HUMANITARIAN HEALTH DIGEST

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JOHNS HOPKINS CENTER for HUMANITARIAN HEALTH

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Featuring articles on COVID-19 and humanitarian assistance

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WELCOME

to the *Humanitarian Health Digest*—a biannual bibliography of published peer-reviewed journal articles on humanitarian health. The *Digest* is compiled by the Johns Hopkins Center for Humanitarian Health and *The Lancet*. It includes one or two new commentaries on peer-reviewed articles cited in the *Digest*.

The objective of the Digest is to provide links to peer-reviewed articles on humanitarian health from a wide variety of journals in one place for ease of reference. Peer-reviewed articles will be searched systematically using the PubMed and Global Health (OVID) databases. Articles will mostly include primary research and systematic reviews. Humanitarian health will be divided into three broad categories:

- Conflict and Forced Displacement
- Natural Disasters
- Technological Disasters

The articles will be further divided into low- and middle-income countries and high-income countries.

Under each of these two sub- categories, articles will be subdivided into the following public health-related categories:

I. COMMUNICABLE DISEASE
II. NON-COMMUNICABLE DISEASE
III. REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH
IV. NUTRITION AND FOOD SECURITY
V. WATER, SANITATION AND HYGIENE (WASH)
VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE
VII. HEALTH SYSTEMS
VIII. MULTI-CATEGORY

All featured articles from the Lancet family of journals will be free to read with registration on TheLancet.com. It is the Center for Humanitarian Health's goal that other journals will follow suit to allow all peer-reviewed articles to be free to read so that humanitarian workers worldwide can learn from and apply lessons learned and conclusions immediately in the field to benefit persons affected by conflict, natural disasters and technological disasters.

We hope that you will learn and benefit from the articles presented in the *Humanitarian Health Digest*.

Paul Spiegel MD MPH
Director of the Center for Humanitarian Health

Richard Horton FRCP FMedSci
Editor-in-Chief of *The Lancet*

COMMENT I.

The need for integrated COVID-19 response in humanitarian settings

by Natalya Kostandova BS MPH, PhD student, Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health

▲ *Dr Lia Tadesse, Minister of Health, with the first shipment of COVID-19 humanitarian supplies for use by health workers in Ethiopia.*

As the confirmed COVID-19 cases worldwide have exceeded 17 million[1], and with the pandemic nowhere near its end, it is critical that we consider its indirect effects on morbidity and mortality among populations in humanitarian settings. The funding requirements for implementation of the Global Humanitarian Response Plan (GHRP) for COVID-19 are estimated at $6.71 billion.[2] As daily activities and trade continue to be upended, threatening a long-term contraction of the global economy, there is a concern about diverting already strained resources towards the COVID-19 response, thus reducing funding flows to address other pressing humanitarian needs.

As illustrated by Tran and colleagues[3] in a comment included in this issue of the *Digest*, evidence suggests that discontinuing essential health services unrelated to the pandemic may have devastating effects on the morbidity and mortality of populations in humanitarian settings, with excess deaths from these discontinuations surpassing the direct deaths from the outbreak itself. This comment specifically underscores the importance of maintaining sexual and reproductive health (SRH) services during this time, arguing that the suspension of these services in countries affected by fragility and crisis would have debilitating consequences. Tran and colleagues echo the guidance issued by the Inter-Agency Working Group for Reproductive Health in Crises on SRH and COVID-19, outlining a four-pronged approach for ensuring that life-saving SRH services remain available, appropriate public health information is available to practitioners and communities, and COVID-19 transmission risks at health facilities are mitigated through appropriate infection, prevention, and control..

A comment by Olu and colleagues[4] emphasizes lessons learned in preparing for cross-border introduction of Ebola virus disease (EVD) into the Republic of South Sudan. The authors attribute the effectiveness of preparedness efforts to a cohesive strategy that established outbreak response capacity while simultaneously strengthening existing health systems. This led to an increase in EVD preparedness from 17% in November 2018 to 61% in March 2019, as measured during Joint Monitoring Missions carried out by the Ministry of Health, World Health Organization (WHO), and in-country partners using the EVD readiness checklist developed by WHO and collaborators. A report by Mobula and colleagues[5] presents recommendations for COVID-19 response based on the lessons learned from the EVD outbreak in the Democratic Republic of the Congo. They similarly underscore the importance of continued service provision to mitigate the secondary effects of the outbreak. The authors address the challenges of food insecurity, armed conflict, and limited access to safe water in containing EVD outbreak, thus advocating for a multisectoral approach to addressing the current pandemic.

Tijjani and Ma's commentary[6] anticipates that COVID-19 will worsen the humanitarian situation in complex settings such as northeast Nigeria, a region already susceptible to emergence and re-emergence of endemic diseases such as cholera, Lassa fever, meningitis, and measles. The authors draw attention to the call from the United Nations to maintain a consistent flow of funding to address the unmet humanitarian needs that are not directly tied to COVID-19 response. This is especially important given the likelihood that public health measures established to reduce the spread of COVID-19, such as movement restrictions and lockdowns, may increase the operational challenges and decrease the ability to address the existing humanitarian needs of communities.

The failure to maintain and ensure continued access to routine services

▲ *In May 2020 communities around Uganda's western Rwenzori mountains found themselves facing a concurrent humanitarian emergency of COVID-19 and large-scale destruction caused by flash floods when the banks of the Nyamwamba and Mubuk rivers burst. The Kilembe mines hospital was destroyed. The Uganda Red Cross quickly moved in to support affected families, assisting with emergency evacuations, providing first aid and distributing food and non-food items to at least 1,750 people.*

will likely disproportionately affect the populations in positions of lesser power who already experience the undue burden of disease. An article by Lokot and Avakyan[7] notes the importance of employing a lens of intersectionality in COVID-19 response in humanitarian settings. The authors highlight the reduction in SRH services in Sierra Leone during the Ebola outbreak, and the resulting increase in neonatal and maternal deaths in 2014 and 2015. Lokot and Avakyan argue that power hierarchies that persist in conflict-affected populations are likely to deepen during the pandemic. A reduction in resources and services available, as well as social isolation and distancing, may further the discrimination and inequality of power experienced by some community groups. Individuals already facing barriers to accessing services may again be disproportionately affected by the reduction of services due to the diversion of resources to the COVID-19 response.

Our response to COVID-19 should not be considered as a parallel or a competing endeavor independent of provisioning routine health services and interventions that address unmet humanitarian needs. While there is a clear need to counter the direct threat to life health posed by COVID-19, the indirect consequences of the pandemic cannot be overlooked. The provision of COVID-19-specific measures must be approached through a lens of a holistic response that takes into account the basic unmet needs, socioeconomic structures, and power hierarchies of communities in humanitarian settings. If not, the alternative has the potential to have a devastating impact on populations already facing excess morbidity and mortality in such contexts.

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COMMENT II.

Not a luxury: a call to maintain sexual and reproductive health in humanitarian and fragile settings during the COVID-19 pandemic

by Nguyen Toan Tran, Hannah Tappis, Nathaly Spilotros, Sandra Krause, Sarah Knaster, for the Inter-Agency Working Group on Reproductive Health in Crises¶

About 1·8 billion people live in fragile contexts worldwide,[1] including 168 million individuals in need of humanitarian assistance. Approximately a quarter of those in fragile contexts are women and girls of reproductive age.[2] Experience from past epidemics in these settings has showed that discontinuing health-care services deemed unrelated to the epidemic response resulted in more deaths than did the epidemic itself.[3] Issues related to sexual and reproductive health are among the leading causes of mortality and morbidity among women of childbearing age, with countries affected by fragility and crisis accounting for 61% of maternal deaths worldwide.[4]

Poor health outcomes will surge from the absence or disruption of lifesaving services, including emergency obstetric and newborn care, contraception to prevent unwanted pregnancies, and the management of abortion complications. Gender-based violence and sexual exploitation and abuse might increase during outbreaks because of confinement, increased exposure to perpetrators at home, economic precarity, and reduced access to protection services. The care for children and others confined at home further reduces women's ability to properly care for themselves.[5]

In the context of the pandemic preparedness and response, members of the Inter-Agency Working Group for Reproductive Health in Crises have issued various field guidance documents on sexual and reproductive health and coronavirus disease 2019 (COVID-19). Building on the overarching need for humanitarian actors to coordinate and plan to ensure that sexual and reproductive health is integrated into the pandemic preparedness and response,[6] there are four prongs on how to mitigate the impact of COVID-19 on mortality and morbidity due to sexual and reproductive health conditions in crisis and in fragile settings.

First, with the understanding that the risks of adverse outcomes from medical complications outweigh the potential risks of COVID-19 transmission at health facilities, the availability of all crucial services and supplies as defined by the Minimum Initial Services Package for sexual and reproductive health should continue.[6] These services include intrapartum care for all births and emergency obstetric and newborn care (caesarean sections should only be performed when medically indicated as a COVID-19 positive status is not an indication for a caesarean section[7]), post-abortion care, safe abortion care to the full extent of the law, contraception, clinical care for rape survivors, and prevention and treatment for HIV and other sexually transmitted infections. Early and exclusive breastfeeding and skin-to-skin contact for neonates should be promoted, and mother and neonate should not be separated unless one or both are critically ill in cases of suspected or confirmed COVID-19 infections.[7]

Second, comprehensive sexual and reproductive health services should continue as long as the system is not overstretched with COVID-19 case management. For relevant consultations and follow-up, remote approaches should be considered where feasible (eg, telephone, digital applications, text messaging). In addition to the Minimum Initial Service Package, these comprehensive services—ie, all antenatal care, postnatal care, newborn care, breastfeeding support, and cervical cancer screening, as well as care for individuals experiencing intimate partner violence—should remain available to all individuals who need them, including adolescents.

¶ *Lancet Glob Health* 2020; **8:** e760–61. doi:10.1016/S2214-109X(20)30190-X.
https://www.ncbi.nlm.nih.gov/pubmed/32330429/

Third, clear, consistent, and updated public health information crafted with representatives of the targeted audiences should reach the community and health-care workers. This information should reaffirm that medical complications outweigh the potential risk of transmission at health facilities and that community members should continue to seek and receive care during childbirth and for all other essential sexual and reproductive health needs or emergencies resulting from other diseases, trauma, or violence. The community should understand that any changes in routine services are for patients' benefit to ensure support to the COVID-19 response, avert undue exposure to the risk of contracting the virus in a health facility during the outbreak, or both. However, the coordination and planning to re-establish such comprehensive services should occur as soon as the situation stabilises.

Fourth, COVID-19 infection prevention and control precautions, including hand hygiene, physical distancing, and respiratory etiquette should apply to patients (and accompanying family members if their presence is necessary). Additionally, staff should be protected with adequate personal protective equipment. Facilities also need to establish a patient flow that incorporates triage before entrance into the facility, and an isolation area and separate consultation room for suspected or confirmed cases.

To minimise preventable deaths, crucial health-care services, including sexual and reproductive health services, should remain accessible during public health emergencies, even when resources from already fragile health systems are often redirected for outbreak response. The COVID-19 pandemic will magnify the risks inherent to resource reshuffling at the expense of other services; however, sexual and reproductive health cannot be viewed as a luxury.[8] On March 31, 2020, the United Nations Secretary-General highlighted in relation to COVID-19 that "we are only as strong as the weakest health system in our interconnected world".[9] To echo this statement, we have offered guidance on sexual and reproductive health and COVID-19, and we call on health authorities to prioritise these lifesaving services in humanitarian and fragile settings. Such interventions should be considered as indispensable components of health services that do not strain, but strengthen health systems during COVID-19 preparedness and response efforts. The collective health of women, girls, and the wider community depends on these services.

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HIGH-INCOME COUNTRIES

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III. REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH

LOW- AND MIDDLE-INCOME COUNTRIES

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LOW- AND MIDDLE-INCOME COUNTRIES

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LOW- AND MIDDLE-INCOME COUNTRIES

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N/A.

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LOW- AND MIDDLE-INCOME COUNTRIES
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HIGH-INCOME COUNTRIES
N/A.

II. NON-COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES
N/A.

HIGH-INCOME COUNTRIES
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LOW- AND MIDDLE-INCOME COUNTRIES

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LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

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V. WATER, SANITATION, AND HYGIENE (WASH)

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

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VIII. MULTI-CATEGORY

VII.–VIII., N/A.

Technological Disasters

I. COMMUNICABLE DISEASE

II. NON-COMMUNICABLE DISEASE

III. REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH

IV. NUTRITION AND FOOD SECURITY

V. WATER, SANITATION, AND HYGIENE (WASH)

I.–V., N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

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VII. HEALTH SYSTEMS

VIII. MULTI-CATEGORY

VII.–VIII., N/A.

▼ **Children demonstrate hand washing at Kakuma refugee camp, Kenya**. *Photographs courtesy of the Lutheran World Federation/P Omagwa. As the main implementer of education at the camp, LWF has reinforced hygiene education to prevent the spread of COVID-19.*

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