Ready & Resilient: Community Social Protection for Preparedness and Response

EPI WIN Webinar on 29 January 2026

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What is Social Protection (SP) in emergencies?

- A basic human right,
- A life-saving measure for vulnerable groups, minorities and disadvantaged, underserved, single headed households, disabled, chronic disease etc. in the context of provision of essential health services and health security at community level in emergencies.
- Social protection programs are often the first line of defense to protect the poor and vulnerable in a fragile or conflict-affected situation; they are designed to address inequalities and vulnerability,
- In conflict settings, social protection systems can support preparedness, mitigate the effects of crises, foster recovery, and contribute to resilience and peacebuilding (ILO).
- Helps protect people against shocks today and build resilience and human capital.
- The evidence also suggests impacts on a range of outcomes—from nutrition and early childhood development to climate adaptation and mitigation to women's empowerment and livelihood diversification. (WB)
- In resource constrained environments, SP contributes to self reliance and resilience of communities to ensure their health needs are covered/addressed.
- In conflict-affected settings, robust, risk informed, and inclusive social protection systems are essential. These systems, combined with humanitarian aid and long-term development strategies help build resilience, ensure sustainable socio-economic development and contribute to peace building.
- Social health protection provides a rights-based approach to reaching the objective of universal health coverage that ensures financial protection and effective access to health care services. (WHO)

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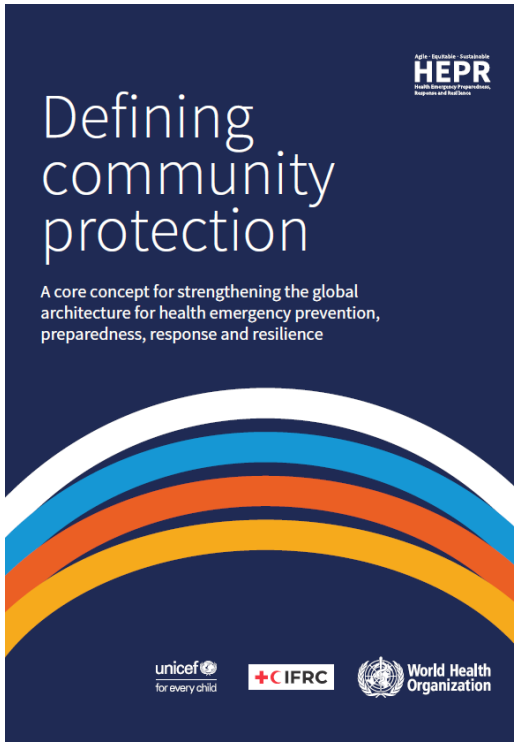
Defining community protection under HEPR



Effective health emergency management achieves protection of those at-risk or directly affected. Community Protection is the outcome of **health emergency management** that involves and engages the people who are affected by an emergency event in decisions and actions aimed at protecting their **health and well-being**.

2.1 Community engagement, risk communication and infodemic management

Communities are included and involved, their expertise is listened to, and activity engaged to co-create solutions. They are provided with the right information at the right time to take action in ways that protect health and wellbeing. **RCCE/IM Team, Collective Service**

2.2 Population and environmental public health interventions

Strengthening community level capacities for early detection and response, including those to control zoonotic spillover, public health and social measures, WASH and vaccination. **Public Health and Service Delivery team, Collaboration with IPC/WASH, PHSM, HAI, UNICEF**

2.3 Multisectoral action for social & economic protection

Minimizing secondary impacts from health emergencies through social protection, business continuity, education, food security, psychosocial support. **Collaboration with UNICEF, WB, UNDP, UNHCR, MHS, ILO**

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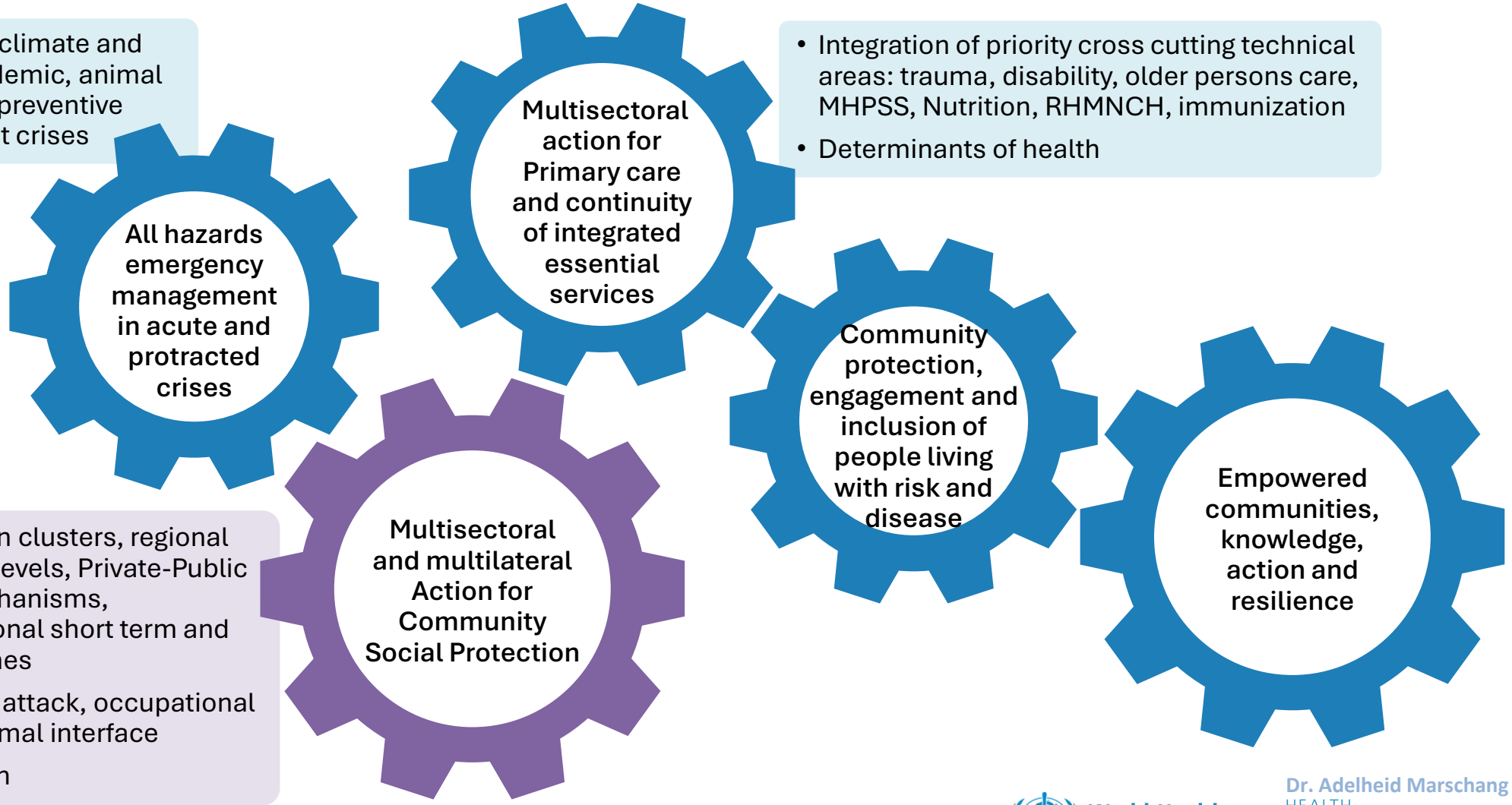
Implementation

- The multisectoral public health response for community social protection must address the intersection of humanitarian and HEPR functions and coordination mechanisms.
  - HEPR and humanitarian systems only partially talk to each other
- There is a distinct multisectoral set up for the humanitarian response and the IASC inter-agency cluster mechanism to support national response.
- The HEPR work is based on strengthening national action plans and national actors; multisectoral coordination for its actions needs to be better defined
- The multisectoral action to mitigate vulnerabilities in emergencies needs to rely on clear needs assessments, determination of vulnerability in the specific context, underlying/ongoing actions, and be mindful of roles and responsibilities of partners and stakeholders.
- Multisectoral coordination also needs to be a whole of government, whole of society, multistakeholder; subnational, municipal and community-based effort
- We need to look at surge requirements (tools and capacities) when national systems fail/can't cope or are overstretched; intranational surge and from external

Social Protection at the Intersection of Emergency Management, Multisectoral action, Primary Care and Community Resilience

Conflict, outbreaks, climate and weather crises, pandemic, animal human interface for preventive action, displacement crises

- National, humanitarian clusters, regional and local community levels, Private-Public partnerships and mechanisms, International and national short term and basic financing schemes
- Health workers under attack, occupational risks at the human animal interface
- Determinants of health



- Integration of priority cross cutting technical areas: trauma, disability, older persons care, MHPSS, Nutrition, RHMNCH, immunization
- Determinants of health

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Dr. Adelheid Marschang
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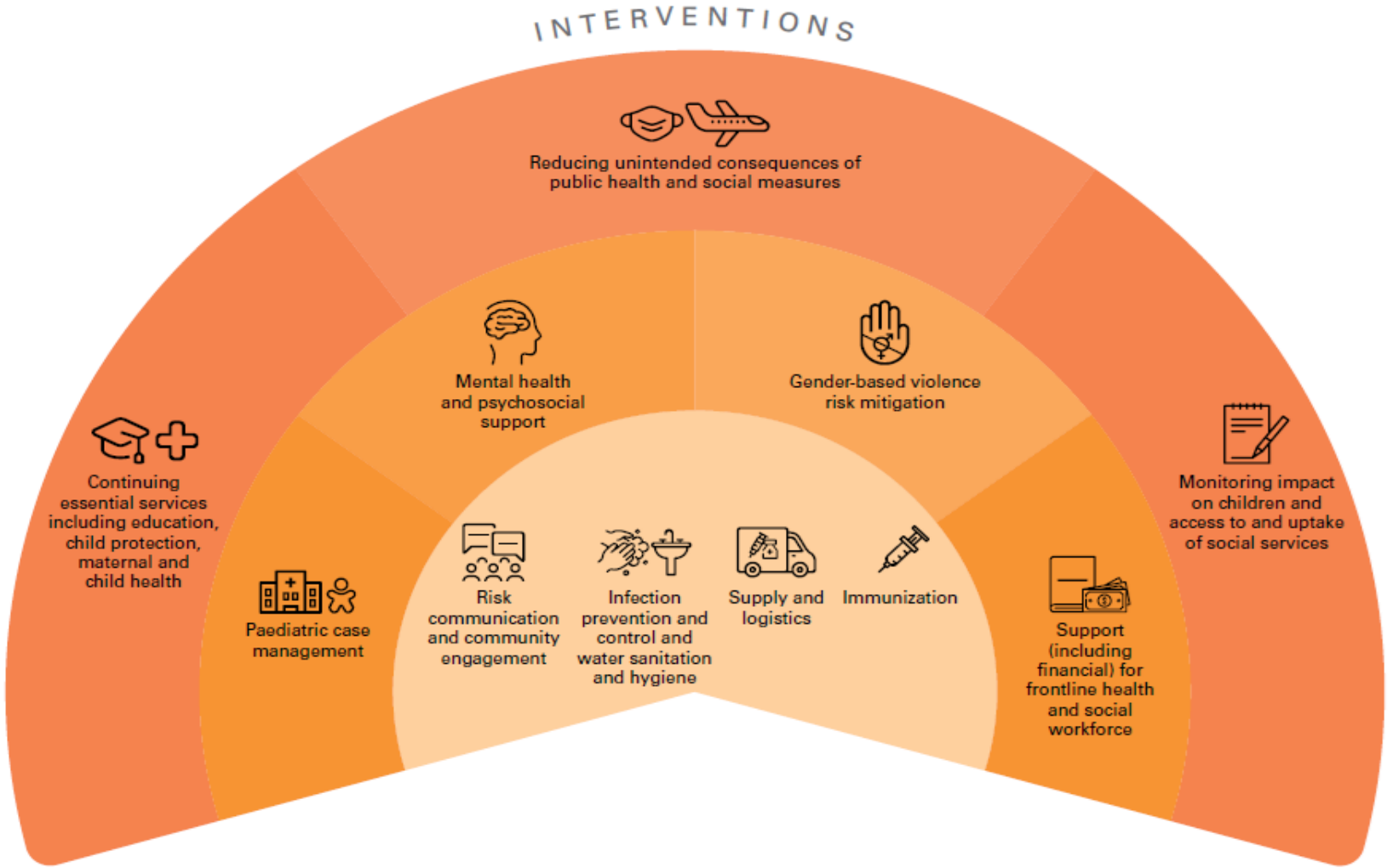
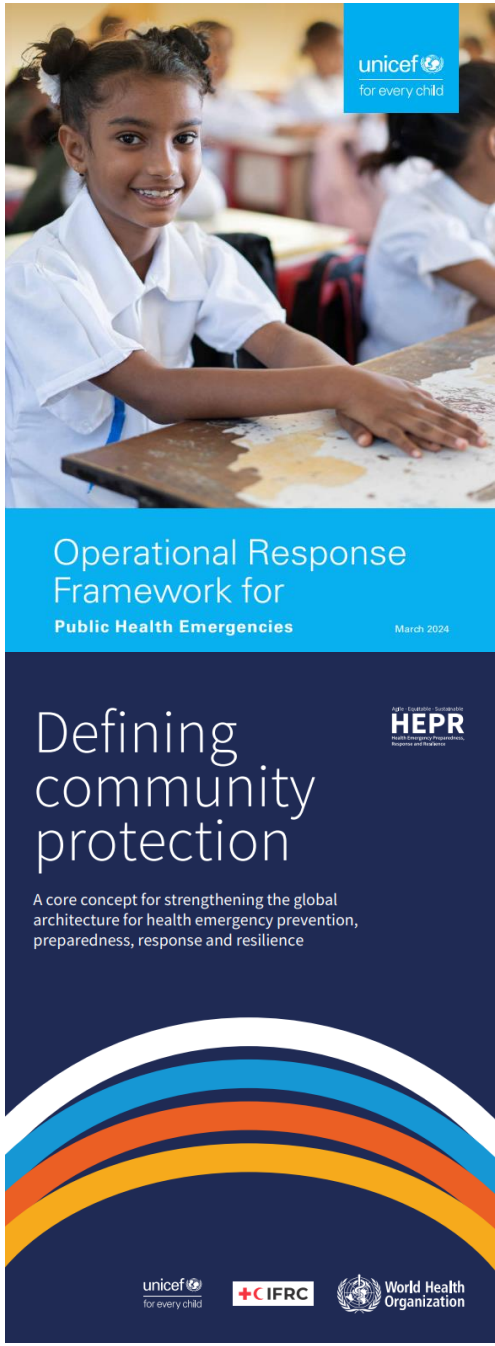
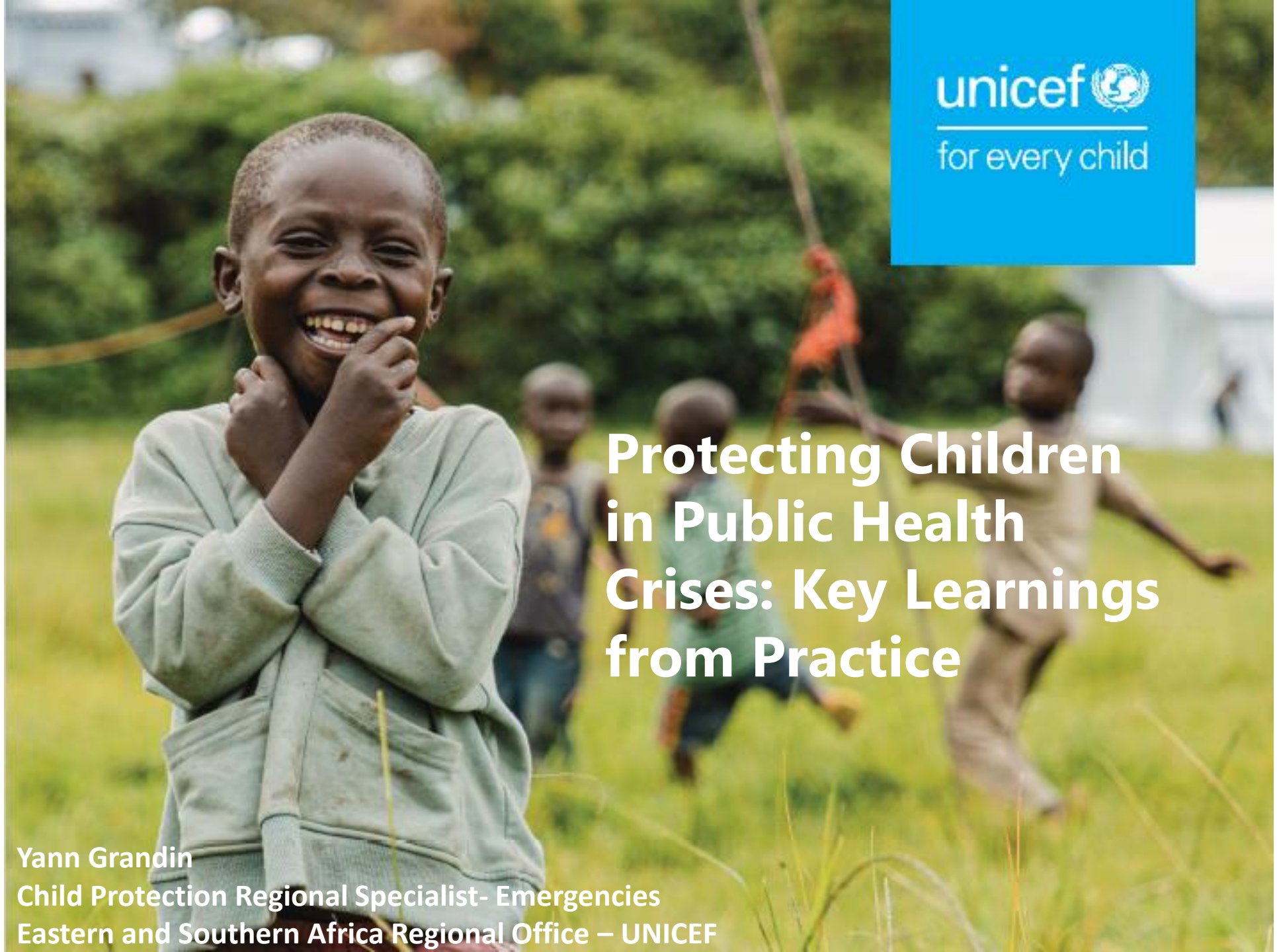
Children and Women in Public Health Emergencies

- PHEs impact the physical and mental health and wellbeing of children and women
  - disrupt the socio-economic status of families
  - foster uncertainty within communities
- The best interests of children, women and marginalized communities are central to preparedness and response (e.g. protection)
- Consequences extend beyond the public health threat
  - loss of education and learning opportunities
  - negative impacts on mental health
  - increased risk of violence, exploitation, and abuse
  - Socio-economic and development impacts of policy decisions and interventions
- The health and social service systems need to work together to prepare for and respond to public health emergencies
- Women, children and communities need to be included in the creation and delivery of interventions

UNICEF's interventions for a multisectoral approach to PHEs





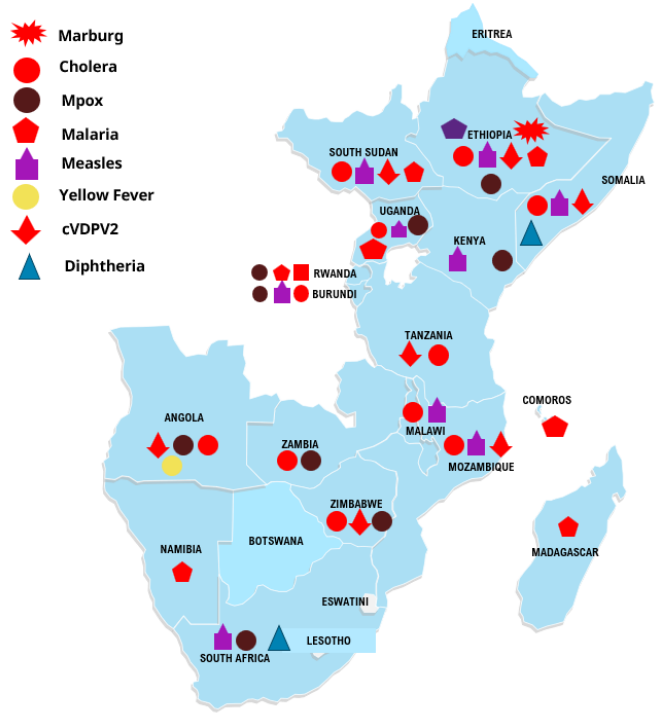


Protecting Children in Public Health Crises: Key Learnings from Practice

Yann Grandin
Child Protection Regional Specialist- Emergencies
Eastern and Southern Africa Regional Office – UNICEF

Why Child Protection Matters in PHE ?

Ongoing Public Health Emergencies in Eastern and Southern Africa



20/21* countries are experiencing a Public Health Event, with 15 (75%) being Vaccine Preventable Diseases

- In early 2026, over **80% of countries faced public health events**
- Health responses mobilize fast, but **child protection risks remain largely invisible**
- PHEs do not only create health risks for children; they systematically **increase protection concerns**
- Child protection is essential not only for outbreak control but also to **effective, qualitative and sustainable health responses**

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1. Different emergencies, similar child protection risks

Across cholera, Ebola, mpox, COVID-19 or Marburg, **the pattern of child protection risks is consistent**, even when epidemiology differs:

- Sudden **family separation**
- Increased **GBV**, particularly against girls
- Economic shocks leading to **child labour, early marriage, transactional sex**
- Severe **psychosocial distress** (exacerbated by isolation and stigma)

2. Community systems are the backbone when formal services are stretched

- During PHEs, **social services are often overwhelmed**, restricted by movement controls, or deprioritized.
- **Communities become the first—and sometimes only—line of protection for children**, particularly in rural or underserved areas.
- Committees are **cost-effective, rapid, and sustainable and can address longer term issues.** Preparedness investments must include community systems

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3. Isolation and treatment facilities are high-risk protection environments

- Isolation and treatment Centres are designed to contain disease—but **often overlook children's developmental and protection needs**.
- Risks include:
  - Children **isolated** without caregivers
  - Lack of child-friendly spaces and **materials**
  - Poor registration, increasing **risk of long-term separation**
  - Heightened risk of **SEA** and GBV
  - Heightened risk of traumatic experiences

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4. Recovery and reintegration are where invisible harm persists

- Discharge from treatment centres marks **the beginning—not the end—of protection risks**.
- Families return home facing:
  - Stigma and discrimination
  - Loss of income
  - Debt and material deprivation
- Without support, these pressures drive **harmful coping strategies affecting children**

Moving forward …

- **Integrate child protection from day one** of PHE planning.
- **Invest in preparedness and community systems**, not just surge capacity.
- **View child protection as life-saving**, not optional.
- **Use PHEs as opportunities to build the resilience of systems**

Overcoming Financial and Access Barriers to Health Care in Ukraine

The Role of Cash and Voucher Assistance in Service Delivery

Dr Amaah Penn – WHO/Health Cluster Ukraine

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Context

Context Ukraine:

- Population of 41.2M*, Internal Displacement 3.39M**

Attacks on Health care:

- In 2025 alone, WHO verified **578 attacks on healthcare**
- **Since 2022, a total of 2828 attacks on healthcare** have been verified by WHO.
- **Attacks cause barriers to health services**: damage HFs, ambulances and prevent health workers from delivering services.
- Public services affected, including transportation

Ukraine's Health System:

Health Services **provide free-of-charge** (constitutional rights)
Patients sign **contracts with a family doctor** (point of entry into health system)
National Health Service Unit (pays for consultation costs),
Program of Medical Guarantees (provides medicines to patients after consultation)
Compromise of system in conflict-affected locations, + limited budget to frontline facilities

**State statistic service, as of 1 January 2022*
*** IOM, General Population Survey Round 22, January 2026*

Photo: Okhmatdyt hospital damaged by a rocket attack (Vitaliy Nosach/RBK-Ukraine).

Triple risk of attacks for Ukraine's health transport workers (WHO Ukraine)

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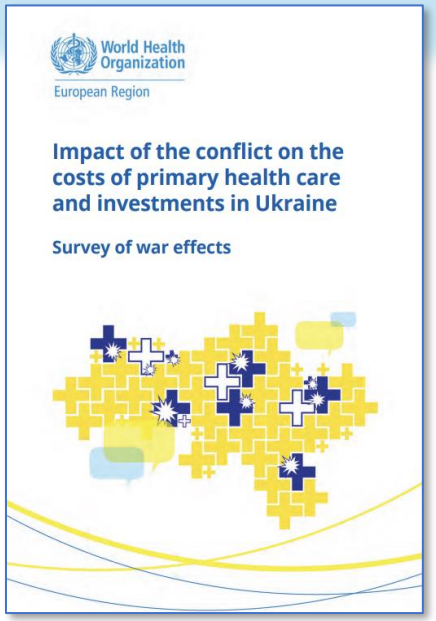
Rationale for the Use of Cash in Health

Impact of War on Ukraine's Health System

- Damage to HFs
- Staff shortage
- Supply chain disruption
- Displacement caused demographic shift in patients
- Frequent electricity cuts
- Inflation & prices increase
- NHSU funding reduced (war)



Rationale for Cash/Voucher Use

- **Access barriers**: Disability, transportation, medicines, laboratory, health workforce shortage, non-functional health facilities
- Partner engagement **enabling vulnerable and displaced persons** to meet needs amplified by **Access Barriers**.
- Evidence-based **needs expressed by assessment findings** (Multi-Sector Needs Assessments(MSNA), REACH Assessments, Health Needs Assessments)
- Failure of Multi-purpose cash (MPCA) in meeting intended health outcomes **following** addressing barriers. **Accountability + health risks + Disruption of the health system (informal payments)**

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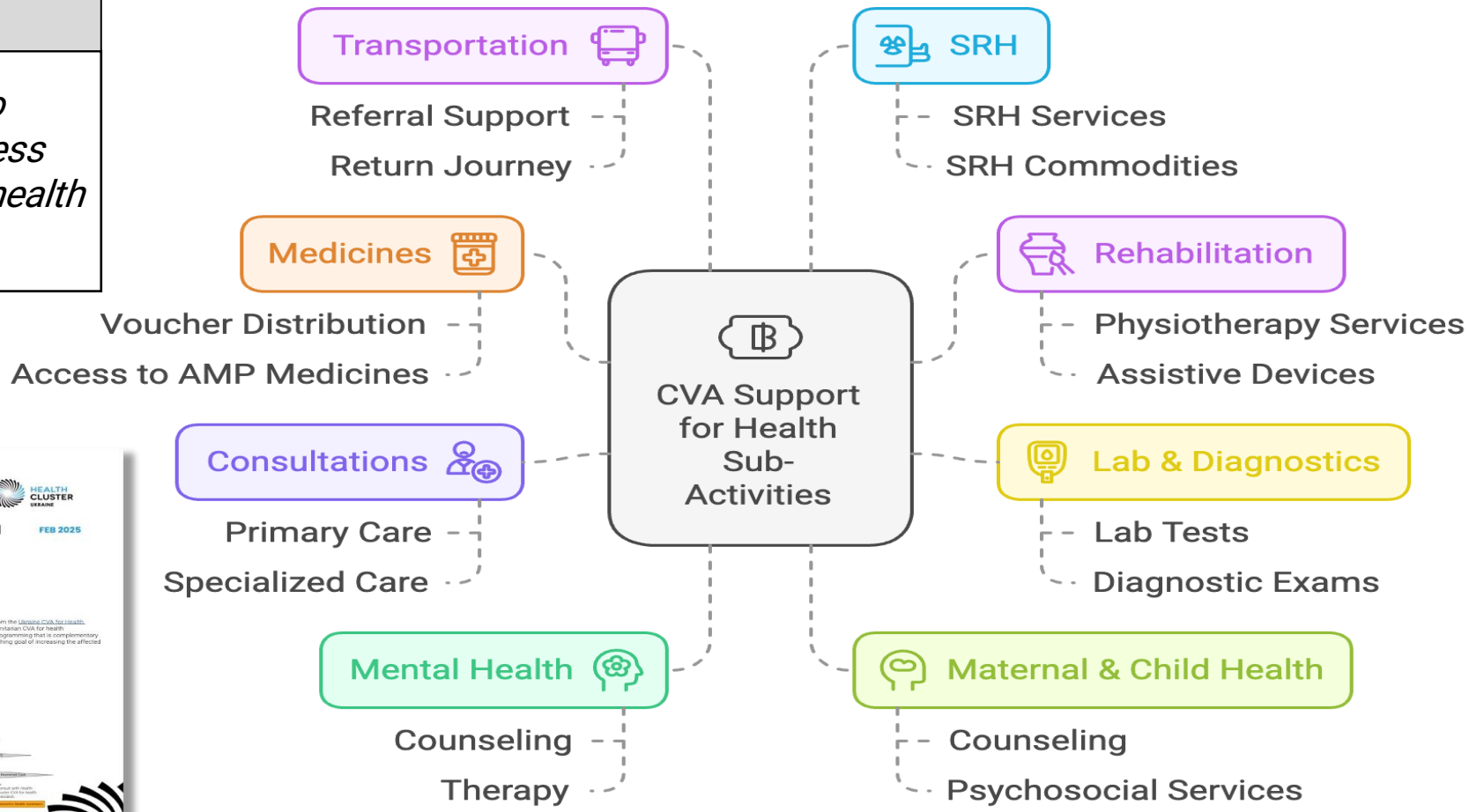
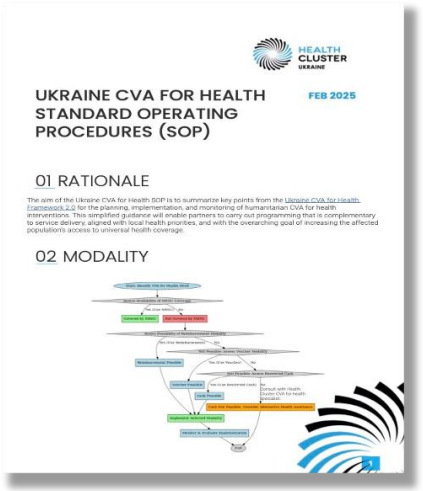
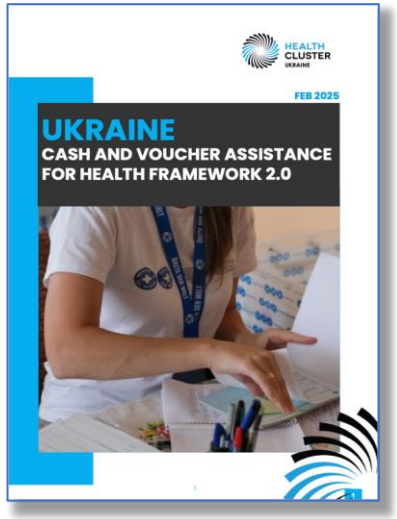
Strategy - CVA for Health Activities (based on barriers)

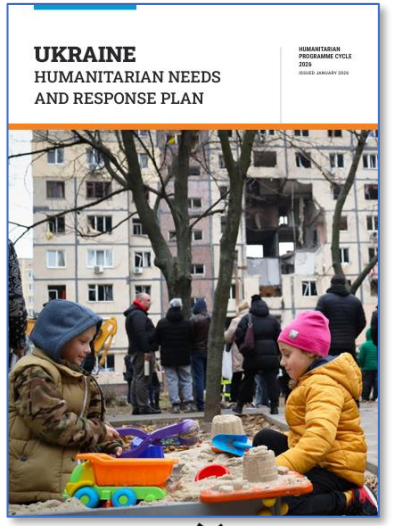
HE 102

Vouchers to reduce access barriers to health care









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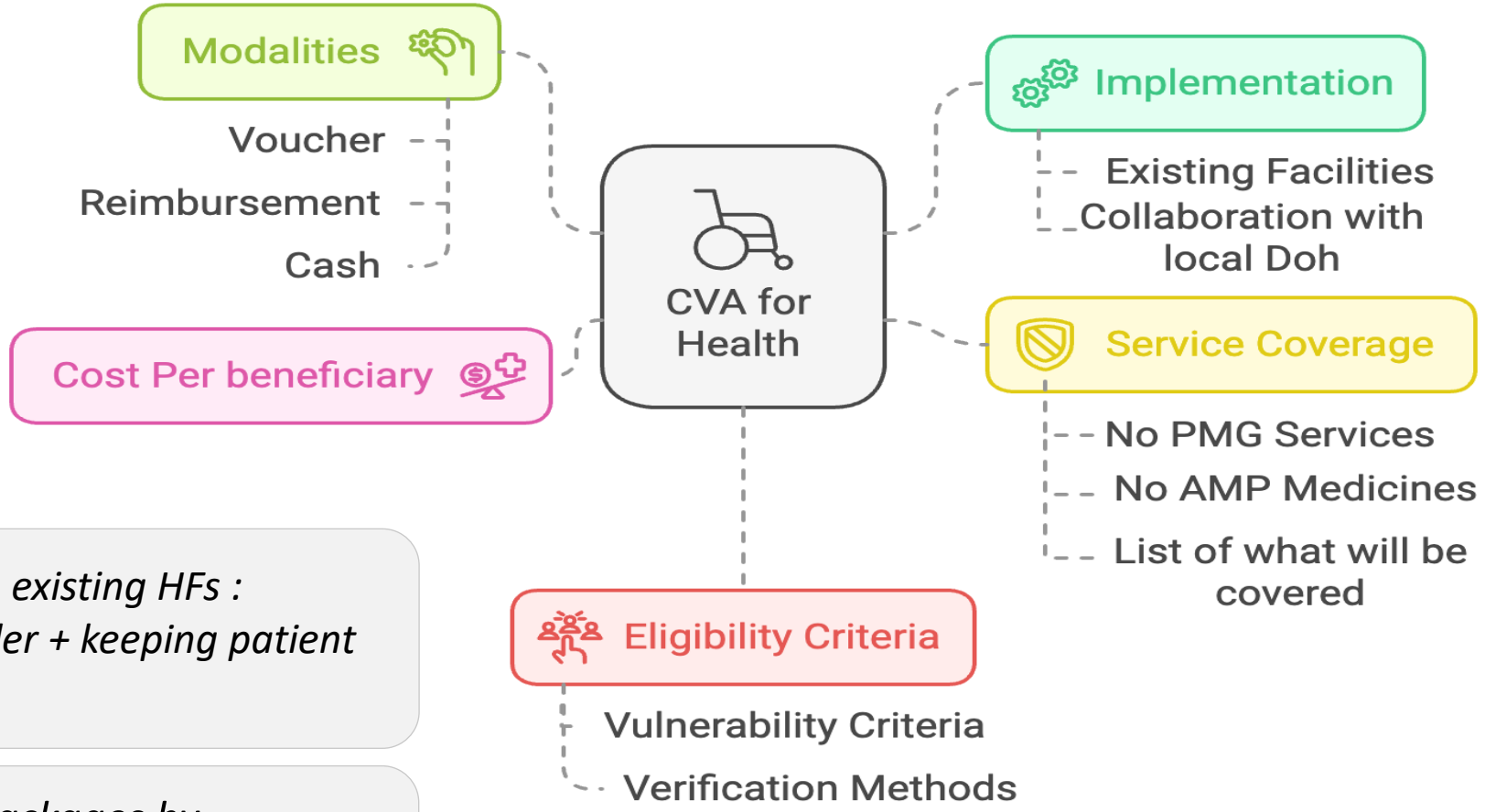
Operationalizing CVA for Health: What Needs to Be in Place



!! *CVA implementation through existing HFs : linking patient to service provider + keeping patient data on the e-health platform*

!! *CVA: Complements NHSU packages by covering services/medicines where lacking/not covered.*

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Achievements and Challenges

Achievements	
	Development of guidance: CVA Framework, CVA Standard operating Procedures,
	Referral/Counter-referral: Intersector/InterCluster referral dashboard.
	31,571 vulnerable people in frontline areas receiving services (2025).
	USD **$3.59 million** CVA funding for partners only for 2025 alone.
	Target populations included older people, people with disabilities, and displaced individuals.
	Documentation: Lessons learned on the Ukrainian experience

Challenges	
	Weaknesses in CVA referral systems.
	Difficulty programming CVA in frontline areas (transportation and insecurity).
	Limited CVA coverage for specific health needs.
	Lack of supply-side interventions
	Operational challenges due to security risks.
	Power outages and unreliable internet connectivity affecting CVA delivery.

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Reflections - Way Forward

- Cash and Voucher use should be designed to **complement and protect national health systems.**
- The selection of CVA modalities should be **evidence-based and informed by health-system assessments**.
- **Do no harm: Flexibility to adapt** CVA should be a priority to accompany government-led initiatives and evolving regulatory contexts
- **Community engagement and education** are key in harmonizing expectations on the demand and supply side.

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Further Examples and Research

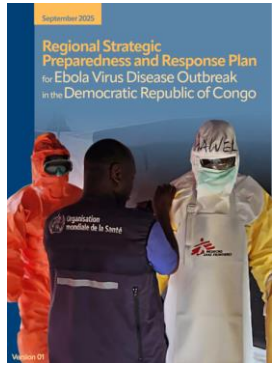
- Ebola response West Africa – ILO, UNDP, AU
- Marburg virus response Tanzania, Ebola virus Sudan response in Uganda 2025 (isolation, quarantine)
- Cash Assistance and Social Protection in conflict settings
- HIV/AIDS: food security response – WFP, UNICEF, UNAIDS
- COVID-19: Review of social protection and public health and social measures
- Community Social Protection package EVD DRC 2025

Health cluster DRC: Social Protection for mpox patients in the context of multisectoral humanitarian cluster response (health, livelihoods, food security, coordination) in DRC

Quarantine measures in the context of VHF responses require additional social protection interventions for affected, at risk groups

WHO UKR: Targeted cash voucher assistance for patients to access defined packages of health care at different levels of care

UNICEF Gaza: food and cash, mhpss services to patients with severe acute malnutrition in SAM stabilization centers



HIV related Kenya's Cash Transfers for Orphans and Vulnerable Children, a government-led national unconditional cash transfer program targeting the poorest households with vulnerable children: improved the financial stability of households, the enrolment of adolescent girls in school, delayed age of sexual debut, thus helping to reduce the risk of new HIV infections (WFP Kenya, 2021; Handa et al., 2015), incl. in the context of HIV/AIDS orphaning compounded by COVID-19 bereavement.

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Key take home messages

- Integrate community social protection into health emergency responses to protect livelihoods, health and well-being and reduce long-term socioeconomic harms.
- Embed community social protection in preparedness plans — not just in emergency response. Design for equity and inclusion, ensuring the most vulnerable and marginalized are prioritized across sectors.
- Ensure clear definition and targeting of the recipient groups of community social protection assistance
- Plan and institutionalize multisectoral coordination before crises — coordination works best when established and practiced ahead of emergencies. Monitor and evaluate over time to strengthen resilience.
- Ensure broad stakeholder commitment — from government ministries to subnational, municipal levels, private sector and communities incl women's groups, people living with NCDs, adolescents, people with disabilities
- Strengthen linkages between health, other social services, local governance, to share data, target support, scale assistance quickly and ensure continuity of these services.
- Leverage existing community structures and informal networks — recognizing local solidarity systems and emphasizing community leadership. Strengthen community engagement throughout.
- Use anticipatory actions and early support to protect livelihoods, ensure continuity of essential services and prevent harmful coping mechanisms.

What can you do? - Key take home messages

- Consider the community perspective throughout the emergency management and planning cycle
- Include community social protection (CSP) and information on vulnerabilities, key target groups for social protection into the SPRPs/HRPs from the outset; to access response funding fast during early response phase
- Tailor CSP intervention packages ahead of time by discussing with other agencies and sectors during the preparedness phase, with community involvement
- Integrate multisectoral coordination mechanisms for CSP interventions in all hazards responses from the outset
- Contribute to and look forward to upcoming guidance on CSP and a tool on an initial set of core actions to ensure continuity of community services, especially for preexisting conditions (malnutrition, disability, physical rehabilitation, non- communicable diseases, home based and self care etc)