grassroots support, community engagement, and service delivery.
- Community-Based Organizations (CBOs): These organizations work directly with communities, advocating for child and adolescent

activities, and engage with stakeholders at the local level.

2. International Organizations:
    - Senior Program Managers: They oversee the planning, implementation, and monitoring of child and adolescent health programs, ensuring alignment with organizational goals and priorities.
    - Junior Technical Officers: They provide technical expertise, conduct research or data analysis, and contribute to program development and evaluation.
3. Local NGOs and Civil Society Organizations:
    - Senior Managers: They provide organizational leadership, strategic planning, and advocacy for child and adolescent health priorities.
    - Junior Field Officers: They work directly with communities, conducting outreach, providing health education, and supporting program implementation at the grassroots level.
4. Healthcare Professionals:
    - Senior Medical Officers: They provide clinical expertise, guide health policies, and mentor junior healthcare professionals.
    - Junior Doctors and Nurses: They deliver frontline health services, including diagnosis, treatment, and

health priorities and facilitating community participation and ownership.

4. Healthcare Professionals:

- Pediatricians, Obstetricians, and Gynecologists: These specialists provide medical care, guidance, and expertise in child and adolescent health.
- Nurses and Midwives: They play critical roles in delivering health services, including immunizations, maternal and child health care, and sexual and reproductive health services.
- Community Health Workers: These frontline workers are often embedded in the community and can provide essential health services, health education, and referrals.

5. Educators and School Administrators:

- Teachers: They have direct contact with children and adolescents and can contribute to health education, including promoting healthy behaviors and providing psychosocial support.
- School Principals/Administrators: They can support the integration of health services within the school system and ensure a safe and supportive environment for children and adolescents.

preventive care for children, adolescents, and mothers.

5. Educators and School Administrators:
    - Senior Education Advisors: They provide guidance on integrating health education into the curriculum, develop policies, and support teacher training.
    - Junior Teachers: They deliver health education lessons, provide counseling, and identify students in need of additional support.
6. Donors and Funding Agencies:
    - Senior Program Officers: They manage funding portfolios, assess project proposals, and monitor program performance.
    - Junior Grants Administrators: They support the administrative aspects of funding, including proposal review, budgeting, and reporting.

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[1] L'analyse IPC vise à fournir des indications pour la réponse d'urgence de même que pour la politique de sécurité alimentaire et la programmation à moyen et long terme.

6. Donors and Funding Agencies:

- Bilateral and Multilateral Donors: Governments and organizations that provide financial assistance and support for child and adolescent health programs.
- Philanthropic Foundations: Organizations such as the Bill & Melinda Gates Foundation and the Ford Foundation contribute funding and technical support for health initiatives.

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[1] L'IPC est également un forum qui réunit les gouvernements, les Nations Unies, les ONG et la société civile et qui réalise des analyses conjointes de la sécurité alimentaire afin de parvenir à

des consensus techniques sur la nature et la sévérité de l'insécurité alimentaire dans leurs pays.	

4. What were the challenges to effectively implement child and adolescent health initiatives and how were they addressed?

Challenges to implementation(IPC_Djibouti_Acute_FoodInsec_Malnutrition_JanDec2023_Report_French,Page10 & 11)	**How were they addressed?**
1. Limited Resources: Humanitarian crises often result in strained resources, including funding, healthcare infrastructure, and trained personnel. Limited resources can hinder the establishment and functioning of health facilities, procurement of essential supplies, and recruitment of skilled healthcare workers. 2. Insecurity and Access Constraints: Conflict and instability in Somalia can make it difficult to access and deliver healthcare services, particularly in remote or conflict-affected areas. Insecurity may restrict the movement of healthcare workers, hinder supply chains, and pose risks to the safety of healthcare facilities and personnel. 3. Disrupted Health Systems: Humanitarian crises can disrupt the existing health systems, leading to weakened infrastructure, inadequate governance, and limited capacity to deliver essential services. Disruptions may result from damaged or destroyed healthcare facilities, interrupted supply chains, and displacement of healthcare workers.	1. Mobilizing Resources: Efforts are made to secure funding from donor agencies, international organizations, and philanthropic foundations to support child and adolescent health programs. Resource mobilization includes advocating for increased funding for health programs, establishing partnerships with donors, and leveraging innovative financing mechanisms. 2. Strengthening Health Systems: To address disrupted health systems, efforts are made to rebuild and strengthen infrastructure, including the rehabilitation and construction of healthcare facilities. Health workforce development initiatives, such as training and capacity-building programs, are implemented to address the shortage of skilled healthcare professionals. Supply chain management systems are established or improved to ensure a consistent flow of essential medicines and supplies. 3. Security and Access: Collaborative efforts are made to improve security conditions and

4. Malnutrition and Food Insecurity: Somalia faces high levels of malnutrition and food insecurity, exacerbating the health challenges for children and adolescents. Limited access to nutritious food, inadequate breastfeeding practices, and waterborne illnesses contribute to the high prevalence of malnutrition and its associated health consequences. 5. Cultural and Social Factors: Cultural beliefs, norms, and practices can influence health-seeking behaviors and acceptance of certain interventions. Cultural taboos, gender disparities, and social stigmas may hinder access to reproductive health services, mental health support, and child protection services. 6. Lack of Awareness and Health Literacy: Limited health literacy and awareness among caregivers, adolescents, and community members can impact the uptake of health services and adherence to recommended practices. Lack of understanding about preventive measures, disease management, and available healthcare options can hinder the effectiveness of interventions. 7. Humanitarian Coordination and Collaboration: Effective coordination and collaboration among stakeholders, including government entities, international organizations, and local NGOs, are crucial for successful program implementation. Challenges in coordination, information sharing, and resource mobilization can hinder the effectiveness and efficiency of child and adolescent health programs.	negotiate safe access to deliver healthcare services. This may involve coordination with local authorities, peacekeeping forces, and humanitarian actors to establish safe zones, facilitate humanitarian corridors, and ensure the protection of healthcare facilities and personnel. Mobile health clinics or outreach services are utilized to reach remote and inaccessible areas. 4. Nutrition and Food Security: Programs addressing malnutrition and food insecurity are implemented, including therapeutic feeding programs for severely malnourished children, distribution of nutritional supplements, and promotion of breastfeeding and complementary feeding practices. Additionally, efforts are made to support agriculture, livelihoods, and food production to improve food security in the long term. 5. Cultural Sensitivity and Community Engagement: Interventions are designed to respect and incorporate cultural beliefs, norms, and practices. This may involve engaging community leaders, religious leaders, and traditional healers to raise awareness, address misconceptions, and promote the adoption of healthy behaviors. Community health workers and peer educators are trained and deployed to provide culturally appropriate health education and services.

8. Data Collection and Monitoring: In humanitarian settings, collecting accurate and timely data on child and adolescent health indicators can be challenging. Weak health information systems, limited data collection tools, and disruptions to data reporting and monitoring systems can impede evidence-based decision-making and program evaluation.	6. Health Education and Literacy: Health literacy programs are developed to enhance understanding among caregivers, adolescents, and community members. These programs focus on raising awareness about preventive measures, disease management, and available healthcare services. Education campaigns utilize culturally appropriate communication channels, including community gatherings, radio programs, and mobile messaging platforms. 7. Humanitarian Coordination and Collaboration: Coordination mechanisms are established among stakeholders to facilitate information sharing, avoid duplication of efforts, and ensure efficient use of resources. Coordination platforms, such as health cluster meetings, inter-agency working groups, and regular reporting mechanisms, are utilized to enhance collaboration and harmonize activities. 8. Data Collection and Monitoring: Efforts are made to strengthen health information systems and data collection mechanisms. This includes training healthcare workers on data collection tools, establishing reporting systems, and implementing regular data analysis and reporting cycles. Routine monitoring and evaluation activities are conducted to assess the effectiveness and impact of child and adolescent health programs.

5. Was there an RMNCAH/CAH working group in place? If so, how did it help coordinate the key actions? If not, how could this working group have aided in the coordination of the key actions?

No it was not,

1. Coordinated Response: The working group could have facilitated a coordinated response among different stakeholders involved in addressing child and adolescent health needs. By bringing together representatives from government authorities, humanitarian organizations, local NGOs, healthcare providers, and community leaders, the working group could have ensured that efforts are aligned, gaps are identified, and resources are optimized.
2. Priority Setting: The working group could have played a crucial role in setting priorities for child and adolescent health interventions. It would have provided a platform for stakeholders to collectively identify the most urgent needs, determine key actions, and establish a common agenda. This would have helped in focusing limited resources and efforts on the most critical areas.
3. Resource Mobilization: The working group could have facilitated resource mobilization by advocating for increased funding and support for child and adolescent health programs. It would have provided a unified voice to engage with donors, international organizations, and government entities to secure financial resources and essential supplies. This would have addressed the resource gaps and ensured the availability of necessary resources for key actions.
4. Collaboration and Information Sharing: The working group would have promoted collaboration and information sharing among stakeholders. It could have facilitated regular meetings, workshops, and knowledge-sharing sessions to exchange experiences, lessons learned, and best practices. This collaboration would have enabled stakeholders to benefit from each other's expertise, avoid duplication of efforts, and leverage available resources effectively.
5. Capacity Building: The working group could have facilitated capacity-building initiatives to strengthen the skills and knowledge of healthcare providers, community health workers, and other relevant stakeholders. Training programs, workshops, and skill-sharing sessions would have improved the quality of care provided to children and adolescents, ensuring that key actions are implemented effectively.
6. Advocacy and Policy Influence: The working group could have advocated for child and adolescent health priorities through engagement with policymakers, government authorities, and other influential stakeholders. It would have raised

awareness about the specific health needs of children and adolescents in conflict settings, influenced policies, and advocated for the integration of child and adolescent health into the broader humanitarian response.

While the absence of RMNCAH or CAH working groups during the conflict in Somalia limited the opportunities for coordination, establishing such a working group retrospectively could still contribute to enhancing the response. It would bring stakeholders together, promote collaboration, set priorities, mobilize resources, and advocate for improved child and adolescent health services in future humanitarian crises.

6. What lessons have been learned? Please consider both positive and negative experiences.

Positive Lessons:

1. Community Resilience: Despite the challenging circumstances, Somalia has demonstrated resilience and the ability of communities to adapt and respond to child and adolescent health needs. Local communities have shown strength in mobilizing resources, establishing makeshift healthcare facilities, and supporting each other during crises.
2. Partnership and Collaboration: Positive experiences have highlighted the importance of partnership and collaboration among different actors involved in child and adolescent health in Somalia. Collaboration between government authorities, humanitarian organizations, local NGOs, and community-based organizations has led to more effective and coordinated responses.
3. Innovations in Service Delivery: Over time, innovative approaches to service delivery have emerged in Somalia. Mobile health clinics, community health workers, and telemedicine have been utilized to reach remote and underserved areas, providing essential healthcare services to children and adolescents.

Negative Lessons:

1. Fragile Health Systems: Somalia's prolonged conflict has severely weakened its health systems, resulting in limited access to quality healthcare services. The negative lesson is that conflict exacerbates existing vulnerabilities and disrupts healthcare infrastructure, making it challenging to provide adequate care for children and adolescents.
2. Disruption of Education: Conflict disrupts education systems, leading to limited access to education and psychosocial support for children and adolescents in Somalia. The negative consequences of interrupted schooling include increased risks of exploitation, child labor, and long-term educational gaps.
3. Inadequate Funding and Resources: Somalia has faced significant challenges in securing adequate funding and resources for child and adolescent health interventions. Insufficient funding hampers the implementation of comprehensive programs and limits the availability of essential services and supplies.
4. Protection of Children: Conflict situations pose significant risks to the protection and well-being of children and adolescents. The negative lesson is that Somalia has faced challenges in adequately protecting children from violence, abuse, and recruitment by armed groups, highlighting the need for stronger child protection mechanisms.
5. Data and Information Gaps: The availability and quality of data on child and adolescent health in Somalia have been limited, hindering evidence-based decision-making and monitoring of progress. Insufficient data and information systems pose challenges in assessing the impact of interventions and targeting resources effectively.

These lessons emphasize the need for sustained investment in strengthening health systems, education, child protection mechanisms, and data collection in Somalia. They also highlight the importance of addressing funding gaps, enhancing collaboration, and ensuring the protection and well-being of children and adolescents in conflict settings. By learning from these positive and negative experiences, stakeholders can work towards more effective and comprehensive interventions in future conflict response efforts in Somalia.

7. What could be done better? Were there any aspects of the situation that could have been handled more effectively or improved upon?

Les données sur la tranche d'âge d'adolescentes et adolescents n'ont pas été collectées. L'état nutritionnel de ce groupe d'âge n'a pas capté l'attention des acteurs. Le tableau de nombre de cas de malnutrition aiguë attendue pour 2023 ne contient pas les données sur les tranches d'âge au-delà de 59 mois et le groupe d'âge à procréer n'est pas désagrégé pour avoir une idée sur les adolescentes et adolescents. Il y a peu de chance que les besoins des personnes omises dans les données soient pris en compte lors de la prise des décisions et des stratégies d'amélioration de leur bien-être .

Les adolescents et les jeunes n'ont pas été impliqués dans l'enquête et leurs besoins spécifiques ne seront pas pris en compte.

En effet, le groupe SRMENIA n'y était pas pour défendre la collecte des données désagrégées par âge et sexe même si le secteur de la santé était présent. Ces données ne sont pas abordées de façon spécifique même dans les autres documents de Djibouti.La santé des enfants ayant l'âge entre 9 mois allant vers 25 ans devrait être pris en compte

8. References used: please ensure proper citation of all references used in the box below.

List your references as applicable

- https://www.aljazeera.com/where/somalia/
- https://www.who.int/
- https://www.emro.who.int/countries/somalia/index.html
- https://moh.gov.so/en/
- https://sordi.so/
- https://nih.gov.so/case-studies/reproductive-maternal-neonatal-child-and-adolescent-health-strategy/
- https://moh.gov.so/en/wp-content/uploads/2020/07/Reproductive-Maternal-Neonatal-Child-And-Adolescent-Health-Strategy-2019-2023.pdf
- https://www.somalimedicalarchives.org/media/attachments/2021/0

9/18/rmncah-strategy-2020-2024.pdf
- https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-019-0241-x
- https://www.emro.who.int/images/stories/somalia/RMNCAH-Policy-Brief-August-2023.pdf