HUMANITARIAN HEALTH DIGEST

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JOHNS HOPKINS
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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.

Health worker safety in the context of large-scale outbreak response

by Harsha Rajashekharaiah, MBBS, MPH, Research Associate, Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health

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▲ *Army trainers teach NHS medics how to put on Ebola safety suits. Photo: Simon Davis/ DFID (CC BY 2.0).*

Health workers caring for Ebola patients are 21 to 32 times more likely to contract Ebola as compared to general adult population.[1] As of Oct 13, 2019, 162 health workers have been infected during the Ebola outbreak in the Democratic Republic of the Congo (DRC).[2] Although these numbers are significantly lower than what was recorded during the West Africa outbreak,[1] the risk of infection among the health workers continues to pose serious threat to overall response capacity.

In this quarter's *Digest*, Drevin and colleagues[3] examine why the surgical staff in Sierra Leone continued to perform Caesarean section during the 2014–2016 Ebola outbreak. The authors interviewed 15 surgical staff in five public hospitals who performed Caesarean sections between May 2014 to May 2015. In the article, the authors describe the challenges to surgical care delivery in the context of Ebola and the associated moral dilemmas in clinical decision-making. Scarcity of health workforce compounded by attrition and loss of life, forced surgical staff to work long hour shifts without adequate rest. In addition, lack of rapid diagnostics and personal protective equipment, and poor adherence to infection prevention protocols, significantly increased the risk of infection. Disruption of routine health services such as antenatal check-ups led to patients presenting with complications requiring surgical intervention. This exposed the staff to higher risk of infection. The health workers expressed a strong sense of moral obligation to treat and a heightened dutifulness towards their community. This was the main reason why surgical staff continued to perform Caesarean sections under resource-limited conditions. Long hours of work and exhaustion made them vulnerable to mistakes and increased risk to contract infection.

Beyond the risk of acquiring the infection, responding to large-scale outbreaks exposes the health workers to a wide range of risks such as heat exhaustion, psycho-social stress, unpredictable and delayed remuneration, stigma, poor social protection, and others.[1] Targeted attacks on health facilities and health workers are becoming increasingly common. Destruction of Médecins Sans Frontières' (MSF) Ebola treatment center and the fatal attack on a World Health Organization's epidemiologist in DRC are some of the recent events demonstrating the grave nature of threats health workers face.

In line with this topic, McDiarmid and colleagues[4] provide an insight into MSF's duty of care policy. MSF operationalizes its commitment to health worker protection by implementing four related activities: pre-deployment health risk analysis and biosafety grading; implementing preventive measures (i.e. vaccinations and infection prevention and control practices); risk communication and briefing on safety procedures; and provision of medical and psychosocial support. The commentary advocates for organizational level commitment to protect its staff and provides a framework to establish health worker safety policies and procedures.

By including the article and the commentary discussed above, this quarter's *Digest* brings attention to health worker protection in the context of large-scale outbreak response, a very important and timely topic. The article sheds light on risk factors at an individual level and the commentary provides a framework to address the issue at the organizational level. It is my view that governing bodies at the global, regional, and national level should advocate for organizations to have mandatory health worker safety and protection policies. Pre-deployment threat analysis, risk monitoring and risk communication, emergency evacuation procedures, and care for health workers should be integral part of outbreak preparedness planning.

COMMENT II.

Prioritising mental health in conflict—hope at last

by Sophia Davis, PhD, Assistant Editor, *The Lancet*, and
Pam Das, MSc, PhD, Senior Executive Editor, *The Lancet*

The effects of new and continuing conflicts reach far beyond physical harm and destruction. The consequences of war and humanitarian emergencies for mental health are pernicious and long-lasting. In 2016, 12% of the world's population were living in an conflict zones,[1] including 142 million children in high-intensity conflict zones.[2] By the end of 2017, war, violence, and persecution had uprooted almost 69 million men, women, and children worldwide—the highest number since World War 2.[3] The impacts of conflict on mental health makes it harder for communities to rebuild, trauma is thought to pass down through generations,[4] and when children are affected their futures are thrown onto a different course.

A systematic review and meta-analysis in *The Lancet* by Fiona Charlson and colleagues[5] provides new estimates on the prevalence of mental disorders in conflict and post-conflict settings. Reviewing studies from 2000 to 2017 involving geographical areas that had been in a state of conflict within 10 years before data collection, the study shows the prevalence of mental disorders in conflict-affected populations is higher than previous estimates had suggested. They found that about one in five people in these settings has post-traumatic stress disorder, anxiety disorders, depression, bipolar disorder, or schizophrenia. By contrast, global estimates hover closer to one in 14 people.[5] Charlson and colleagues' estimates for years lived with disability per 1000 people for depression and post-traumatic stress disorder are more than five times higher than existing global mean burden of disease estimates.

The study updated the widely cited WHO estimates from 2005, and one of its key features is the inclusion of separate estimates for mild, moderate, and severe mental disorders. These finely grained estimates are valuable for clinical application and highlight a higher prevalence of the severe mental disorders (around 5%) than previous WHO estimates. Prevalence of depression in the study appears to increase, while anxiety and post-traumatic stress disorder affect children aged 0–10 years with prevalence estimates of almost 20% and 10%, respectively.[5]

Addressing children's mental health in conflict has been woefully neglected. In September 2019, Save the Children published *Road to Recovery: Responding to Children's Mental Health in Conflict*.[6] As their report highlights, the experiences of fear, anxiety, trauma, and separation from care-givers all contribute to feeling unsafe, which affects children's emotional and social development. Without adequate support from caregivers, strong, frequent, or prolonged stress affects developing brain architecture, cognitive development, and emotional regulation, which can have a life-long impact. The report advocates increased funding for mental health and psychosocial support (MHPSS), promotes intervention through education and arts-based psychological support programmes, and calls for states to take action to enforce and uphold international law and norms that protect children affected by conflict. A 2011 *Lancet* article on interventions for children's mental health emphasised that mental and physical health are indivisible and criticised governments' failure to support mental health services and their dependence on non-governmental organisations.[7]

On Oct 7–8, 2019, in Amsterdam, these calls were heeded at an international conference on addressing mental health and psychosocial support needs of people affected by conflicts and emergency situations. The meeting was hosted by the Dutch Minister for Foreign Trade and Development

Cooperation, Sigrid Kaag, rather than the Minister of Health: a step forward in moving mental health out of the silo in which it has been held. Among the representation from 24 countries and ten international aid organisations, a powerful presence at the conference were many participants who had been refugees and migrants.[8] The outcome was a strong declaration stating that "mental health and psychosocial support needs to be given adequate attention in all sectors of the humanitarian response with the aim of individual and collective recovery", adding that "Affected persons and communities should be enabled to participate in the development and delivery of services for their benefit."[9] The declaration recommends scaling up MHPSS during and after emergencies, and it emphasises MHPSS for survivors of sexual and gender-based violence and elaborates detailed aims for MHPSS for children, adolescents, and their families, including children's broader social environment. The Netherlands and WHO signed an agreement on providing a standard package of MHPSS services and tools that can be implemented by countries immediately.[8] Within a host of recommendations covering investment in MHPSS, research, workforce development, and long-term planning, the Amsterdam declaration also advocates facilitating community-based MHPSS involving local actors, protecting the wellbeing of staff and volunteers, and promoting broader societal conditions for mental wellbeing, such as security, justice, and stronger communities.

This high-level declaration is hugely welcome. National governments and international donors must now get behind this agenda with sufficient resources and accelerate the response to the mental health and psychosocial needs of people affected by conflicts and emergencies at all levels of support.

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I. COMMUNICABLE DISEASE

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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

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LOW- AND MIDDLE-INCOME COUNTRIES

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V. WATER, SANITATION, AND HYGIENE (WASH)

N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

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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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HIGH-INCOME COUNTRIES

N/A.

II. NON-COMMUNICABLE DISEASE

N/A.

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

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

IV. NUTRITION AND FOOD SECURITY

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

N/A.

VIII. MULTI-CATEGORY

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HIGH-INCOME COUNTRIES

N/A.

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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.

▼ *Eight-year-old Mohamad sits in his tent in Za'atari Refugee Camp, Jordan having escaped with his family from the violence in Syria. Photo: Naser MJD. [https://flic.kr/p/23dpAhm*

CONTACT

Johns Hopkins Bloomberg School of Public Health
Department of International Health
Center for Humanitarian Health
615 N. Wolfe Street
Baltimore, Maryland, USA 21205

+1 443 287 8746
www.HopkinsHumanitarianHealth.org

The Lancet
125 London Wall
London EC2Y 5AS, UK

+44 20 7424 4950
www.TheLancet.com