HUMANITARIAN HEALTH DIGEST

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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 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.

Conflict and national surveys for reproductive maternal, newborn, and child health in Sub-Saharan Africa

by Dr Marwa Ramadan, MD, MPH, PhD Candidate, International Health Department, Johns Hopkins Bloomberg School of Public Health

https://flic.kr/p/p1ht2y

▲ *Sia Sandi, student midwife from The School of Midwifery in Masuba, Makeni on placement at Makeni Regional Hospital, Sierra Leone. Photo: Abbie Trayler-Smith/CC BY-NC-ND 2.0.*

Large population surveys, such as demographic health surveys (DHS) and multiple indicator cluster surveys (MICS), are important for direct assessments of population health.[1] They can be seen as benchmarks for assessing national trends; however, insecurity and displacement may hinder their use in conflict settings.[2,3] Since the first international conference on health survey methodology in difficult settings, there have been discussions on the appropriateness of surveys in conflict-affected populations.[2,3]

In this quarter's *Digest*, Boerma and colleagues[4] assess the extent to which large national surveys, such as DHS and MICS, can be used to document the impact of conflict on reproductive, maternal, newborn, and child health (RMNCH). The authors considered 170 surveys including 53 surveys in 13 conflict-affected sub-Saharan African countries. Coverage of RMNCH interventions was presented as a composite indicator across a continuum of care from family planning to child health. Additionally, estimates of stunting, wasting and under-five mortality were computed from census and survey-based data sources. Generally, conflict had a negative impact on service coverage, child growth and under-five mortality, with clear evidence of post-conflict improvement in most countries. This effect appeared to be masked in some countries with prolonged conflict, such as Liberia and Sierra Leone, due to methodologic challenges. Additionally, long-term effects, such as stunting, did not show the same level of post-conflict improvement compared to wasting.

Interestingly, there was a limited impact of intensity, duration, and size of conflict on RMNCH in this analysis. The authors explained the latter finding by the incompleteness of databases and the exclusion of key countries with no recent surveys, such as Somalia, South Sudan and the Center African Republic, due to prolonged or recent conflicts. Additional reasons may include the use of an arbitrary cut-off to define the continuity of conflict based on battle-related mortality, beyond other factors like the inaccuracy of reporting deaths and denominators in some conflicts. The authors also discussed the effect of insecurity and population displacement. For example, several clusters in northern Uganda and eastern parts of the Democratic Republic of Congo were excluded because of limited population access. Internally displaced persons were also missed as their new or temporary households were not listed. Such challenges limited the generalizability of the findings and comparison of national trends. The authors recommended the addition of survey questions on conflict-related mortality and displacement in large population surveys to improve the utility of surveys for direct estimation of conflict impact on population health.

Despite the advantage of large population surveys as a rich source of data, they may not always be feasible in difficult humanitarian settings. The use of alternative methods, such as small population-based surveys (e.g. Lot Quality Assurance Sampling, SMART surveys), triangulation of multiple sources of data, and/or the use of administrative and sentinel reporting should be considered, while taking account of their limitations. Conflict settings can differ greatly in context and should be viewed along a spectrum of access and availability of resources; a methodological approach in one setting may not necessarily work in the other. Several articles in this quarter's *Digest* feature these differing scenarios. For instance, Dureab and colleagues[5] investigate the diphtheria outbreak in Yemen and define the methodological challenges encountered in surveillance.

COMMENT II.

PHEICs and their unclear purpose

by Onisillos Sekkides, MSc, Deputy Editor, *The Lancet Infectious Diseases*

The second time it was decided that the current Ebola outbreak in DR Congo did not warrant the designation Public Health Emergency of International Concern (PHEIC), members of the International Health Regulations (IHR) emergency committee expressed moderate optimism that it would be brought under control in the "foreseeable future".[1] That time has come and gone and the committee has since met twice more; ultimately concluding that the situation does now indeed warrant the status of a PHEIC.[2]

Prior to this decision, following the third non-declaration of a PHEIC, *The Lancet* expressed concern at the seeming inaction.[3] In a subsequent letter to the journal,[4] Johan Giesecke on behalf of the WHO Strategic and Technical Advisory Group for Infectious Hazards (STAG-IH) attempted to educate readers about the reasoning behind PHEIC decisions. The way the issues were elaborated in the letter might have led some to conclude that a PHEIC is an unusable instrument or, at least, is ill defined.

In the letter[4] it was described how the PHEIC would impact the outbreak response: "*By declaring a PHEIC, the Director-General requires state parties to share critical information for risk assessment, adjust response plans if deemed necessary, and implement temporary recommendations formulated by the emergency committee*." The letter added further aspects of the deliberations: "*Members of the emergency committee cited potential disadvantages of a PHEIC declaration (effects on travel and trade that could impede support to affected regions and hinder outbreak control)....*"

The reasoning, at that stage, was that many of the PHEIC's functions had already largely been enacted; therefore, a declaration was unnecessary and, furthermore, that there are negative consequences to a declaration. But surely this characterisation means a PHEIC is likely to be seen as a censure, given any declaration of a PHEIC implies that a nation's response has been inadequate. The possibility of this interpretation is recognised in the emergency committee's most recent statement,[2] although they stress that this is not the intended message.

Fundamentally, Giesecke's letter overlooks that the non-declaration of a PHEIC is not a neutral act; it sends a message that the current outbreak is not an emergency that needs international attention—irrespective of any additional clarifications. This consequence is evidenced by the then muted international response, which was waning.[5] Political statements[6] just prior to the PHEIC declaration and subsequent mobilisations[7] add further evidence that this was the case.

The letter concludes by reiterating the potential risks of a PHEIC: "*The public health community must recognise the close link between disease and trade inherent in IHR (2005) and the risks and benefits of using this strong instrument of international law to raise awareness and resources....*" This does seem to reinforce that a PHEIC is an instrument of censure, given the argument that it is inadvisable to use a PHEIC to prompt funding would mean it functions solely as a signal of an inadequate response. In his speech announcing the declaration, the Director-General reiterated that the purpose of a PHEIC was not to prompt funding.[8] However, this was not always WHO's interpretation. In

▲ *"A trip to the front lines of the fight against Ebola." Community representatives come to visit a family in the outskirts of Beni to raise awareness about Ebola. Beni, North Kivu region, Democratic Republic of Congo, January 18, 2019. Photo: World Bank/Vincent Tremeau/CC BY-NC-ND 2.0. [https://flic.kr/p/RipZcT*

the WHO review of the previous major Ebola outbreak[9] it was recognised that it was more than a legal instrument: "*A declaration of a PHEIC is the only mechanism to trigger the considerable financial and human resources that are required to respond to a global emergency, whether in regard to personnel who need to be deployed, to access to diagnostics and drugs, or to the R&D needed for a vaccine*."

When the time comes to assess the impact of recent decisions, it will be essential to transparently account where funding flows from and to. This will at least lay one question about the value of PHEICs to rest. In terms of its other functions, given the rather fluid interpretations that have been circulating, it is becoming clear that a PHEIC is not an instrument of international law, but a political tool.

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HIGH-INCOME COUNTRIES

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LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

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VII. HEALTH SYSTEMS

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

VIII. MULTI-CATEGORY

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

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HIGH-INCOME COUNTRIES

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

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

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IV. NUTRITION AND FOOD SECURITY

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

V. WATER, SANITATION, AND HYGIENE (WASH)

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

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VII. HEALTH SYSTEMS

LOW- AND MIDDLE-INCOME COUNTRIES
N/A.

HIGH-INCOME COUNTRIES
Suda T, Murakami A, Nakamura Y, et al. Medical needs in Minamisanriku Town after the Great East Japan Earthquake. *Tohoku J Exp Med* 2019; **248:** 73–86. doi:10.1620/tjem.248.73.
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VIII. MULTI-CATEGORY

N/A.

Technological Disasters

I. COMMUNICABLE DISEASE

N/A.

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
Oe M, Maeda M, Ohira T, et al. Parental recognition of bullying and associated factors among children after the Fukushima nuclear disaster: a 3-year follow-up study from the Fukushima Health Management Survey. *Front Psychiatry* 2019; **10:** 283. doi:10.3389/fpsyt.2019.00283.
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VII. HEALTH SYSTEMS

N/A.

VIII. MULTI-CATEGORY

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

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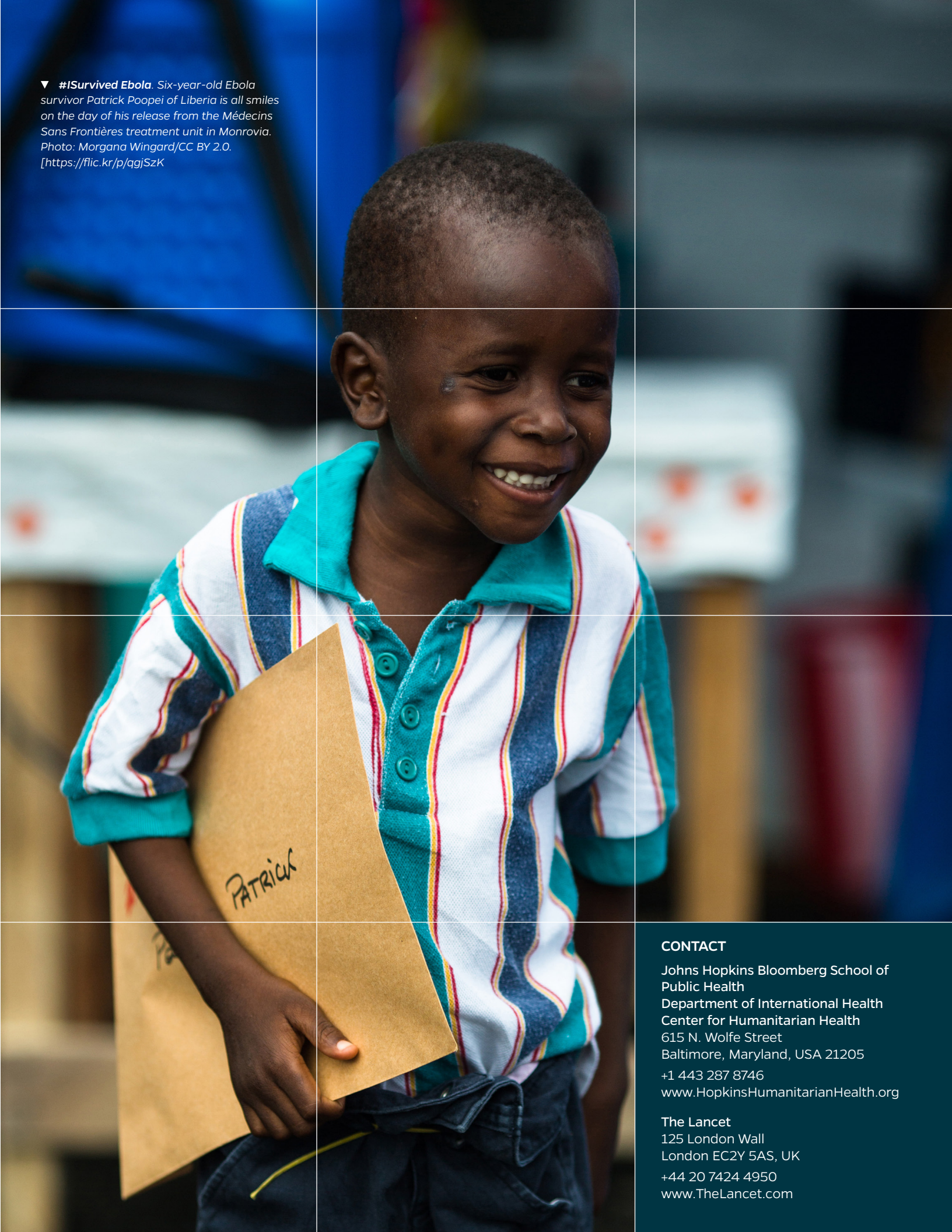

▼ ***#ISurvived Ebola***. *Six-year-old Ebola survivor Patrick Poopei of Liberia is all smiles on the day of his release from the Médecins Sans Frontières treatment unit in Monrovia. Photo: Morgana Wingard/CC BY 2.0. [https://flic.kr/p/qgjSzK*

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