

The Movement at the Women Deliver Conference – 16 - 19 May 2016.

## Local action, global gains – Breaking barriers, improving women's health.

Summary report



The 4th Global Women Deliver Conference was held in Copenhagen, Denmark. The focus of the Conference was on how to implement the Sustainable Development Goals (SDGs) so they matter most for girls and women, with a specific focus on health – in particular maternal, sexual, and reproductive health and rights – and on gender equality, education, environment, and economic empowerment. For the first time, the International Red Cross and Red Crescent Movement (Movement) was present with a large delegation of 44 participants from IFRC, ICRC and National Societies.

## Pre-meeting at Danish Red Cross HQ, 16 May 2016, 12:45 – 15:00

### Proceedings

- 1) Overview of the agenda by Facilitators.
- 2) Opening words by Birgitte Bischoff Ebbesen and Dr Julie Lyn Hall
- 3) Introduction of the participants.
- 4) Introduction to the booth and the side event at Women Deliver
- 5) Exercise to ensure Movement's participation in Women Deliver concurrent sessions based on a thematic matrix.
- 6) Sharing of some draft RCRC messages
- 7) Introduction to Social Media activities such as tweets
- 8) Logistical remarks by Signe followed by distribution of conference bag including materials
- 9) Closing remarks



## Side event at Bella Centre, 17 May 2016, 18:00 – 20:00

The International Red Cross and Red Crescent Movement and World Vision International together held the side event. The opening and closing remarks were by Sue England, Maternal, Newborn, and Child Health Director for World Vision International.



Dr Julie Lyn Hall, Head of the Health and Care Department at the International Federation of Red Cross and Red Crescent Societies (IFRC) moderated the main panel discussion, reflections of panellists and participants after field presentations in the Market Place session and provided a conclusive wrap up.

### Panelists at the side event:

- § Her Royal Highness Princess Sarah Zeid of Jordan, Global Advocate for Maternal, Newborn and Child Health/Chair of Every Woman Every Child Everywhere
- § Helga Fogstad, Director of the Department for Global Health, Education and Research, Norwegian Agency for Development (NORAD)
- § Fatima Gailani, President of the Afghan Red Crescent Society (ARCS)
- § Dr Alfonso Rosales, Maternal and Child Health Senior Technical Advisor, World Vision US (WVUS)
- § Sigrid Kopp, Regional Midwife/ Reproductive Health Advisor, International Committee of the Red Cross (ICRC), currently based in Nairobi, Kenya
- § Bernadette Peterhans, Head of Unit, the Swiss Tropical and Public Health Institute Basel (Swiss TPH)

The side event was structured in three parts.

Part One: Initial Panel discussion that highlighted 6 main barriers that are resulting in thousands of women and children dying unnecessarily in complex humanitarian settings. Part Two: Marketplace where case studies and examples of how different barriers have been overcome were displayed. Part Three: Second panel discussion where each panellist reflected on what they have learnt from the Marketplace. Comments, suggestions and observations were invited from the floor. (*Annexed – Side event format*)



### Summary highlights of panel

1. Recognition of the high burden of preventable deaths (60 %) in fragile settings calls for prioritisation of fragile and humanitarian settings by duty bearers and radical shift in ways we function today. This change is not just required but is possible even in the most difficult places, from where we have evidence that barriers can be overcome.
2. Although barriers are challenging, but they can be broken when the humanitarian-development divide is bridged with joined efforts of Governments and other multisectoral agencies.
3. Accountability and responsibility of duty bearers to communities is essential to decrease vulnerability of communities everywhere.
4. Following and upholding Humanitarian Principles and Humanitarian Regulations should be paramount while providing help in fragile and humanitarian contexts.
5. It is important to work on wider influences that hinder access to information and slow down much talked about empowerment of people especially the women and girls.
6. Collective efforts for following up the Global Strategy *Every Woman, Every Child - Everywhere* in its implementation needs to be stressed at the World Health Assembly and UN General Assembly in order to get serious attention.

### Key barriers addressed by panellists:

#### § Financing (HRH Princess Sarah Zeid of Jordan)

- Funding is a huge problem, since funding is a year-to-year mechanism, but maternal health is more than a year-to-year concern. A longer-term, predictable, and flexible funding mechanism needs to be worked on, so that Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) can be recognized.
- Only 1,93 US\$/per person/per year has been spent on RMNCAH from 2002 to 2011, which is a tiny amount of money. Above all, there is also the need to invest in fragile and humanitarian settings.
- Although there is highest morbidity and mortality in complex and humanitarian settings, the international funding for health services especially in protracted crisis is scarce.
- She called upon the global community, including the private sector, to commit to financing mechanisms and modalities to ensure equitable and timely health and key services access, such as WASH facilities.

#### § Data and information (Helga Fogstad)

- The issue of what gets counted counts is the issue of data
- Make information visible on levels where it becomes adequate and useful for better funding

- There is a need not only for cross-budget, but also cross-sectoral work
- Collective efforts for following the Global Strategy *Every Woman, Every Child - Everywhere* in its implementation stage needs to be stressed at the World Health Assembly and UN General Assembly in order to get serious attention, since the question of how to make people accountable and keep the spotlight on maternal health is still unanswered.

#### § Conflicts and security (Sigrid Kopp)

- In Sub-Saharan Africa 20 out of 100 women need maternal care from which almost about 11 often need a Caesarean section. If those 11 do not get help, at least one of them will die during child birth.
- In South Sudan, a woman might be lucky enough to reach a health facility, but the facility usually lacks skilled staff, equipment and medicines.
- The war is the problem. I am the voice of these women, who's voices cannot be heard due to war and conflict.
- Stopping war is the solution, but before anything gets done it's the responsibility of the duty bearers to ensure that women children and young people in such settings are protected to be able to access and to provide health care.

#### § Gender (Fatima Gailani)

- How can gender be a barrier for health? Although the three delays are often mentioned in maternal mortality – Deciding to seek help, reaching appropriate facility and receiving adequate care. However, in many places the first barrier is being a girl or a woman itself. In Afghanistan, girls are brought up by thinking about them as less important and not to express the pain and need for help until it gets too late. The second barrier is the psychology of women and mothers, since she was brought up in a culture where boys come first and their needs and desires are more important.
- Where are the facilities for women in such places? There are only a few female doctors and no female teachers, which is unacceptable. For 13 Million people in Afghanistan there are 2 x-ray machines, which is painful and makes me angry and outrageous. We must look at the broader determinants of health and for getting access to health as equally important. It requires education of people – both women and men, girls and boys.
- Things such as access to electricity is less mentioned, but to close the gap of information it plays an essential role for delivering messages through media and in health care where a lot of clinical work cannot happen without access to basic electricity. It is important to work on wider influences that hinder access to information and slow down much talked about empowerment of people especially the women and girls.

#### § Accountability and Responsibility (Bernadette Peterhans)

- Communities are resourceful and when empowered with right skills and commodities they are more resilient. Accountability and responsibility of duty bearers to communities is essential to decrease vulnerability of communities especially in fragile and humanitarian settings.
- For achieving improved health outcomes of women and children it is important that a strong link exists between communities and health care systems. This is a huge strength of the Red Cross and Red Crescent Movement, which engages people by involving them in decision making, planning and implementation.
- Authorities do change very often and there is a reluctance to take on responsibilities. This is more the case when NGOs fill in the gap. This actually weakens capacities with authorities, makes them less likely to take over/ the transition process.
- We need to create trust and a long-term relation with people, since an ad-hoc planning approach does not support a long-term vision.

## § Health System and Coordination (Dr Alfonso Rosales)

- Description of a personal experience in Somalia: "I ran into a woman lying on the ground with two children, since she got excluded from her community. She had no shelter, meagre food to eat and not enough breast milk to give to her two lactating children. She did not know where to go and who to ask for help. She needed to make a choice on which child to breastfeed, a terrible example of the survival of the fittest."
- Survive, thrive and transform are the three objectives of the Global Strategy for Women's, Children's, and Adolescent's Health (2016-2030), but they are empty words for the woman I met in Somalia.
- We need to re-build public health services, not parallel ones, but aligned with government services with a higher work force, good service delivery, and medical devices. Supply chains need to be addressed, so that shortages turn into capacity.
- A call for the global community to come together and complement each other, so that the words survive, thrive and transform become meaningful objectives in our work.

## The Market Place

The marketplace was a very successful part of the event as it engaged participants and gave it energy. The feedback from panellists was very positive and Helga Fogstad particularly made a number of comments on how impressed she was. It provided opportunity to "see the practical work" and gave credibility to how both our organisations work in the field. This could also have positive outcomes for future funding opportunities. Marketplace presenters reported that their stations were well attended, they had a chance to cover the main points of their posters and had interest and engagement from participants. Given this positive experience we would advise using this sort of format for future events. Market place had eight stations with presentations as listed below. Participants visited to hear presentations, ask questions. Snacks and drinks were served at the same time.



1. Afghanistan – Finding solutions for women and girls health and education: a meta-analysis – Sue England & Dennis Cherian (WV)
2. Somalia - "The challenges of reducing Female Genital Mutilation" – a 6-year project in 2 districts of North Somali focussed on reducing FGM/C - Yeva Avakyan (WV)
3. South Sudan – Medical Service Volunteers (MSV) model Improving Health Services for Mothers and Newborns in South Sudan Lianna Sarkisian (WV)
4. Sierra Leone - The Ebola experience from a FBO perspective: women as champions for safe burial care Christo Greyling (WV)
5. A partnership approach to addressing the barriers in humanitarian settings– Rolando Tomasini & Clara Hoermann (UNOPS)
6. Myanmar - Supporting Maternal, Newborn & Child Health - Strengthening feedback and response mechanisms in hard-to-reach communities in Southern Chin - Fran Stevens (Danish Red Cross Health Delegate)
7. Breaking the Barriers - Engaging communities in maternal and child health in humanitarian settings - Sigrid Kopp (ICRC)
8. A solution to reduce maternal mortality? The role of health workers with midwifery competencies in the community – a description of approaches in three projects- Monika Christofori-Khadka (Swiss Red Cross)

## Reflections by Panelists post market place

The panel reconvened after the market place session. They reflected on what they had heard at the market place and answered questions from the audience. Below are key comments at the discussion.

*Dr Alfonso Rosales:*

- Fragile settings imbibe different types of issues that range from emergencies that cause health disasters to situations that by themselves are health emergencies such as outbreaks, epidemics etc. We are challenged by developing models and frameworks for fighting issues with short term solutions. However, since these problems are long-term we cannot function in the mind-set of short-term solutions. We need to strengthen health care coordination mechanisms and systems by being a part of it and not create parallel mechanisms which are not sustainable.
- The dialogue with religious leaders is important, so that they can become agents of change and a pillar of peace and stability.

*Sigrid Kopp:*

- The wider community requires more people-centred research in order to find out what people really need and what is culturally acceptable. Being practical in humanitarian settings is important and Governments should realise how important it becomes to work with local resources that are existing even in adversity. For example, if governments do not accept programmes for working with or training traditional birth attendants (TBA) it becomes difficult. In reality we have to at times link with TBAs, since they are the ears and eyes in the communities and we cannot ask a traumatised society with broken health infrastructure to function by our ideal standards.

*Helga Fogstad:*

- We need a total reform of financing when it comes to humanitarian funding. We need to have this funds provided transparently and effectively and to be ready for any kind of crisis.

*HRH Princess Sarah Zeid of Jordan:*

- Parts of the problem go back on how the money is spend, since 20 % go to humanitarian aid, and a extreme meagre of 1 % of it to women health and support.

*Bernadette Peterhans:*

- We need to be flexible enough to adapt our work to all levels. We need to engage with communities, because they have the solutions and that's where the working staff and volunteers come from.

*Fatima Gailani:*

- Strengthen the role of female leaders. Even religious leaders are scared to talk about specific topics. Working with religious leaders and women groups parallely is important. This will help convince leaders of community needs.

*Dr Julie Lyn Hall*

- It is overwhelming to pose the big figures and tiny figures and see the contrast. 800 women die every day and only about 1,93 US\$ per person / year is spent
- Dialogue is the power behind our work. It is about the dialogue that we have started and it is these words that will inform our actions, especially in fragile settings that are dangerous and different. We need to keep giving out continuous coherent messages and keep a flexible mind. Our work will be positive and rewarding.

## Highlight comments from the floor

Fatima Saif Al-Hakim (*The Palestine Red Crescent Society*): I agree completely that we need to educate people about their rights and empower them by health education. At the same time there should be health services that women and children can go to, services that are sustainable and are always accessible.

Karen Swartz (*Danish Mission Council*): I agree that faith-based organizations are a valuable link between the community and religious leaders and show comparative advantages. It is time that all organisations must come together regardless of their founding ideals and work for a common cause – to reduce morbidity and mortality of women and children and adolescents that can easily be prevented.

Barni Nor (*Swedish Embassy in Kenya*): Health care needs are continuous. I feel that it becomes important to study on what resources are there, in countries that have extremely high mortality rates, that can be leveraged. We need to strengthen the health financing and introduce coping mechanisms, which will lead to sustainability and not just short term solutions put in place by civil societies and aid agencies.

## Review

With few interventions at the Conference focusing on humanitarian and fragile settings, the Side event stood out as one of the only forums for discussing women’s and children’s health in these contexts. Furthermore, the informal format and inclusion of the market place allowed participations to engage and interact with each other and indeed to focus not only on ‘barriers’ but also on solutions from various operational contexts. Many people wanted to intervene during the Q&A but unfortunately there was not sufficient time for this part.

103 participants were registered, but some attended without registering, so probably the actual number of participants was a bit higher and close to maximum capacity of 120 people. Besides a good representation from RCRC and WVI, participants included (not comprehensive list);

Donors and UN agencies;	NGOs and Foundations;	Other
<ul style="list-style-type: none"> <li>- UNFPA</li> <li>- UNOPS</li> <li>- Australian Department of Foreign Affairs and Trade</li> <li>- JICA</li> <li>- Swiss Development Cooperation</li> </ul>	<ul style="list-style-type: none"> <li>- World Diabetes Foundation</li> <li>- Phillips Foundation</li> <li>- Birth Kit Foundation</li> <li>- Danish family Planning Foundation</li> <li>- Danish Mission Council</li> <li>- MSF International</li> <li>- MSF Denmark</li> <li>- Salud Medical</li> </ul>	<ul style="list-style-type: none"> <li>- MoH Palestine</li> <li>- Metropol College Denmark</li> <li>- University of North Florida</li> <li>- Novometrics</li> </ul>

## The Red Cross and Red Crescent Movement Booth: Go the last mile with RCRC for improving women`s health

The booth was opened during all days of the Conference. The main purpose of the booth was to make the Movement visible as an important global and local actor in terms of improving women’s health in fragile situations and settings. The booth was meant to provide a space for Movement participants to interact with conference participants from peer organizations and institutions, display case stories, studies and good practice approaches in order to position the Movement as a relevant



and indispensable local actor in achieving SDG 3 and 5. In this way, the booth was intended to provide a platform for engaging in new partnerships.

### Display and set-up

The main features of the booth included;

- A global map indicating which countries RCRC works actively for improving women's health
  - 2 poster stands (changed every day) displaying 14 case stories from 16 countries
  - A sowing workshop: 'make your own menstrual hygiene pad'
  - Display of studies and tools (mainly RMNCH overview and GBV in Disasters study)
  - 2 collection boxes where guests could leave their business card /get a prize
- The booth was staffed with 3 RCRC participants at a time



### Reflections

The booth was very well visited. A little less than 100 business cards were dropped off in the collection boxes which is estimated to represent only a fragment of the people who stopped by. It is likely that 5-10 times that many people actually visited the booth. On the first day, the booth was visited by prominent guest i.e. the Danish Minister of Foreign Affairs, Kristian Jensen as well as DRCs President Hanne Line Jakobsen.

A particular popular item was the sowing workshop which attracted a lot of people (mainly women), some of which joined the workshop for 15-30 minutes. In this way the work of RCRC on menstrual hygiene in Malawi got very well displayed. Interestingly several other booths featured menstrual hygiene items but only the RCRC booth had the very participatory activity. Most probably for this reason the sowing activity also generated some media interest, thus, MRCS representatives were interviewed for by a journalist from the Philippines and by Women Deliver media. The booth also functioned well as a RCRC meeting point and contributed to a 'team spirit' among the delegates.

### Media and Promotion

RCRCs participation was advertised at WD on IFRC's website and all associated material and films has been uploaded onto the site. In terms of media coverage, this was handled by BRC social media representative (in consultation with IFRCs Communication Department) who took part in the conference and DRCs media team.

BRC's social media representative report;

- Tweets from BRC social Media person's account have been seen over 30,000 times
- Tweets from British Red Cross on WDC have been seen more than 45,000 times
- Periscope interview with Julie Hall and Devex to be picked up at WHS

From DRCs communication Department report;

- Interviews with Fatima Gailani to national newspapers (Politikken) and to DRC magasin
  - Interview with DRC President to other Danish Newspaper (Kristeligt Dagblad)
  - Story on women refugees brought by Ritzau
  - Facebook post on menstrual hygiene pads from Malawi reached 180.000 people
- From a communication point of view, we had draft messages at the beginning of the event to position us on social media and to pitch media.

## Post-meeting at Bella Centre, 19 May 2016

### Outcomes and feedback from RCRC participants

Immediately after the conference, RCRC participants broke into groups and provided their quick feedback to 5 facilitators. Below are a compilation of responses to the questions; 1) what did you learn? 2) Ideas for innovative approaches or tools? 3) Ideas for new partnerships and 'recommendations for next time.

#### What did we learn?

##### About policy trends:

- Clear global commitment on MNCH. "R" and "A" (i.e. reproductive and adolescent health) are strong as well including abortion.
- Re-confirmation that MNCH and ASRH is non-negotiable
- NCD is an emerging core component for women and girls health
- Re-confirmation that there is an urgent need to bridge the humanitarian-development divide
- Much better understanding of the SDGs, especially that GBV crosscuts so many areas

##### About health and gender programming:

- Ensure that RMNCAH and GBV programmes do involve men, as a key intervention for long-term impact and behavioural change. This involves working with traditional leaders, including faith leaders, men alliances and men in clinical settings. Gender is not, and should not become, a 'women only' issue. Also educating adolescent boys is important
- The importance of closely and systematically work with faith leaders, and bring together faith leaders and communities, to positively change traditional negative practices. Experience and existing methodologies from faith-based organisations can be very useful.
- Looking at Sexual and Reproductive Health and Rights (SRHR) from multiple perspectives – for example, including people living with disabilities – and ensuring comprehensive programming.
- The importance of, and need to renew efforts both at strategic and operational level for, ensuring that good data on SRHR (disaggregated) are collected and used.
- The importance to involve the very young generation, and sensitise them on SRHR – therefore, areas of focus need to be work in schools, comprehensive sexual education etc. Work on trust and intergenerational dialogue is also crucial
- Education (CSE) are key drivers of population and community health results
- Menstrual hygiene Mgt – SRH and WASH as key entry points for comprehensive approaches and access to services
- Respectful health care (e.g. dignified birthing) is possible but takes time and investment. Competent and confident workforce is a key link between community and facility.
- Re-confirmation that we have the evidence on what works – we must support our partners to implement, replicate and scale evidence-based interventions
- Opportunity to better position women as first responders in disaster by positioning health and well-being and the role of women and girls in comprehensive DRR programmes
- GBV prevention is important part of SRHR programming
- GBV/health programmes must be inclusive and take into consideration of different units in the community i.e. parents, (extended) families, couples.
- Diabetes and pregnancy- The need to test all pregnant women for diabetes
- Important barriers to safe abortion is religion, legal frameworks and awareness

### About RCRC

- The RCRC Movement has significant expertise on RMNCAH, and this could be more strategically shared through platforms such as Women Deliver.
- Acknowledge and then address knowledge gap and resistance within our own organisations is a starting point

### What was missing?

- Very little attention to emergency and fragile/complex settings. Good it was main focus for RCRC but should gain more attention at the Conference.
- No mention of women and migration and refugee health in spite of the European crisis- very Anglo-phone Africa focused
- Representation of RCRC in panels as speakers and moderators plus display of RCRC innovations i.e. RAMP
- RCRC did not present the unique value of RCRC in MNCH. How can we link emergency, recovery and resilience? NSs plays critical role during different stages.
- There is a need to elevate community voices for global events (not the usual suspects!)

### Ideas for innovative approaches and tools

- Lots of ideas were shared around comprehensive sexual education – this is not systematically included in RCRC programmes, and might be something to consider in future
- Identify new ways to hold our RCRC leaders to account re: RMNCAH
- Explore new ways to work with/ through RCRC Youth, especially re: meaningful engagement of younger generations on SRHR
- Incorporate new approaches to Menstrual Hygiene Management in Health and integrated programmes/ Creative thinking around menstrual health especially in emergencies (data, tools, position papers)
- Focus on RMNCAH supply side – improve quality of services, training of community health staff, new partnerships with health stakeholders, etc. RCRC Movement traditionally focuses on the demand side (CBHFA, etc.) and this is not always sufficient.
- Ensure that SRH is systematically incorporated into emergency response – even better, that the approach of SRH is consistent across the long term/ preparedness-emergency-recovery continuum
- Phone applications for community health volunteers (many! – technical, algorithm, community feedback and accountability etc)
- Comprehensive and experiential workforce capacity building –different models to build competent workforce (not just didactic training)
- Global Financing Facility (GFF)
- § New ways to finance health services
- § Mobilizing local resources
- § Harmonizing donor funding
- § Decreasing duplication
- Working for fathers and families caring for pregnant women and new mothers through health systems
- Local societies can take role in developing gender sensitive laws

### Ideas for key partnerships

- Less 'new ideas for partnerships' than expected – RCRC Movement already has regional/ local contacts – which were indeed strengthened during the conference
- EWEC
- WHO, MSH Unit
- Jhpiego (<https://www.jhpiego.org/>)

- Phillips (device – already tested by ICRC and NLRC)
- GAIN and Nordic nutrition network
- Novo Nordisk (NCDs)
- Maternity Foundation (Safe Delivery app) – Guinea and Myanmar
- As above, GFF (who to partner with through the “grand bargain” – make sure RCRC is central to ongoing debates and brokering of resources)
- IPPF – SPRINT (keen to partner with RCRC for localized response)
- Philippines in SE Asia (health apps)
- UNFPA, UNISCO
- Some private companies that have taken role in empowering health recently: Johnson/Philips etc

Some recommendations for the next time

Went well:

- Good visibility for RCRC with side event and booth
- Side event was a success and booth was well attended
- Consistent, well- coordinated RCRC presence
- Good networking opportunities both within and outside movement

Recommendations/ Questions:

- RCRC need to engage in the organisation/preparation of the Conference to ensure RCRC representation in larger panels (IFRC?)
- Clear position statements on RMNCAH at Movement level need to be agreed, shared and used for advocacy – and timely prepared for future conferences etc. It is important to have clear advocacy agenda for RMNCAH for 2020 and specific ones for 2016-17- what is out focus, what can we contribute with?
- IFRC position on issues like abortion, at least at a technical level.
- Need to increase visibility in next WDC – RCRC present at panels, technical discussions etc.
- Some organizations have excellent relation with media and do much better than RCRC in communication and advocacy – if we engage another time, we need more support for communication and advocacy
- At some points, the conference felt as ‘preaching to the converter’ – a lot of concepts/ tools that were considered innovative in community work, are already common practice within the RCRC Movement. So there is space for the Movement to share learning and engage more systematically – visibility could be considered the innovation, in this case!
- Expectations (and pre-work) as well as follow-up could be done electronically (questionnaire or similar)
- Include more volunteers (and not the ‘usual suspects’)
- What are next steps, and how could we link this with RMNCAH TWG
- Preparation; good to be participatory but more effective if someone clearly takes the lead in coordinating.

## Annex – Side Event Format

Part One: Initial Panel discussion that will highlight 6 main barriers that are resulting in thousands of women and children dying unnecessarily in complex humanitarian settings. The objective of the first panel is to highlight the key barriers and expand on why they needed to be addressed

Part Two: Marketplace where case studies and examples of how different barriers have been overcome will be displayed. Participants and panellists will be free to move around the room and view and discuss the different studies.

Part Three: Second panel discussion where each panellist will reflect on what they have learnt from the Marketplace and how what has been demonstrated could be used to address the main barriers discussed in the first panel. Comments, suggestions and observations will also be invited from the floor. The objective of the second panel discussion is to clearly identify what can be done to address barriers and what more – research, training, investment, dissemination of good practice etc – is still needed to ‘break the barriers’.

The three parts will then feed into the final outcome document that will pull together panel one: highlighting the barriers’, market place: demonstrating of what can be achieved even in complex humanitarian settings and panel 2: how barriers can be addressed and what more is needed.

### I. Barriers:

1. *Princess Sarah*:- Financing barriers due to little committed long term funding even though complex settings present unique challenges to health care of women, adolescents and children. Points can include present and upcoming financial mechanisms, the global price tag to overcome the burden in such settings, the proposed framework of financing and accountability in EWEC.
2. *Helga Fogstad* :- Poor planning and weak accountability of duty bearers and donors in complex and fragile settings are barriers to providing equitable health service. In complex and fragile humanitarian contexts within existing security, resource and political constraints there is always a tendency to focus on picking the “low lying fruit” without studying and addressing demographic specificities.
3. *Bernadette Peterhans* :- Barriers on accountability and responsibility from communities’ perspective. In complex humanitarian contexts rights-based approaches to health are weak and there is usually a huge gap in sharing information and evidence between stakeholders and local communities on reach of women, adolescents and children. Poor data and information is also linked with poor accountability mechanisms for services, capacity to demand rights and government capacity to take responsibilities.
4. *Sigrid Kop*:- Barriers to access health care due to safety and security issues of people caught in conflict, broken/damaged infrastructure, scarcity of commodities due to loot and destruction, poor or not available health service providers. The most vulnerable and affected women, adolescents and children are likely to be from social strata that can be defined in terms of displacement status, socio-economic status, and geographically defined sub-populations, as well as specific populations that have been targeted during the conflict.
5. *Dr Alfonso Rosales* :- In complex and fragile settings, donors, INGOs, NGOs, government, and civil society stakeholders often do not have a well negotiated and clear, actionable and monitorable agenda which includes strategies for implementation, health system strengthening and health status improvement.
6. *Fatima Gailani* - Gender and health seeking behaviours are other significant driver of inequities in health status in conflict-affected environments. Differential exposure to sexual violence, poor knowledge, ignorance, dependence on others, non-friendly health and support services are critical barriers. The most at risk are again women, adolescents and children with higher rates of morbidities and mortality.

II. Structure/format:

Time - 18:00-20:00 Hrs

06:00 Opening and Introductions by Sue England (WVI)

06:05 Video by IFRC, Finish Red Cross and the Somalian Red Crescent

06:09 – 06:45 Panel Discussion -- Moderated by Dr. Julie Lyn Hall

Total of approx. 35 minutes of which 4 min per panellist and 10 min time included for moderating and the time to suggest method for the marketplace in the end. The panel members will speak on their chosen "Barriers" (as mentioned above).

06:45- 07:15 Marketplace and Refreshments

Total of 30 min - People will be able to get their canapes and hear presentations, discuss points with the presenters and at the same time with the panellists in light of the barriers discussed at the first panel discussion. A menu on a wall display will be put up for the 8 presenting platforms. People will be able to pick any 5 platforms to visit. A bell will be used to indicate movement of groups at every 5 mins.

07: 15- 07:45 Panellist Reflections

Total of 30 min - The panellists and Julie come back again to the panel discussion platform to reflect on what was discussed at the market place. An opportunity to offer thoughts on what we know/ examples to overcome barriers, and what is known little and requires research, studies and more evidence.

Panellists will be in pairs as below with 2 minutes form the pair to give a reflection followed by 8 mins of ideas/comments from participants:

Princess Sarah

And

Helga Fogstad

Fatima Gailani

And

Bernadette Peterhans

Dr Alfonso

And

Sigrid Kop

07:45 – 07:55 Wrap up by Dr. Julie Lyn Hall

Total of 10 min - By Julie to bring together/wrap up on issues, barriers, opportunities and success.

07:55- 08:00 Closing Remarks and Acknowledgements by Sue England