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# Introduction

Armed conflicts and natural disasters have spared no area of the world – from Afghanistan, Indonesia, India, Palestine in Asia, to Sierra Leone, Democratic Republic of Congo and Angola in Africa, to Bosnia and Kosovo in Europe and Nicaragua and Peru in the Americas. According to the United Nations High Commissioner for Refugees (UNHCR), as of January 2003, there were approximately 20.6 million “people of concern,” falling under the mandate of UNHCR, including refugees and people in refugee-like situations, such as asylum-seekers, internally displaced persons, and returnees, in more than 150 countries in all regions of the world. An estimated 10 million of these people of concern are children under the age of 18 (The World of Children at a Glance, UNHCR 2001 (<http://www.unhcr.ch/children/glance.html>)).

Children are particularly vulnerable in complex emergencies. They are often the first and most common victims of human rights violations, violence, disease, malnutrition and death. Addressing their specific needs, including health, in complex emergencies is critical to the success of relief efforts and requires child-specific, effective and coordinated interventions.

The provision of health care to children in complex emergencies differs from that of children in stable situations. The severity and magnitude of childhood diseases is often exacerbated by forced migration, conflict or disaster, necessitating the rapid assessment and treatment of large numbers of severely ill children. In complex emergencies, the provision of health care is often less uniform than in stable situations and ensuring comprehensive, coordinated and appropriate care is difficult where multiple organizations are working, different levels of referral services, supply and delivery systems are lacking or insufficient, and health care workers with minimal training are often the primary providers. Disease surveillance systems must be rapidly established, particularly for diseases known to cause outbreaks with high mortality, such as measles and diarrheal diseases. The logistics of drug delivery and distribution are complicated by the myriad of organizations involved, inadequate communication, delivery and transportation systems and threats to security.

Other factors confound efforts to develop standards and guidelines for the care of children in complex emergencies. The typology of the emergency, whether armed conflict, famine or natural disaster, determines the specific health risks and each type demands responses sufficiently flexible to adapt to these risks. Regionally, children differ in their general health, nutritional status and exposure to communicable diseases prior to the onset of an emergency, and these regional differences persist for the duration of the emergency and determine the type of health interventions needed. Health and nutritional needs often also vary in the acute phase of an emergency from the post-emergency setting or in a chronic emergency. Children separated from their families and care-takers face additional and unique health risks.

Despite the complexities of addressing the specific health needs of children in emergencies, the majority of the burden of disease continues to be caused by malnutrition and several

infectious diseases, those that contribute to high rates of mortality and morbidity of children in non-emergency settings as well and for which there exist evidence-based guidelines for prevention and treatment. This body of information and clinical experience serves as the foundation for addressing the unique health needs of children in complex emergencies. However, child health in complex emergencies encompasses broader issues that are essential to successful relief efforts. The basic human rights and dignity of children, which are so easily and often transgressed in emergencies, must be protected. In conflicts, children may be recruited as soldiers, subject to violence and torture, and sexually or physically abused. The provision of care and protection to children in complex emergencies, although often overwhelmed with immediate concerns, should maintain a vision of fostering sustainable health care during the transition to the post-emergency situation.

Based on these principles and drawing on field experience, the United Nations Children's Fund (UNICEF) has developed a set of "Core Corporate Commitments" (CCCs) to ensure an effective response to the needs of children and women affected by unstable situations, in which capacities to forecast and respond to crises and/or unstable situations are mainstreamed into the programming and operational approach of UNICEF at country, regional and global levels. The CCCs are divided into 4 broad categories: rapid assessment, coordination, programme commitments in 5 areas (Health and nutrition, water supply and sanitation, child protection, Education, HIV/AIDS) and operational commitments (organizational capacity, procedures and resources – funds, staff and supplies – to ensure that the appropriate response will be available on a timely basis).

To further address such issues, the World Health Organization (WHO) and UNICEF convened an inter-agency consultation to bring together major international and national partners addressing and responding to child health in complex emergencies. The objectives of the two-day consultation were:

- To review the extent of health problems affecting children in complex emergencies and what tools are available to address them.
- To discuss roles and contributions of various partners working on child health in complex emergencies.
- To identify existing gaps/challenges and how to provide technical and operational support to child health in complex emergencies.
- To identify priority research needs for clinical care and technical operations in child health during complex emergencies.
- To reach consensus on recommendations and next steps in addressing child health in complex emergencies.

Opened by Ms. Carol Bellamy, Executive Director of UNICEF, and Dr. Jong-Wook Lee, Director General of WHO, the consultation was an initial step for identifying gaps and reaching consensus on concrete actions to address child health in complex emergencies. In addition to reviewing technical issues, the meeting participants were encouraged by Ms. Bellamy and Dr. Lee to focus on both a variety of service delivery strategies to strengthen to role of local health care providers and promote behavior change at the community level as well as mechanisms for ensuring effective coordination among partners, while utilizing and supporting existing health policy processes and capacity.

The meeting began by setting a framework for defining complex emergencies. In 1990, complex emergencies were identified as acute situations in which excess mortality (greater than 1 death per 10,000 population per day), most often caused by measles, diarrheal diseases, acute respiratory tract infections and malaria and confounded by the prevalence of both protein-energy malnutrition and micronutrient deficiencies, plagued refugees and displaced persons living primarily in camps and dependent on international relief assistance for their survival (Toole MJ, Waldman RJ. *Prevention of excess mortality in refugee and displaced populations in developing countries*. JAMA. 1990;263(24):3296-302).

The nature of complex emergencies and the environment of providing humanitarian assistance, however, have changed dramatically over the last 13 years. Daily activities are no longer confined to refugee camps or within clearly defined boundaries. Rather cross-border as well as internal population movements, local and regional variations in epidemiology, typology of the emergency, from acute to chronic, the pre-emergency health status of the affected population and geographic variations have all added to the complexity of defining and responding to complex emergencies.

Today, complex emergencies may not necessarily be acute situations with excessive mortality or malnutrition, as was the experience in Kosovo, East Timor or Iraq. Nor may a complex emergency necessarily be the same as a health crisis, such as the HIV/AIDS epidemic in southern Africa, which is clearly a crisis and complex. For the purpose of this consultation, a complex emergency was defined as a situation in which the following factors are evident:

- The failure of existing health, government and community systems to cope with relatively acute changes of varying nature within a short period of time.
- Usually, but not always, a precipitating event frequently related to conflict and/or food insecurity.
- Usually a time bound event, with an end in sight in which the emergency phase will eventually lead to development. ■

# Objective I

*To review the extent of health problems affecting children in complex emergencies and what tools are available to address them*

While the nature of responses will vary according to the epidemiology and typology of the emergency, all populations face burdens and challenges for survival during such times. Yet, children remain particularly vulnerable in complex emergencies and addressing their specific health needs is critical to the success of any intervention.

The major causes of child mortality and morbidity in complex emergencies are already well-known and documented: diarrheal diseases, acute respiratory tract infections, malaria, measles and malnutrition; as are the major contributors to childhood mortality and morbidity, most notably micronutrient deficiencies. The impact of each, however, depends on the pre-emergency health status of the affected population and geographic variations.

Outbreaks of other communicable diseases may also be significant causes of child mortality and morbidity depending on regional or local epidemiology or the nature of the emergency. Some examples include meningococemia, pertussis, leishmaniasis, tuberculosis and dysentery. Other health problems, which may not be significant causes of mortality or morbidity in the acute stage of an emergency but also need to be addressed, include HIV/AIDS, physical and sexual abuse, psychosocial health problems and trauma.

Prioritization of interventions to address these child health issues is critical. Often the right interventions are done but not necessarily at the right time. The meeting participants recognized that interventions to reduce excess mortality and morbidity should be prioritized at all levels in the health care system (community, health center and hospital). Such interventions include diarrhea prevention, oral rehydration therapy (ORT), ensuring food security and feeding programmes for severely malnourished infants, measles immunization and vitamin A supplementation. Interventions to maintain low mortality and reduce excess morbidity were recognized as second priority interventions and those to improve health and development as third priority interventions [See annex I – Matrices for prioritization of emergency interventions].

Some comprehensive guidelines for addressing the specific health needs of refugees and displaced population in complex emergencies are available, such as the Refugee Health handbook by MSF, and some targeted guidelines for some causes of mortality and morbidity in complex emergencies, such as those for reproductive health for refugees, infant feeding and malaria. Additionally, case management guidelines, such as those for Integrated Management of Childhood Illnesses (IMCI), exist for the diagnosis and treatment for the major causes of child mortality and morbidity in stable situations.

Generally, however, existing guidelines are not adequate for ensuring optimal care to children in complex emergencies. There are many limitations to using the existing guidelines, including the length of training required to understand and use the guidelines, inadequate or non-functioning health facilities limited staffing, staff capacity, and supervision, poor coordination,

insufficient links with communities, lack of security for delivery of services and limited accessibility to guidelines in the field.

It was agreed that there is a need for additional guidelines to be compiled and developed, if necessary, for addressing the specific health needs of children in complex emergencies. In particular, these guidelines should be user-friendly and simple, appropriate for various levels of health care workers, especially at the community level, and easily accessible in the field.

UNICEF, in partnership with CDC, and Tufts and Columbia Universities, has developed a training course for UNICEF health and nutrition staff. This course, “Training for Improved Practice in Public Health and Nutrition in Emergencies,” aims at strengthening technical expertise and improving decision-making skills in emergency settings. This 10-day training covers issues ranging from rapid assessments and surveys to basics of epidemiology and disease-specific issues (measles and other vaccine-preventable communicable diseases, malaria, HIV/AIDS, cholera, infant feeding and micronutrients etc.). After its first year, the training is now expanding, whereby it is hoped that more UNICEF health and nutrition staff as well as key health staff from partner agencies will benefit from this training.

The WHO Communicable Disease Working Group on Emergencies (CD-WGE) has developed training modules specifically targeted at communicable disease control in complex emergencies, the content of which includes risk assessments, setting up surveillance systems, outbreak preparedness and response, with disease-specific modules on prevention and control of malaria, diarrhoeal diseases, acute respiratory infections, tuberculosis and measles in complex emergencies. ■

- Develop and pilot a minimum package and a mechanism of prioritization for essential child health interventions in complex emergencies (see working example in annex I).
- Adapt and simplify existing guidelines for all levels of care (community, health center and hospital) of children in complex emergencies.
- Develop a training curriculum based on a minimum package for child health interventions in complex emergencies.

ACTION POINTS

## Objective 2

*To discuss roles and contributions of various partners working on child health in complex emergencies*

Multiple parties, including international organizations, such as WHO and UNICEF, international and local NGOs, national and local governments, communities and health care workers, are involved in addressing and responding to the specific health needs of children in complex emergencies. While several NGOs presented on their work in responding to the health of children in complex emergencies, successful programmes and obstacles they have faced and overcome to implement activities, much of the discussion focused on the respective roles of the Ministry of Health (MoH) and WHO at both the international and national level.

It is recognized that ideally, the MoH should be the lead for coordinating NGO and international agency activities, establishing of a minimum package of services and health interventions, adapting training materials and guidelines to respond to local circumstances and strengthening health information systems. By definition, however, complex emergencies are not business as usual and are characterized by the deterioration or absence of traditional authority and administrative structures. As such, in a vacuum of traditional leadership, which agency is the most appropriate and capable of assuming this leadership role for responding to child health in complex emergencies?

Globally, WHO has the mandate to provide policy guidance to existing institutions and quality assurance and standard setting for performance and implementation of activities. In preparation for the meeting, WHO commissioned a review document entitled “Building the Evidence Base on the Provision of Health Care to Children in Complex Emergencies” prepared and presented by Johns Hopkins University (available on request). In the background document, and through discussion, meeting participants recommended that the primary role of WHO in complex emergencies should be to apply this global mandate at the local level by supporting the MoH through the provision of technical assistance as well as fostering coordination among various agencies and health care providers on the ground. In situations where WHO may not be the most appropriate or capable agency to assume this function, identification of another institution will be necessary, depending on strengths and weaknesses in that particular situation.

Effective leadership is imperative in any complex emergency. The agency identified for this role must be able to provide a vision, set priorities, define accountabilities and communicate with the other players. The agency must have the human, financial and technical resources to assume this role and be credible with other organizations. Likewise for leadership and coordination to be successful, other agencies must buy-in to and support this role, be transparent about their own abilities and capacity, endorse the “rules of engagement” in the humanitarian response and be willing to work as a team and share information with partners.

As the majority of children are ill or will die before they reach a clinic or health center, the role of all agencies to support and strengthen capacity at the community level is also essential.



In particular, the ability of local health care workers should be strengthened to provide primary care, and communities should be empowered to identify illness, provide home-based care, practice appropriate health-seeking behavior, mobilize other community members for immunization campaign and strengthen community surveillance. ■

- Strengthen health systems and build capacity of Ministries of Health to assume coordination functions, and in the absence of a Ministry of Health, ensure an alternative coordination body.
- Inter-agency group to develop a “code of conduct” or principles of working as a team in complex emergencies, with roles and responsibilities, to improve survival outcomes.

**ACTION POINTS**

## Objective 3

*To identify existing gaps/challenges and how to provide technical and operational support to child health in complex emergencies*

Multiple challenges to ensuring effective health care to children in complex emergencies were identified in the background document and through discussion. Several major obstacles to providing health care to children in complex emergencies identified include limited access to care, limited resources and lack of coordination among the various players as well as competing priorities and gaps in technical guidelines for managing illness at all levels.

“Lack of access” is a multi-faceted barrier to providing care to children in complex emergencies. It may include physical barriers, such as weak, overburdened or non-existent health care systems; behavioral and cultural barriers, including traditional beliefs about illness or gender-specific constraints; and financial barriers, such as charging fees for services or medicines to populations without the adequate resources to pay. Several options for overcoming such access barriers may include strengthening the capacity of non-traditional health care systems, such as communities and households, to respond to illness. Likewise, alternative methods and strategies for service delivery, such as using private providers for antibiotics or scaling up delivery of nets for malaria control may increase access to populations. Capacity building and training of both international and national staff are avenues for filling gaps in service delivery. On the other hand, under some circumstances, emergencies may in fact provide unique opportunities for accessing populations through community solidarity and strengthened logistics.

Poor coordination and lack of leadership in complex emergencies are still fundamental problems. In reality, poor coordination and lack of leadership may be the biggest problem and leading cause of death in complex emergencies, as they hinder the introduction of essential disease prevention and life-saving interventions. In addition, lack of accountability and the inability to sanction inappropriate action are challenges in most emergency situations. Preparedness plans for potential emergencies in high risk countries or regions are possible tools for overcoming such problems. Preparedness plans at both the global and country levels could include pre-identification of an appropriate and capable institutional leader, common standards and rules of engagement for the major players, assessment and evaluation tools to measure success of interventions and commitment of financial, human and technical resources by partners.

While reasonable consensus exists among the major partners in the humanitarian relief community on *what* to do in a complex emergency, *how* to do it in the most rapid and effective way is still debated. In reality, interventions are often determined not by what is needed most but by individual organizational or donor priorities. The prioritization of interventions, therefore, is essential to providing effective, life-saving interventions as quickly as possible. Meeting participants broke into small groups and attempted to prioritize health and nutrition interventions, according to levels of mortality and morbidity and identify distractions to providing appropriate and effective health care interventions. The development of an algorithm/step-wise approach based on the typology of the emergency for prioritization and response was explored and recommended for further development.

To address the gaps in technical guidelines for the treatment of severe disease in emergencies as well as for community-based treatment and management of illness and disease, compilation of appropriate and available guidelines in an easy-to-use and accessible package is needed. In addition, the meeting participants suggested that a comprehensive minimum package for child health in complex emergencies, including the exploration of alternative ways to deliver services be developed. ■

- Develop an advocacy strategy for referring to all issues addressed in the consultation.
- Link up with work of the Inter-Agency Standing Committee (IASC) and other ongoing activities to ensure the development of standards, assessment and evaluation tools and performance measurement.
- Develop guidelines for the care of children with severe disease in the absence of referral facilities, and field-test the guidelines.
- Adapt existing guidelines for the management of trauma, burns and sexual abuse (including post-exposure prophylaxis for HIV) to be used in complex emergency settings, and field-test the adapted guidelines.
- Address the reproductive health of refugees and prevention of neonatal mortality in complex emergencies, including the prevention of hypothermia and hypoglycemia, proper skin and umbilical cord care, and recognition and therapy of infections.
- Develop better tools to assess mental health problems in children that can be applied across cultures, based on the broad experience in evaluating children who have experienced complex emergencies.
- Develop and evaluate alternative methods to measure mortality.

ACTION POINTS

# Objective 4

*To identify priority research needs for clinical care and technical operations in child health during complex emergencies*

Several areas for further research were identified in the background document and during the consultation. Priority research areas should focus on the 5 major causes of child mortality and potentially result in cost-effective interventions within a reasonable time frame. In addition, research priorities should focus on studies that cannot be conducted in stable settings, e.g. effectiveness of insecticide-treated plastic sheeting in the prevention of malaria. The list that follows is not exhaustive and further operational and management research issues should be identified. A list of research priorities for the care of children in complex emergencies can draw upon previous efforts by the Advisory Group on Emergencies. To facilitate this research, collaborations with research institutions should be explored (e.g. Tropical Disease Research Centres). ■

## ACTION POINTS

- Evaluation of several technical issues in the case management of child health in complex emergencies, including:
  - cost-effectiveness of short courses of more expensive antibiotics for the treatment of antibiotic-resistant diarrheal disease, specifically additional studies of short courses of ciprofloxacin for the treatment of *Shigella* dysenteriae and macrolides for the treatment of *Vibrio cholera*
  - effectiveness of short courses of antibiotics for the treatment of pneumonia in complex emergencies, including home management
  - development and field-testing of rapid diagnostic tests (e.g. antigen detection tests) for infection with *Vibrio cholera*, *Shigella* dysenteriae and malaria, and for determination of antibiotic susceptibility
  - intermittent presumptive treatment of malaria in children in complex emergencies
  - methods to improve effective community adherence to retreatment of insecticide-treated nets.
  - prevention of maternal-infant HIV transmission in complex emergencies and the optimal management of HIV-infected children
  - prevalence, diagnosis and treatment of tuberculosis in children in chronic complex emergencies

# Objective 5

*To reach consensus on recommendations and next steps in addressing child health in complex emergencies*

Consensus on recommendations and next steps in addressing child health in complex emergencies reached as stated in above action points for each objective 1 to 4 above. ■

# Annex IA

## Matrices for prioritization of emergency interventions (Community level)

Progression	General Characteristics	Health Interventions	Nutrition Interventions	Other	“Distractions”
Priority 1	<ul style="list-style-type: none"> <li>● Prevent/reduce excess mortality</li> <li>● Prevent/reduce increased acute malnutrition</li> </ul>	<p><b>Diarrhea</b></p> <p>Prevention:</p> <ul style="list-style-type: none"> <li>● Distribution of non-food items (soap, jerry cans)</li> <li>● Water purification</li> <li>● Improvement of sanitation/waste management</li> </ul> <p>Treatment:</p> <ul style="list-style-type: none"> <li>● Management of diarrhea at home (ORT)</li> <li>● Identification of sick children and inform community of where help is available</li> </ul> <p><b>Malaria</b></p> <ul style="list-style-type: none"> <li>● Distribution of nets (i.e. in camps)?</li> <li>● Private supply of medicine?</li> </ul> <p><b>Acute Respiratory Infections</b></p> <ul style="list-style-type: none"> <li>● Identification of sick children (i.e. fast breathing) and inform community of where help is available</li> </ul> <p><b>Measles</b></p> <ul style="list-style-type: none"> <li>● Community mobilization/organization for immunization campaigns</li> </ul>	<p><b>Malnutrition</b></p> <ul style="list-style-type: none"> <li>● Ensure food security (access/availability)</li> <li>● Ensure food for malnourished children (infant feeding programmes)</li> <li>● Vit A provision</li> <li>● Promotion of breastfeeding</li> </ul>	<p><b>HIV/AIDS</b></p> <ul style="list-style-type: none"> <li>● Work for cash</li> <li>● Condom distribution?</li> </ul>	<ul style="list-style-type: none"> <li>● Uncoordinated approach (too many players/donor-driven)</li> <li>● Visibility-driven</li> </ul>
Priority 2	<ul style="list-style-type: none"> <li>● Maintain lowered mortality</li> <li>● Reduce excess morbidity</li> <li>● Restore basic primary health services</li> <li>● Plus?</li> </ul>	<ul style="list-style-type: none"> <li>● Improve community-based health information systems</li> <li>● Increase water availability to community</li> <li>● Mobilizing community for EPI</li> <li>● Distribution of ITNs</li> <li>● Should we train community health workers?</li> </ul>	<ul style="list-style-type: none"> <li>● Targeted nutrition services</li> <li>● Breastfeeding promotion and complementary feeding</li> </ul>	<ul style="list-style-type: none"> <li>● Develop community coordination committees to plan interventions</li> <li>● Develop community surveillance systems</li> <li>● Food security (distribution of seeds and tools)</li> <li>● Cash for work</li> </ul>	
Priority 3	<ul style="list-style-type: none"> <li>● Improving health and development</li> </ul>	<ul style="list-style-type: none"> <li>● IMCI community component to strengthen key family practices &amp; participation of community volunteers (TBAs, teachers, etc)</li> </ul>			

# Annex I B

## *Matrices for prioritization of emergency interventions (Hospital level/severe disease)*

Progression	General Characteristics	Health Interventions	Nutrition Interventions	Other	“Distractions”
Priority 1	<ul style="list-style-type: none"> <li>● Reduce excess mortality</li> </ul>	<ul style="list-style-type: none"> <li>● Effective case management, including case definitions and standard protocols</li> <li>● Big 5 killers plus local killers</li> <li>● Triage, including guidelines (ETAT), danger signs, rapid training</li> <li>● ORS/ORT</li> <li>● Antibiotics for ARI, cholera, dysentery</li> <li>● Measles vaccine</li> <li>● Severe malaria, including combined therapy, IV quinine</li> <li>● Life threatening trauma, including emergency first aid, blood transfusion, IV fluids, oxygen</li> </ul> <p><b>Consider</b></p> <ul style="list-style-type: none"> <li>● Single dose of more expensive drugs</li> <li>● Rapid diagnostics</li> <li>● Delivery of services by less qualified personnel</li> </ul>	<ul style="list-style-type: none"> <li>● Standard definitions and guidelines Vitamin A</li> <li>● Therapeutic feeding, including therapeutic milk, local food, feeding center equipment, food for hospitalized children and parents</li> </ul>	<ul style="list-style-type: none"> <li>● Water/food/shelter</li> <li>● Surveillance (deaths, CFR)</li> <li>● Hospital surveillance for communicable diseases</li> <li>● Hospital security</li> </ul>	<ul style="list-style-type: none"> <li>● Polio campaigns and less relevant vaccines (even measles)</li> <li>● Rigid policy issues</li> <li>● Inappropriate drug donations</li> <li>● Unskilled NGOs</li> <li>● Donor defined priorities</li> <li>● Global initiatives</li> <li>● Lack of leadership and coordination</li> <li>● Lack of clear policies</li> </ul>
Priority 2	<ul style="list-style-type: none"> <li>● Maintain low mortality</li> <li>● Reduce excess morbidity</li> </ul>	<ul style="list-style-type: none"> <li>● Hygiene/sanitation</li> <li>● Infection control</li> <li>● Medical waste disposal</li> <li>● Universal precautions</li> <li>● Neonatal health, including warming, early breast feeding</li> <li>● Emergency obstetrics</li> <li>● PMTCT</li> <li>● Micronutrients</li> <li>● Psychosocial support</li> </ul>	<ul style="list-style-type: none"> <li>● Breastfeeding promotion</li> <li>● TB/HIV in nutrition</li> </ul>	<ul style="list-style-type: none"> <li>● Protection in hospital</li> <li>● Recording evidence of mental illness and abuse</li> <li>● Field hospitals in very selective situations</li> <li>● Focused repair of health system infrastructure and processes</li> <li>● Essential equipment</li> <li>● Drug delivery</li> <li>● Re-establish referral system</li> </ul>	
Priority 3				<ul style="list-style-type: none"> <li>● More comprehensive strengthening of hospitals</li> </ul>	

# Annex 2

## *Provisional agenda*

### DAY 1

- 8:30-9:00 Registration
- Chairperson: Dr Pascal Villeneuve, Chief of Health, UNICEF
- 9:00-9:45 Welcome and introductions
- Dr Jong-Wook Lee, Director-General, WHO  
 Ms Carol Bellamy, Executive Director, UNICEF  
 Dr David Nabarro, Representative of the Director-General for Health Action in Crisis, WHO  
 Ms Joy Phumaphi, Assistant Director-General, Family and Community Health Cluster, WHO
- Objectives of the meeting/Overview of the agenda - Dr Ivan Lejnev, FCH/CAH
- Ground rules for the meeting - Dr Ron Waldman, Columbia University
- Objective 1: *To review the extent of health problems affecting children in complex emergencies and what tools are available to address them.*
- Chairperson: Dr Matthew Chico, American Red Cross
- 9:45-10:30 Review of child health in complex emergencies – Dr William Moss, Johns Hopkins University
- 10:30-10:45 COFFEE BREAK
- 10:45-11:45 Review of experiences: presentations by countries
- 10:45-11:00 Burundi  
 11:00-11:15 DR Congo  
 11:15-11:30 Iraq  
 11:30-11:45 Zimbabwe (WHO/AFRO perspective)
- 11:45-12:15 Review of experience: some remarks by agencies
- 11:45-12:00 MERLIN  
 12:00-12:15 Save The Children, UK
- 12.15-13:00 DISCUSSION



13:00- 14:00 LUNCH

Objective 2: *To discuss roles and contributions of various partners working on child health in complex emergencies.*

Chairperson: Dr Hakan Sandbladh, International Federation of Red Cross and Crescent Societies

14.00 -17:30 Group work and plenary

Theme: *Experience of partners in addressing child health in complex emergencies: constraints, lessons and recommendations to improve child health in complex emergencies*

GROUP 1: Experience in involving communities for child health care

GROUP 2: Experience in improving delivery of basic child health services (both curative and preventive)

GROUP 3: Experience in the care of the child with severe illness

15:30-15:45 COFFEE BREAK

15:45-16:30 Group work continues

16:30-17:30 Group presentations and discussion

18:30 RECEPTION AT MAIN CAFETERIA

## DAY 2

9:00 – 9:15 Wrap up of Day 1

Objective 3: *To identify existing gaps/challenges and how to provide technical and operational support to child health in complex emergencies.*

Chairperson: Dr Emmanuel d’Harcourt, International Rescue Committee

09:15- 13:00 Group work and plenary:

### 1. Leadership and coordination.

- What is it?
- Who should do it?
- What are the roles of the different entities?
- What are the preconditions to make it work?
- How do we get accountability?
- How do we sanction inappropriate action?
- How do we achieve all of this “next time”?

### 2. Stepwise approach for child health in complex emergencies

- Define a stepwise approach/algorithm to organize/prioritize action for child health in a complex emergency.
- What critical things need to be done to get a collapsed health system up and running again?

## 3. Technical guidelines and capacity building.

(Review background paper recommendations)

- Are existing guidelines adequate?
- What are the gaps/research needs?
- What policy areas may need to be different in complex emergencies?
- Capacity building.

10:30-10:45 COFFEE BREAK

10:45-12:00 Group work continues

12:00-13:00 Group presentations and discussion

13:00-14:00 LUNCH

Objective 4: *To identify priority research needs for clinical care and technical operations in child health during complex emergencies.*

Chairperson: Dr Nadine Ezard, UNHCR

14:00- 14:15 Priority research needs to support child health in complex emergencies - a brief summary – Dr William Moss

14:15-15:00 DISCUSSION

15:00-15:30 COFFEE BREAK

Objective 5: *To reach a consensus on recommendations and next steps in addressing child health in complex emergencies.*

Chairperson: Dr Jim Tulloch, WR, Cambodia

15:30-17:00 (PLENARY)

17:00-17:30 Summary, Conclusions and Recommendations

17:30 CLOSING – Dr Hans Troedsson, Director, FCH/CAH

# Annex 3

## *Provisional list of participants*

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