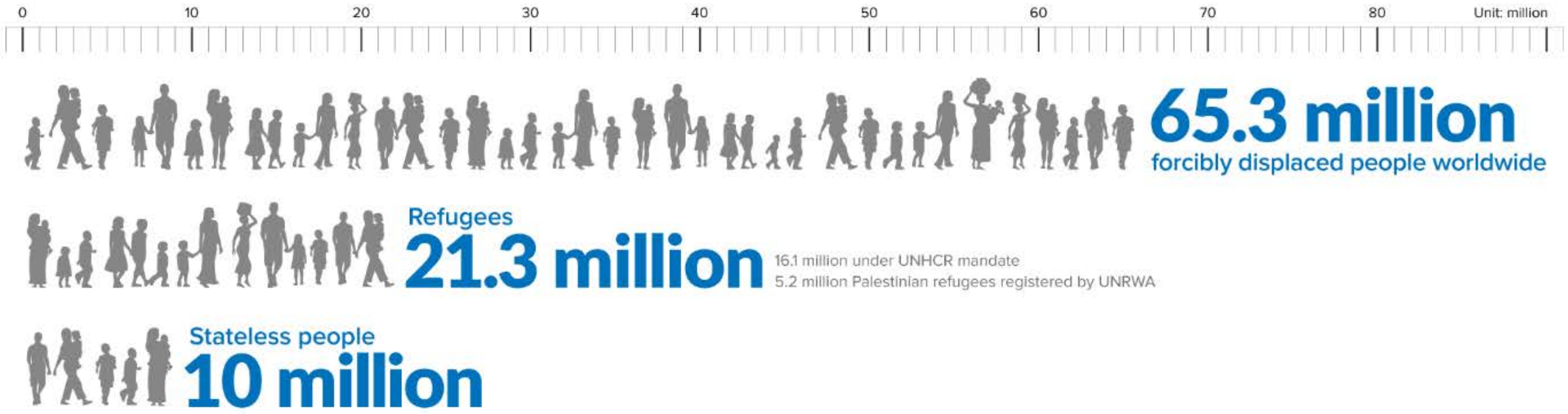
Women, Children and Adolescent Sexual Reproductive Health (SRH) in Humanitarian Settings: Evidence and Gaps

Paul B. Spiegel MD, MPH

Professor, Health Systems, Department of International Health,
Johns Hopkins Bloomberg School of Public Health

Director, Johns Hopkins Center for Humanitarian Health, Johns Hopkins University

Global Trends 2015 Statistical Yearbooks



UNHCR
The UN Refugee Agency

Johns Hopkins
Center for
Humanitarian Health

The Humanitarian 'Norm' was… (and still is)

- Low income countries in Sub-Saharan Africa and Asia
- Persons in refugee camps
- Weak Govts and few national non-governmental organisations (NGOs)
- Communicable diseases

South Sudanese refugees in Kenya

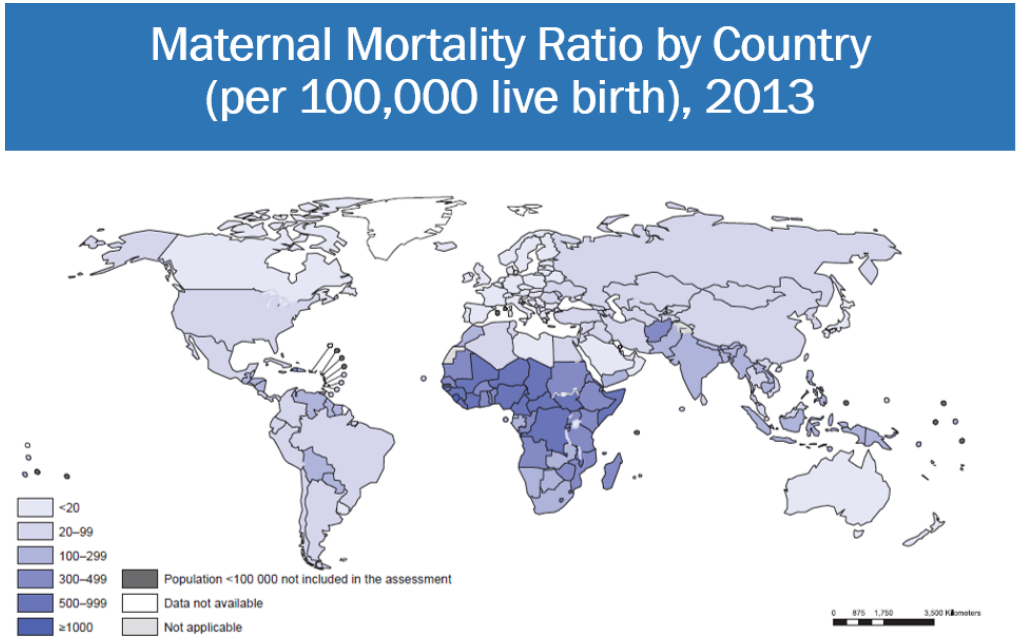
Za'atri refugee camp, Jordan

Key Questions for SRH in Humanitarian Settings

- How do we interpret and apply evidence in multitude of different and evolving contexts?
- How valid is it to use existing evidence, mostly gathered in development settings, and apply it to humanitarian settings?
- Do we accept ‘poorer’ methodological standards for studies in humanitarian settings?
- How precise do our estimates need to be for action compared to advocacy compared to publishing in peer–reviewed journals?

Epidemiology of SRH in Humanitarian Settings

- In 'fragile settings' which includes conflict and natural disasters[1-4]
  - **'<u>60%</u>'** of preventable maternal deaths
  - 53% of deaths in children <5yrs
  - 45% of neonatal deaths
- *Conditions are generally worse in humanitarian <u>emergencies</u> than non-emergency settings; can one always assume worse outcomes?*



World Health Organization Map Production: Health Statistics and Information Systems (HSI)
World Health Organization
http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/l

Michelle Hynes, CDC, 2015

1. Organisation for Economic Co-operation and Development. States of fragility 2015: meeting post-2015 ambitions. Paris: OECD, 2015.
2. WHO, UNICEF, UNFPA, World Bank, United Nations Population Division. Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, World Bank and United Nations Population Division. Geneva: World Health Organization, 2014.
3. UNICEF, WHO, World Bank, UN, UN Inter-agency Group for Child Mortality Estimation. Levels and trends in child mortality report 2014: estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund, 2014.
4. Helena Nordenstedt, Hans Rosling. Chasing 60% of maternal deaths in the post-fact era. Lancet. Vol 388 October 15, 2016

Neonatal Health in Humanitarian Settings

In low and middle income countries (non-humanitarian settings):

- >33% of all deaths in 1st mos of life (neonatal) occur In first 24 hrs, and 75% in first wk after birth
- Major causes of newborn death globally are:
  - Preterm complications (35%)
  - Intrapartum-related events (28%)
  - Severe infections (24%)
- Neonatal death contributes to 44% of under-five mortality globally

- *Conditions are generally worse in humanitarian <u>emergencies</u> than non-emergency settings; can one always assume worse outcomes?*

The countries with highest neonatal mortality <u>rates</u>

1	Somalia (52)
2	Mali (48)
3	DR Congo (46)
4	Sierra Leone (46)
5	Afghanistan (45)
6	Central African Republic (43)
7	Burundi (42)
8	Angola (41)
9	Pakistan (41)
10	Chad (41)

90% of the 20 highest NMR countries are in Africa

Many have recent & ongoing conflict

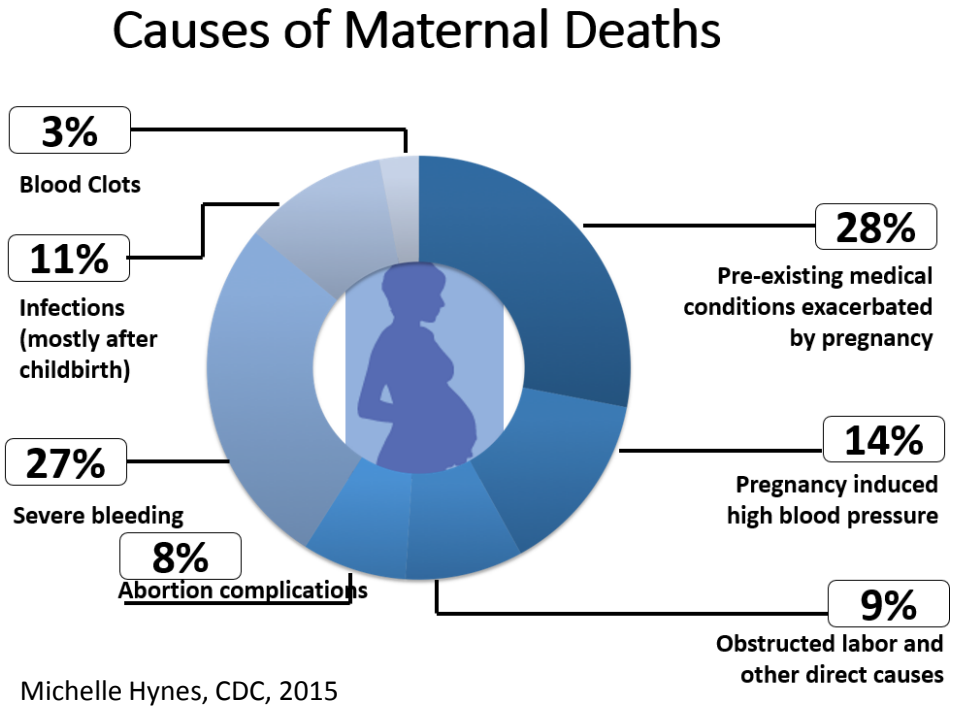
Prof Zulfiqar A Bhutta, 2012

Epidemiology of SRH in Protracted Refugee Camp Settings

- *SRH outcomes generally lower among refugees than host pop. in protracted refugee camp settings, and improvements observed over time*

  - Data on 7 SRH indicators from HCR HIS database (2007-2013) in 10 countries showed mean camp maternal and neonatal mortality rates lower than the host country estimates for all countries and yrs
    - *Whitmill et al. Retrospective analysis of repro health indicators in UNHCR post-emergency camps 2007–2013. Conflict and Health (2016) 10:3*

  - Maternal death review (2008–2010) in 25 refugee camps in 10 countries showed maternal mortality ratios lower among refugees than host pop in all countries except Bangladesh (N=108)
    - *Hynes et al, A study of refugee maternal mortality in 10 countries 2008-2020. Int Perspectives on Sexual & Reproductive Health; 38 (4) 205-13, Dec 2012*



Evidence: Review of SRH Interventions in Humanitarian Crises

- Of 7,149 citations reviewed (1980-2014), only 15 met inclusion critieria[1]
  - Only one randomised controlled trial was identified; remaining observational studies were of moderate quality

- Evidence of effectiveness was available for:
  - Impregnated bed nets for pregnant women
  - Subsidised refugee healthcare
  - Female community health workers
  - Tiered community SRH services

[1] Observational study designs that measured change in health outcomes before, during and/or after intervention as well as experimental and quasi-experimental study designs that compared against another intervention or control group. Bayard Roberts et al., LSTMH

[2] Warren E, Post N, Hossain M, et al. Systematic review of the evidence on the effectiveness of sexual and reproductive health interventions in humanitarian crises. BMJ Open 2015;5: e008226. doi:10.1136/bmjopen-2015-008226

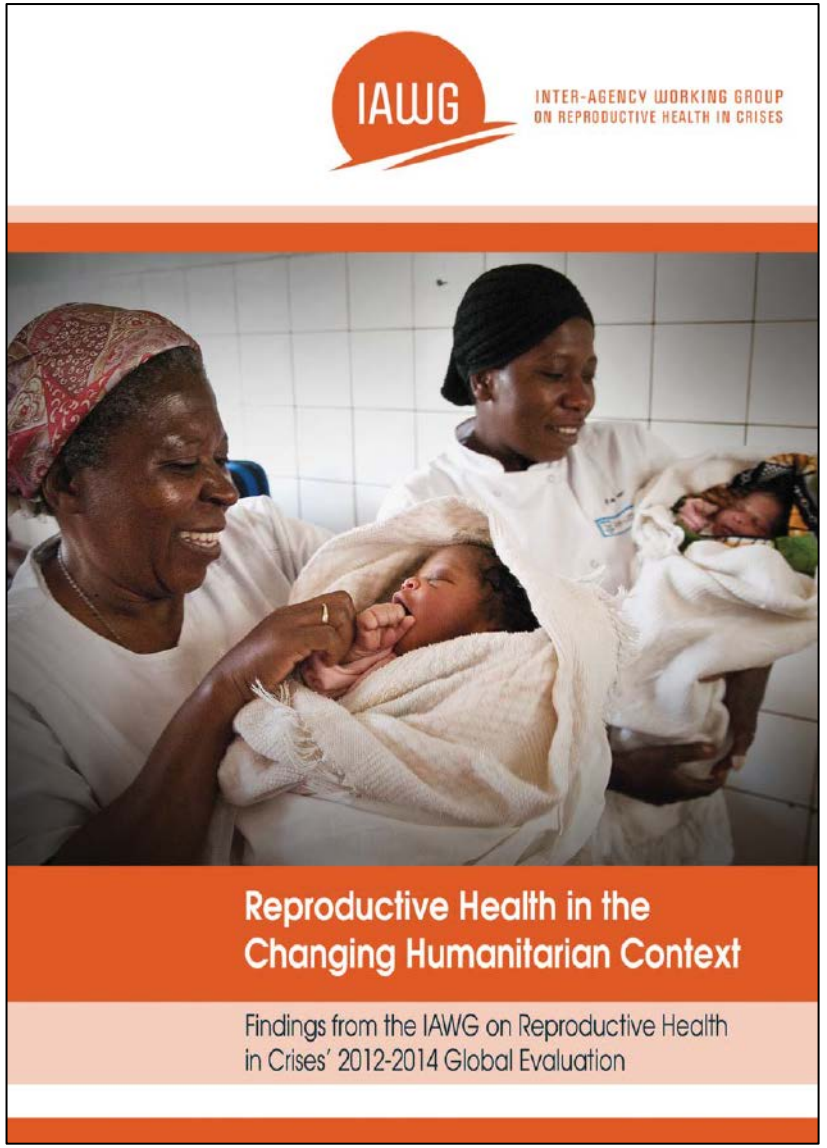
Findings from IAWG on RH in Crises' 2012-14 Global Evaluation

Since the 2004 IAWG Global Evaluation…*

Progress includes:

- Increased number of emergency health and protection proposals to implement reproductive health
- Increased funding for reproductive health to conflict-affected countries
- Reported growth in institutional capacity to address reproductive health in crises, including organizational policy frameworks and accountability mechanisms
- By technical area:
  - Increased awareness of, funding for, and implementation of the MISP
  - Increased funding for and provision of maternal health services broadly
  - Increased provision of post-abortion care
  - Increased funding for and attention to gender-based violence broadly, including documentation of prevalence of sexual violence in conflict settings

Chynoweth *Conflict and Health* 2015, **9**(Suppl. 1):I1 http://www.conflictandhealth.com/content/9/S1/I1



Inter-Agency Working Group on Reproductive Health in Crises
www.iawg.net

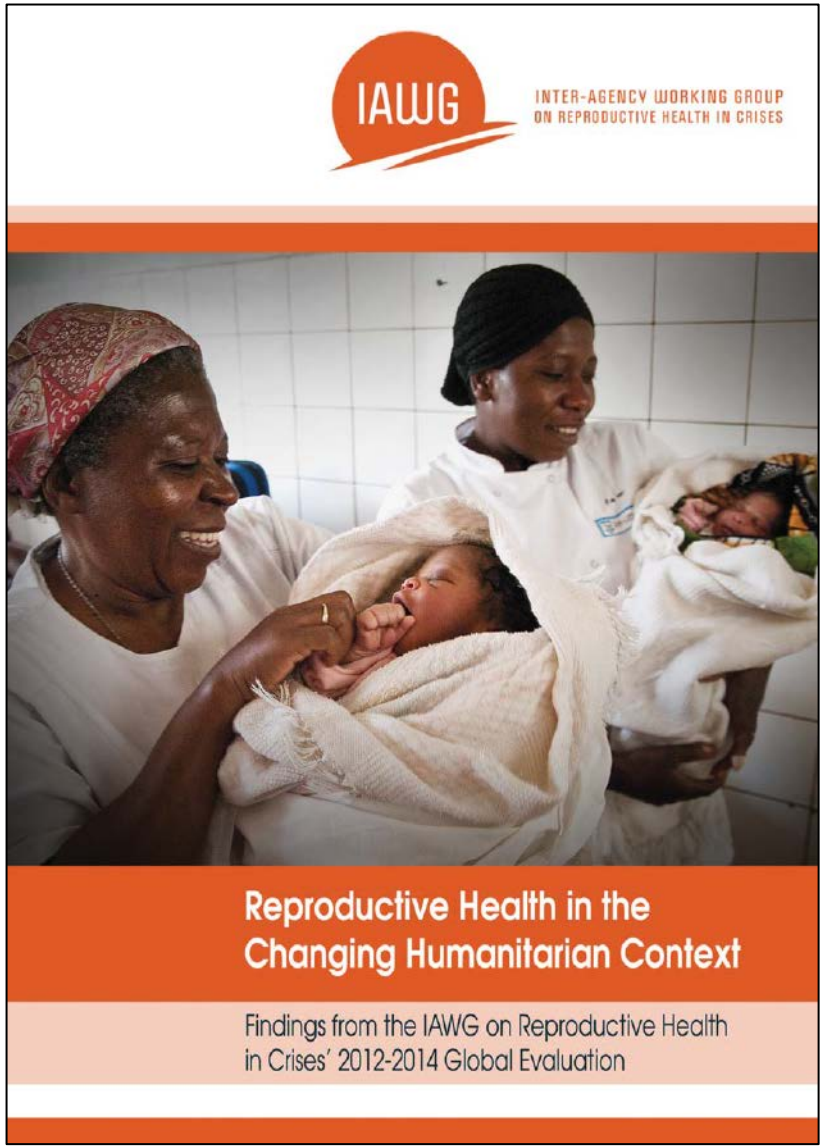
Findings from IAWG on RH in Crises' 2012-14 Global Evaluation

Key gaps include:

- Equitable and adequate reproductive health funding for crisis-affected settings
- Commodity management and security
- Community engagement to increase utilization of services
- Adolescent reproductive health
- High quality evaluation of reproductive health programming
- By technical area (gaps in funding, provision, and access across all areas):
  - Full, systematic MISP implementation
  - Emergency obstetric care
  - Newborn care
  - Comprehensive abortion care, including safe abortion and post-abortion care at the primary care level
  - Long-acting and permanent family planning methods
  - Emergency contraception as a family planning method
  - Prevention of sexual violence and comprehensive clinical management of rape
  - Antiretroviral therapy at the primary care level
  - Diagnosis and treatment of sexually transmitted infections
  - Diagnosis and treatment of cervical cancer

**Based on findings from the selected studies of the 2012-2014 IAWG Global Review*

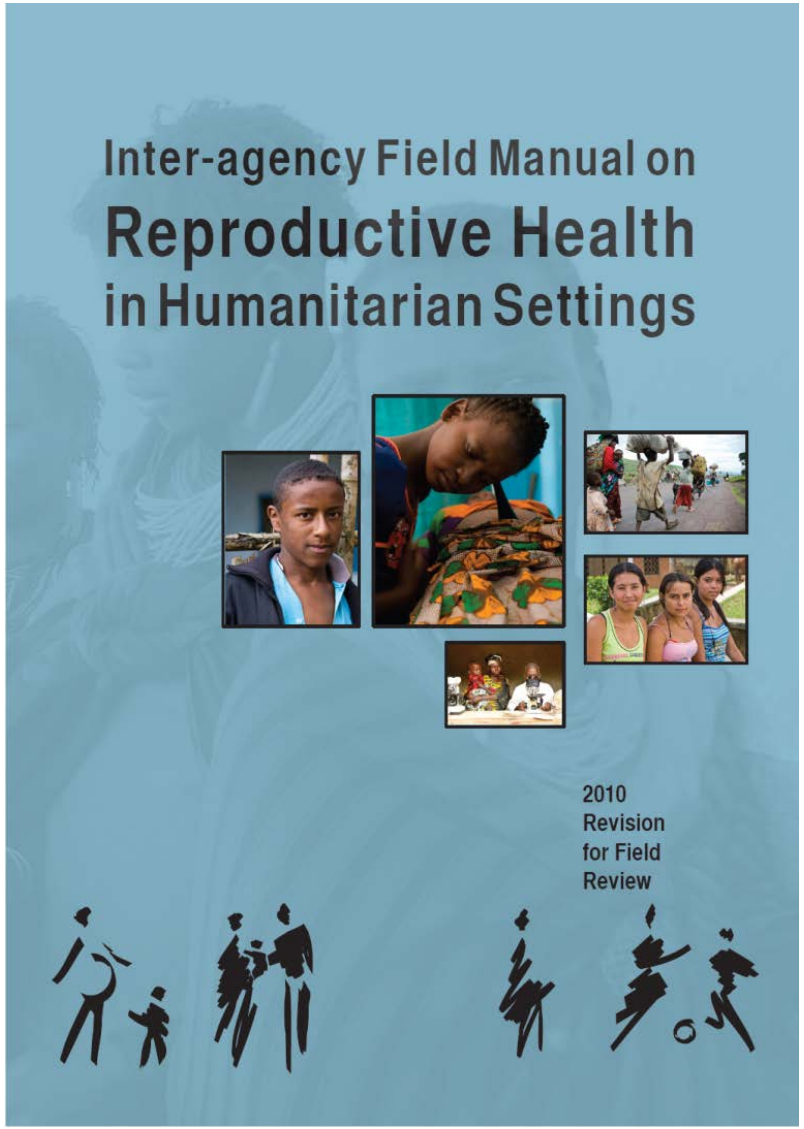
Chynoweth. *Conflict and Health* 2015, **9**(Suppl. 1):I1 http://www.conflictandhealth.com/content/9/S1/I1



Inter-Agency Working Group on Reproductive Health in Crises, www.iawg.net

Other Key Areas in SRH in Humanitarian Settings

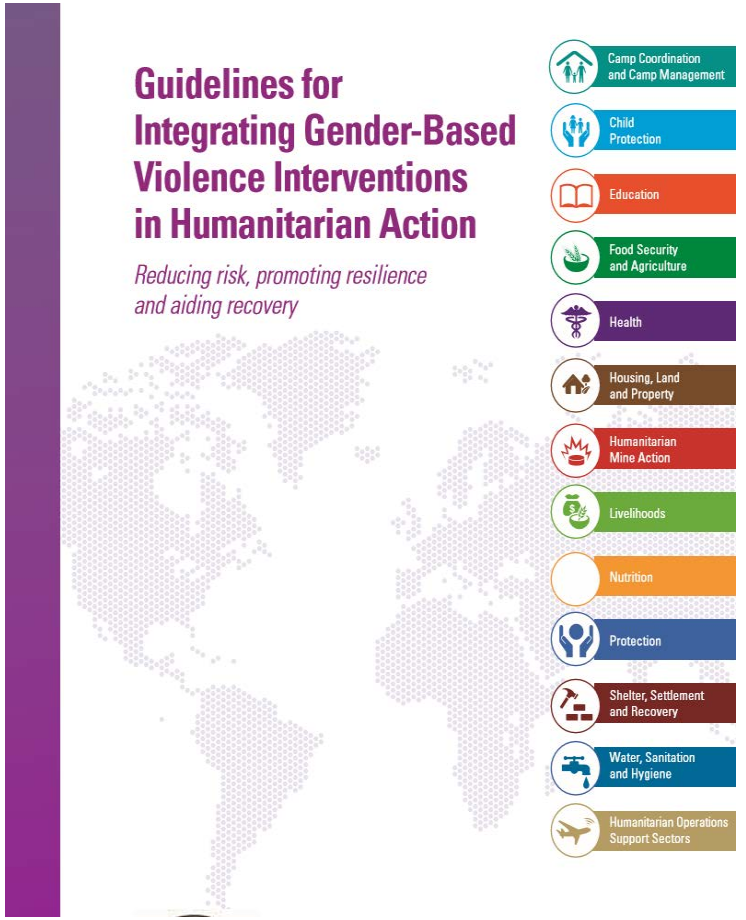
- Adolescent health
- Family planning
- Post-abortion care
- HIV and other sexually transmitted infections



http://www.who.int/reproductivehealth/publications/emergencies/field_manual/en/

Sexual and Gender-Based Violence (SGBV)

- Broad field including prevention, protection and care
- Difficult to get prevalence and much poor data; mostly used for advocacy
- Increased funding, policies and programming since 2004, yet program evaluation, prevention efforts, and systematic, comprehensive clinical management remains limited
- 2013 review found extremely limited research (LSTMH, 2013)



http://gbvguidelines.org/

Summary of SRH in Humanitarian Settings

- SRH awareness, funding and programme provision has increased over past decade
- SRH epidemiology needs further elaboration and precision
- Interventions need to be more evidence-based
- Monitoring and evaluation of programmes need to go beyond qualitative and process indicators