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

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65.3 million forcibly displaced people worldwide

Refugees 21.3 million
16.1 million under UNHCR mandate
5.2 million Palestinian refugees registered by UNRWA

Stateless people 10 million
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
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\(^1-^4\)
  - ‘60%’ of preventable maternal deaths
  - 53% of deaths in children <5yrs
  - 45% of neonatal deaths

- Conditions are generally worse in humanitarian emergencies than non-emergency settings; can one always assume worse outcomes?

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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 emergencies than non-emergency settings; can one always assume worse outcomes?

The countries with highest neonatal mortality rates

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

  - 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)


**Causes of Maternal Deaths**

- **Blood Clots**: 3%
- **Infections (mostly after childbirth)**: 11%
- **Severe bleeding**: 27%
- **Abortion complications**: 8%
- **Pre-existing medical conditions exacerbated by pregnancy**: 28%
- **Pregnancy induced high blood pressure**: 14%
- **Obstructed labor and other direct causes**: 9%

Michelle Hynes, CDC, 2015
Evidence: Review of SRH **Interventions** in Humanitarian Crises

• Of 7,149 citations reviewed (1980-2014), only 15 met inclusion criteria\(^1\)
  • 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

**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):11 http://www.conflictandhealth.com/content/9/S1/I1
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

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