

Child health in complex emergencies

Meeting the health needs of children, women and families presents considerable challenges in peacetime. These challenges are compounded many times during emergencies, natural or human-made. Yet delivery of health services to populations in general and to children in particular is especially critical in these contexts. In effect, a significant proportion of the children who are not currently being reached through existing interventions live in countries where the delivery of health services has been severely disrupted. Between 1989 and 2000, 110 recorded conflicts took place; 103 of them were civil wars, many of them protracted, accompanied by institutional collapse and violence directed against civilians. At present, more than 40 countries, 90 per cent of them low-income nations, are dealing with armed conflict. UNICEF's *Humanitarian Action Report 2006* highlighted 29 emergency situations affecting children and women.

A complex emergency is defined broadly as a situation of armed conflict, population displacement and/or food insecurity with associated increases in mortality and malnutrition. Most of the major causes of child mortality in complex emergencies are the same as the top killers of children in general. They include measles, malaria, diarrhoeal diseases, acute respiratory infections and malnutrition. These are often compounded by outbreaks of other communicable diseases, such as meningitis, and nutritional deficiencies that can contribute substantially to child morbidity and mortality. The highest mortality rates in refugee populations, for example, tend to occur among children under five.

Child mortality rates are usually highest during the acute early phase of a complex emergency. By contrast, in post-

emergency settings, where children have remained in stable refugee camps for prolonged periods, child mortality might be lower in the refugee population than among neighbouring resident children. Obstacles to the provision of health care to children in complex emergencies include limited access, cultural barriers, insecurity, limitations in resources such as drugs and supplies, and a lack of communication among the various organizations providing relief.

Community leadership and engagement is especially critical in these contexts. Contrary to the assumption that communities in situations of crisis are fragile and tend to fragment under the stress of war, famine or mass displacement, research increasingly suggests that some form of community mobilization is almost always possible and that important elements of community remain intact and even gain in importance under conditions of stress. Evidence from Ethiopia, Malawi and Southern Sudan focusing on the challenges of treating severe malnutrition in complex emergencies suggests that the success of an intervention depends critically on involving key community figures (such as traditional leaders, teachers and community health workers), as well as community organizations, volunteer networks and women's organizations. In addition, involving traditional health practitioners can be equally important, because in many cases they are the first to be consulted in health-seeking behaviour and can therefore play a critical role in identifying severely malnourished children at an early stage.

See References, page 105.