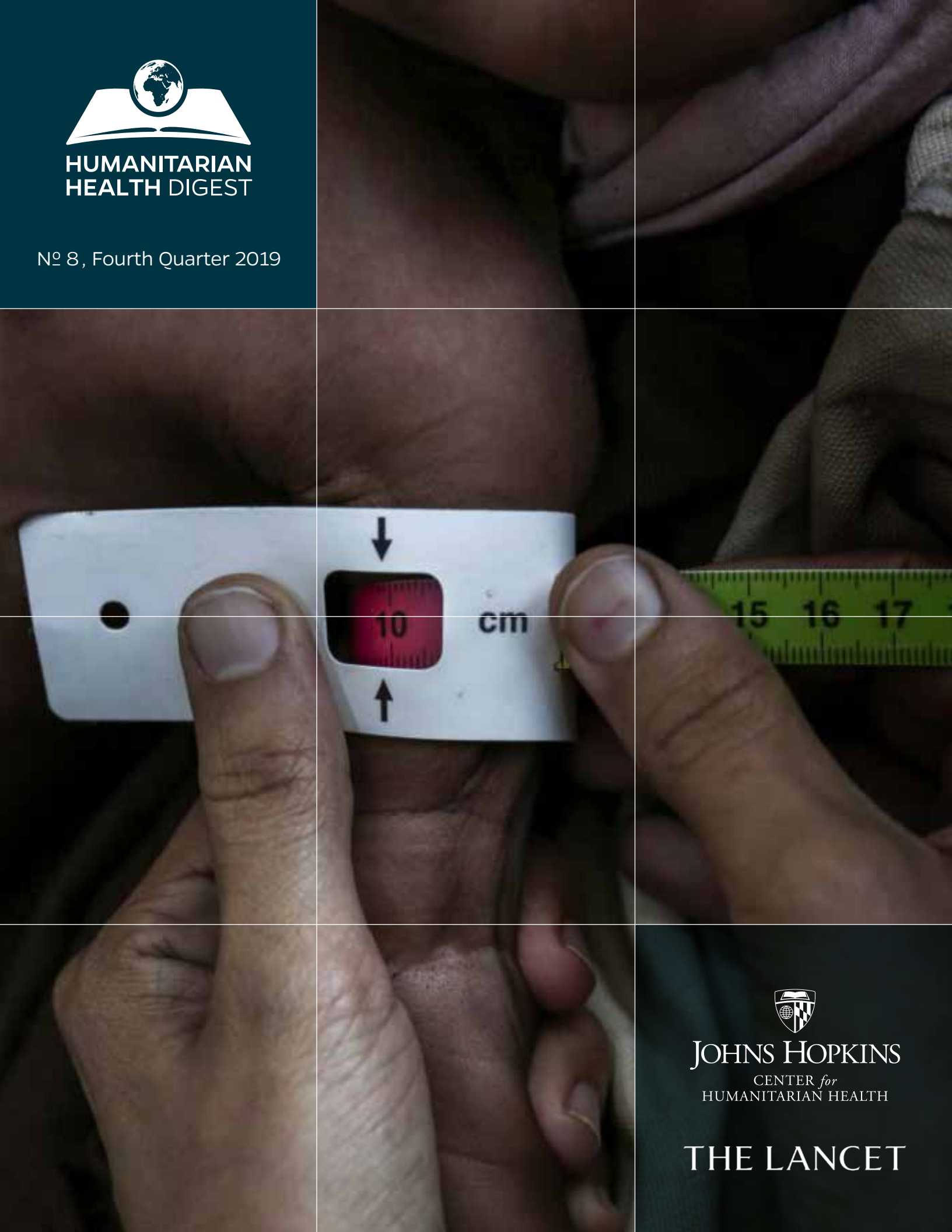
HUMANITARIAN HEALTH DIGEST

№ 8, Fourth Quarter 2019



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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.

Emergency contraception can be lifesaving in humanitarian settings

by Shatha Elnakib, MPH, PhD Student, Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health

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▲ *Emma Shinyaka, team leader, Marie Stopes Outreach, Makambako, Tanzania. Photo: Sheena Ariyapala/DFID (CC BY-NC-SA 2.0).*

The 1994 International Conference on Population and Development (ICPD) in Cairo enshrined access to sexual and reproductive health for women and girls, including those affected by humanitarian crises.[1] Following the ICPD, and building on its momentum, the Inter-Agency Working Group for Reproductive Health in Crises designed and articulated the Minimum Initial Service Package (MISP), which delineates a set of objectives and corresponding activities to be undertaken by first responders in emergencies. As noted by Heidari and colleagues, the MISP has become an important guide to humanitarian field staff and is now incorporated in existing standards and funding mechanisms for humanitarian response. The prevention of unintended pregnancy through contraception is a standalone objective in the MISP with activities that highlight the importance of ensuring the availability of a wide range of modern contraceptive methods. Yet while emergency contraception (EC) constitutes a critically important part of the contraceptive mix, its availability in emergency situations is oftentimes inconsistent, as illustrated in two recent studies cited in this quarter's *Digest*.[2,3]

Women and girls living in humanitarian settings are often at heightened risk of unintended pregnancy and unsafe abortion.[2] The confluence of poverty, breakdown of community cohesion, and interruption of services increases the incidence of transactional sex and sexual violence and disrupts the availability of contraception. As a result, women and girls are at increased risk of unintended pregnancy and its consequences which include maternal mortality and morbidity.[2] Indeed, around 60% of maternal deaths and 45% of neonatal deaths globally occur in humanitarian or fragile settings.[1] The provision of EC during all phases of a humanitarian emergency can thus be a lifesaving intervention.

However, around 46 countries do not have a dedicated emergency contraceptive product registered,[4] and despite being integrated into the MISP and included in Inter-Agency Reproductive Health Kits, EC is not always accessible to displaced populations. Mowafi and colleagues bring attention to the absence of a registered emergency contraceptive pill in Jordan which is striking given that the country is host to hundreds of thousands of displaced persons and EC is presumably part of humanitarian response. They find that among retail pharmacists, there is significant enthusiasm for a registered EC, but that lack of knowledge of EC is widespread.

While the situation is different in Uganda where EC is registered in the country, Nara and colleagues find that access and availability are still inconsistent for both urban and camp refugees. Study participants attributed the lack of EC to supply chain inconsistencies which cause frequent stockouts as well as theft by staff. The study also highlighted insufficient knowledge of EC among refugee women themselves. This, combined with stockouts in EC, has prompted many refugee women to use anti-malarials and analgesics, erroneously believing they could be effective at preventing pregnancy after sex.

Both studies shed light on the unavailability of EC in two settings with large refugee and displaced populations. The lack of familiarity with EC among women and providers and the frequency of stockouts or in the case of Jordan, the altogether absence of an emergency contraceptive product limit the contraceptive options available to refugee women. While contraception is included in several guidelines and international standards, more needs to be done to ensure that women and girls can exercise control over their fertility amid the difficult and unpredictable circumstances of displacement.

COMMENT II.

Health care in humanitarian crises in 2020

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

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▲ *David Miliband, President and CEO, International Rescue Committee. Photo: Chatham House (CC BY 2.0).*

Looking ahead to 2020, the International Rescue Committee (IRC) has ranked the countries at greatest risk of major deterioration in the humanitarian situation. There is little change since last year. The IRC will have had a presence implementing programmes in the top 20 Watchlist countries for an average of 15 years, highlighting the complexity and intransigence of the root causes of these humanitarian crises.[1] At the top of IRC's Watchlist 2020 is still Yemen, where civil war continues and 80% of the population are in need of humanitarian assistance, followed by the Democratic Republic of the Congo, Syria, Nigeria, and Venezuela, with the new additions of Burkina Faso, Burundi, and Chad in the top 20.[2] The ranking integrates current levels of humanitarian need, food insecurity, and displacement with scores for human risk (eg, because of conflict, corruption, or human rights violations), natural risk (eg, drought, flooding), vulnerability (eg, financial underdevelopment, susceptibility to pandemics), the lack of ongoing capability (eg, infrastructure, governance, health- care systems), and the potential for increased instability (eg, upcoming presidential elections).

Although the countries remain fairly constant, the number of people in need of humanitarian assistance is rising. Almost 168 million people worldwide are forecast to need humanitarian assistance this year, according to the 2020 overview by the UN Office for the Coordination of Humanitarian Affairs (OCHA),[3] reflecting an increase of some 22 million people compared with 2019. The consequences of these long-running humanitarian crises—massive displacement, women and girls at risk of sexual violence, increasing hunger, devastated health systems, psychosocial trauma, and loss of livelihoods access to education—offer little hope of abating.

One of the main drivers of humanitarian crises is highly violent conflicts that are becoming more protracted and intense, as well as extreme weather events associated with climate change. Infectious diseases are also becoming more prevalent and harder to control, because of conflict, weak health systems, poor water and sanitation, and poor access to vaccinations.[3] Restrictions on humanitarian access are also a major concern, and the IRC included humanitarian access within its scoring methodology for the first time, drawing on the ACAPS report to ascribe "extreme" or "very high" access constraints in most of the top 20 Watchlist countries.[4]

Another deeply disturbing trend is declining compliance with international humanitarian law. As OCHA observes, explosive weapons are being used in populated areas, where more than 90% of the casualties are civilians, and several parties to conflict have deliberately used starvation as a method of warfare.[3] Armed conflicts are killing and displacing record numbers of children, forcing them to flee their homes, putting their lives on hold, and exposing them to increased risks of malnutrition and disease and vulnerability to forced marriage, forced labour, trafficking, and recruitment into armed groups.[3] Despite the UN Secretary General's resolution in May, 2016,[5] that people must be able to safely seek medical care, especially in areas of conflict, aid workers are facing growing risks and health workers and health facilities continue to come under attack, escalating crises by denying people access to care and aid. Hospitals, clinics, and ambulances are hit with grenades, explosives, and heavy weapons, health workers are threatened, injured, and killed, and aid workers face growing risks of being assaulted, shot, and kidnapped.[3] WHO recorded 978 attacks on health-care facilities in 11 countries in 2019,

with 193 deaths, and many more go unreported.[6]

Greater action is needed from the international community both in response to these violations of international humanitarian law and to the entrenched conflicts. David Miliband, president and CEO of the IRC, called for the UN Security Council members to lead action to "take long-term approaches, re-engage their diplomatic muscle to prevent and resolve conflict and reinvigorate their support of international humanitarian law and accountability for those who violate it".[1] Looking ahead to the health challenges of the next decade, WHO echoed this message, urging for "political solutions to resolve protracted conflicts, stop neglecting the weakest health systems, and protect health-care workers and facilities from attacks".[6]

But can humanitarian organisations wield enough power to bring about these changes? According to OCHA, investment of nearly US$29 billion is required to meet the challenges of 2020,[3] but, as reported in *The Lancet*, the gap between requested humanitarian funding and the amount received has been widening in recent years.[7] Discussing splits in the support of humanitarian work inside the countries that traditionally donated, Médecins Sans Frontières president Christos Christou described humanitarian organisations facing the challenges of donor countries no longer supporting humanitarian organisations "in this era of the 'fallen angels'".[8] Christou referred to the prioritisation of national security in response to the refugee crisis in Europe, adding that "human lives seem to be less valued today".[8] In a turbulent world facing the escalation of humanitarian crises by climate change and conflicts, the inward focus and isolationist rhetoric of nationalism creates an uncertain future for humanitarianism.

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V. WATER, SANITATION, AND HYGIENE (WASH)

LOW- AND MIDDLE-INCOME COUNTRIES

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VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

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VII. HEALTH SYSTEMS

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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

N/A.

II. NON-COMMUNICABLE DISEASE

N/A.

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

LOW- AND MIDDLE-INCOME COUNTRIES

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IV. NUTRITION AND FOOD SECURITY

N/A.

V. WATER, SANITATION, AND HYGIENE (WASH)

N/A.

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VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

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VII. HEALTH SYSTEMS

N/A.

VIII. MULTI-CATEGORY

LOW- AND MIDDLE-INCOME COUNTRIES

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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

N/A.

VIII. MULTI-CATEGORY

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

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▼ **Starvation in Yemen** *Staff measure the middle upper arm of Salima Ahmed Koryat, a six-month-old Yemeni girl in Mocha, Yemen, February 2018. Photo: Nariman El-Mofty/AP. [https://flic.kr/p/JFnRXm*

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