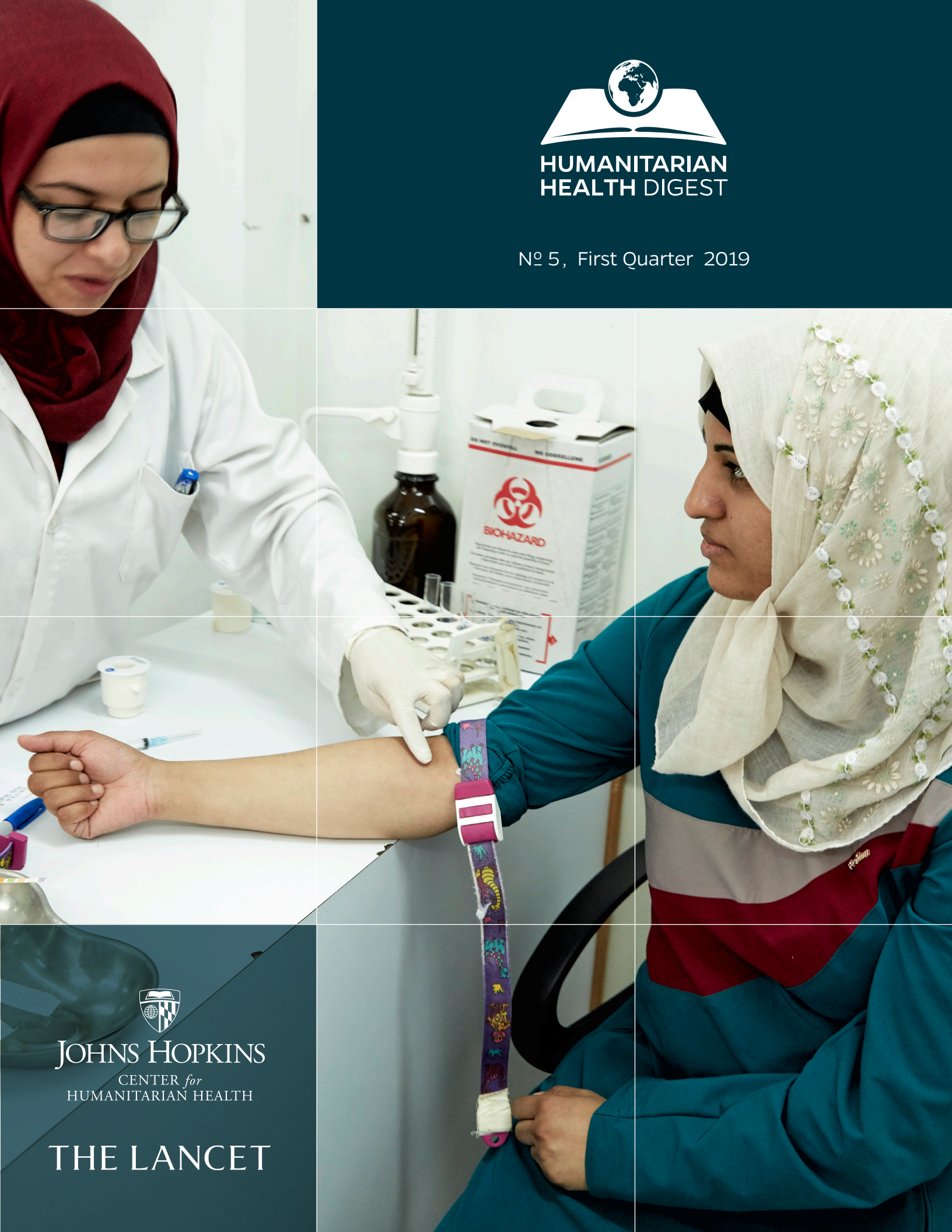


HUMANITARIAN HEALTH DIGEST

№ 5, First Quarter 2019

JOHNS HOPKINS
CENTER *for*
HUMANITARIAN HEALTH

THE LANCET

HUMANITARIAN
HEALTH DIGEST

WELCOME

to the *Humanitarian Health Digest*—a quarterly 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: 1. Conflict and Forced Displacement; 2. Natural Disasters; and 3. Technological Disasters. The articles will be further divided into low- and middle-income countries and high-income countries.

Under each of these two subcategories, 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.

Responding to Ebola in a protracted crisis

by Chiara Altare, PhD, Assistant Scientist, Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health

https://www.flickr.com/photos/monusco/42684940960

▲ *Ebola treatment centre at the hospital in Beni, North Kivu Province, Democratic Republic of Congo. MONUSCO-Alain Coulibaly/ CC BY-SA 2.0.*

The ongoing Ebola outbreak in North Kivu and Ituri provinces, Democratic Republic of Congo (DRC) is the second worst in history, with 1439 cases as of April 27, 2019, resulting in 931 deaths.[1] The recent spike in the number of reported cases sparked widespread alarm, but did not yet lead to the declaration of Public Health Emergency of International Concern or PHEIC.[2] While the outbreak did not cross any international border, thus far, it occurs in an active conflict zone that has been ravaged by insecurity for the last two decades.

Responding to outbreaks in conflict affected areas requires extensive understanding of local powers, community dynamics and history, besides specialized medical and technical expertise. Decades of violence and mistrust of institutions shape the way communities perceive the severity of a given problem, value life and death, and gauge the authenticity of an action. As naïve as it might sound, an outbreak response can only be as effective as it is sensitive and adapted to the local context. In fact, medical innovation without social traction will not deliver the expected results.[3]

In this quarter's *Humanitarian Health Digest*, Vink and colleagues[4] report on the role of trust and misinformation on individual preventive behaviors during the initial phase of the Ebola outbreak in North Kivu. They interviewed approximately thousand people in the cities of Beni, the epicenter of the outbreak at the time, and Butembo, initially little affected, but one of the main hotspots as I write this commentary. Overall, they found a low level of trust in governmental institutions and widespread belief in misinformation about Ebola Virus Disease.

While this might seem predictable given the historical hostility of this part of the country vis-à-vis the central government, what carries more operational implications for the current outbreak response is the impact of trust on individual behavior. Their findings show that individuals are more likely to follow preventive behaviors when they trust the government and its capacity to tackle the Ebola outbreak, as well as when they trust the health work force. Study participants reported having reduced contact with suspected cases, avoiding social gatherings and public spaces, and washing hands more frequently with increasing levels of trust. The authors also found that individual's level of information is affected by the level of trust. People with lower trust tend to be less informed about Ebola and more likely to believe in rumors or misinformation, which resulted in lower adherence to protective behaviors.

Recognized as an essential element of effective public health interventions, trust is playing a pivotal role in the level of success of the current Ebola response in DRC. Yet, how to build and maintain trust in a humanitarian setting remains a significant challenge. Possible ways forward include: working through local actors and existing mechanisms that have knowledge of the context and an established presence in the area; addressing community's needs that go beyond Ebola prevention; and finally, safeguarding the humanitarian principles of neutrality and independence to reduce the politicization of the response.

These recommendations are certainly easier said than done. Yet, the stakes are high and efforts in this direction should continue.

COMMENT II.

Diabetes: an overlooked crisis in humanitarian settings

by Márcia Costa, PhD, Assistant Editor, *The Lancet*

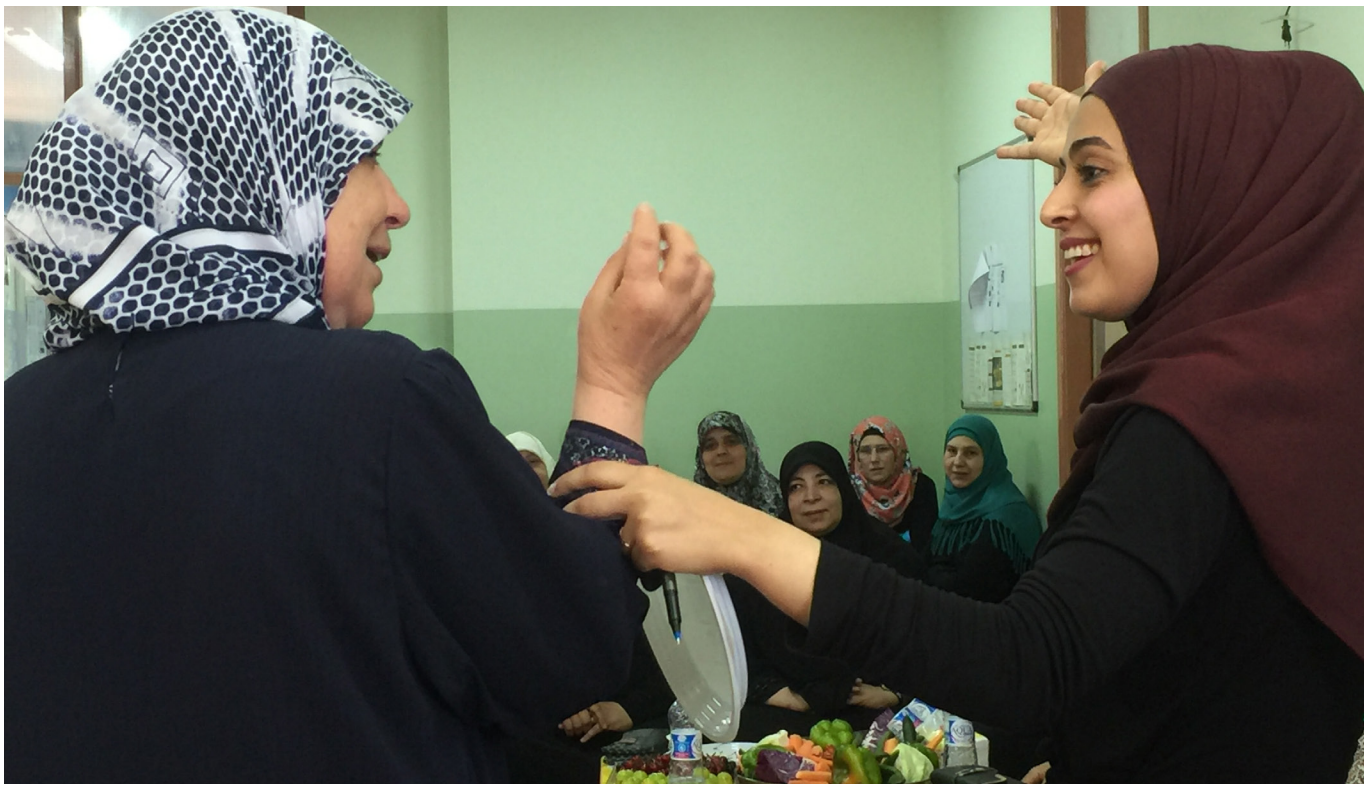
The global non-communicable diseases (NCDs) burden is increasing quickly, particularly in low-income and middle-income countries (LMICs). For many years, NCDs have often been deprioritised in crises settings, with humanitarians often focusing on maternal and child health and infectious diseases. But, with ageing population, worsening climate change, protracted crises on the rise, and funding drives increasingly falling short of their objectives, the need for humanitarians to integrate and account for NCDs in humanitarian settings is becoming more pressing.

Diabetes in humanitarian crises, a series led by Sylvia Kehlenbrink and Phillipa Boulle published online on March 13 in *The Lancet Diabetes and Endocrinology*,[1] is featured in this quarter's *Digest*. Diabetes is particularly difficult to manage in humanitarian settings because food insecurity can compromise its treatment and it is often associated with other comorbidities. This Series reviews the evidence and expert opinion on diabetes management in humanitarian settings, discussing disease burden and challenges to diagnostics and care access. Moreover, the authors reflect on the need for allocated funding and advocate for coordinated efforts among agencies to improve diabetes management.

This Series highlights the paucity of good-quality data on diabetes burden and interventions, not only in humanitarian settings, but in LMICs in general. Accurate baseline data are crucial to place diabetes in the priority list of humanitarian organisations, but also to ensure that stockpiling of diagnostic tools and drugs is fit for purpose. Evidence-based interventions could save even more lives if they were customised to treat diabetic comorbidities. Failing to communicate the impact of diabetes in LMICs is an impediment to the drive of political will, patient advocacy, and, consequently, funding.

Challenges obstructing delivery of care are also investigated in the Series. The authors suggest that agencies need to be better prepared for disruption in diagnostics and insulin supply and guarantee that interventions and storage systems are in place. To enhance access to affordable insulin in these settings, more negotiation is needed among donors, pharmaceutical companies, and governments. Diabetes also requires a continuum of care, which is very challenging for people who have been forcibly displaced. The authors discuss mobile health, which allows provision of health-care support and interventions through mobile technology, as a potential solution; much of the population affected by humanitarian crises now have access to mobile phones and smart devices, an untapped resource for medical intervention. Patients, local doctors, and communities should also be educated in best practice, for instance in the use of insulin—in many LMICs, insulin is still delivered at secondary or tertiary levels, which will not be sustainable in a crisis setting. Interventions for diabetes management should be flexible, adaptable, and cost-effective to overcome the challenges of accessing care during crisis.

Diabetes—and NCDs in general—have been under-represented in the debate for health interventions in humanitarian settings, and, although awareness is growing among the community, this Series should act as a wake-up call. Humanitarian organisations need to increase the pace to prioritise these diseases and make sure no one is left behind. For better resilience, NCDs and humanitarian crises need to be accounted for in countries' health planning and infrastructure. Featuring



https://www.worlddiabetesfoundation.org/projects/west-bank-and-gaza-wdf14-898

▲ *A nutritionist working with the UNRWA Health Programme teaches Palestine refugees about healthy lifestyle practices to prevent diabetes (Photograph courtesy of the World Diabetes Foundation).*

care for NCDs in humanitarian settings high on the agenda of the upcoming UN Universal Health Care High-Level meeting would be a good way to move the discussion forward. Honest debate can give voice and improve the lives of those who are, ultimately, the main actors in these settings: patients.

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V. WATER, SANITATION, AND HYGIENE (WASH)

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VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

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LOW- AND MIDDLE-INCOME COUNTRIES

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Natural Disasters

I. COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES

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II. NON-COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

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

N/A.

IV. NUTRITION AND FOOD SECURITY

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

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HIGH-INCOME COUNTRIES

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V. WATER, SANITATION, AND HYGIENE (WASH)

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VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

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VII. HEALTH SYSTEMS

N/A.

VIII. MULTI-CATEGORY

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Felix ED, Binmoeller C, Nylund-Gibson K, Benight CC, Benner AD, Terzieva A. Addressing disaster exposure measurement issues with latent class analysis. *J Trauma Stress* 2019; **32:** 56–66. doi:10.1002/jts.22368.
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Technological Disasters

I. COMMUNICABLE DISEASE

N/A.

II. NON-COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES
N/A.

HIGH-INCOME COUNTRIES
Murase K, Murase J, Mishima A. Nationwide increase in complex congenital heart diseases after the Fukushima nuclear accident. *J Am Heart Assoc* 2019; **8:** e009486. doi:10.1161/JAHA.118.009486.
https://www.ncbi.nlm.nih.gov/pubmed/30862223

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

IV. NUTRITION AND FOOD SECURITY

V. WATER, SANITATION, AND HYGIENE (WASH)

III.–V., N/A.

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VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

Murakami M, Takebayashi Y, Tsubokura M. Lower psychological distress levels among returnees compared with evacuees after the Fukushima nuclear accident. *Tohoku J Exp Med* 2019; **247:** 13–17. doi:10.1620/tjem.247.13.
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Yoo S, Sim M, Choi J, et al. Psychological responses among humidifier disinfectant disaster victims and their families. *J Korean Med Sci* 2019; **34:** e29. doi:10.3346/jkms.2019.34.e29.
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Shieh V, Huang JJ, Wu TG, et al. Rate of psychiatric disorders and associations with quality of life among community members following the Kaohsiung gas explosion: an 18-month cross-sectional follow-up study. *Health Qual Life Outcomes* 2019; **17:** 7. doi:10.1186/s12955-018-1076-7.
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VII. HEALTH SYSTEMS

VIII. MULTI-CATEGORY

VII.–VIII., N/A.

▲ *Baraa Khamis Salhi, a resident of the Askar refugee camp in the West Bank with type 1 diabetes. Inspired by the care she received from UNRWA, she now works as a nurse helping other refugees (Photograph by Jesper Westley, courtesy of the World Diabetes Foundation).*

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