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

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

10 million Stateless people
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 gleamed 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?
Epidemiology of SRH in Humanitarian Settings

• In ‘fragile settings’ that includes conflict and natural disasters\textsuperscript{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 increase in these statistics?

Neonatal Health in Humanitarian Settings

In low and middle income countries:

• >1/3 of all deaths in the first month of life (neonatal or newborn period) occur within first 24 hours and 75% in first week 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 increase in these statistics?
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
  - Increase in: % of births attended by a skilled birth attendant (p < 0.0001); % of women screened for syphilis across years (p < 0.0001); and % who received post HIV exposure prophylaxis (p < 0.0001)

- 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

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

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

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

• Only one randomised controlled trial was identified; remaining observational studies were of moderate quality, demonstrating limited use of controls and inadequate attempts to address bias

• 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


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Neonatal Health in Humanitarian Settings

Cont

technical consultation, Wash DC, June 2012:

• Evidence-based neonatal interventions
  Panel recommended that basic resuscitation be provided universally in all humanitarian settings (William Keenan)
  • Prevention and management of newborn infections: the ‘six cleans’ (Steve Walls)
  • Care for pre-term and low birth weight babies (Joseph de Graft-Johnson)
  • Kangaroo mother care (KMC)

How valid is it to use existing evidence gathered outside of humanitarian settings and apply it to these settings?
Minimum Initial Service Package (MISP) for Reproductive Health in Humanitarian Emergencies

**MISP**

- **Minimum**: Ensure basic, limited reproductive health services
- **Initial**: For use in emergencies, without site-specific needs assessment
- **Service**: Health care for the population
- **Package**: Activities and supplies, coordination and planning
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/9/51/11
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

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 lots of poor data; mostly used for advocacy
  - Globally (not humanit-related), 1 in 3 women will experience physical and/or sexual violence by intimate partner or non-partner
- Increased funding, policies, and programming since 2004, yet program evaluation, prevention efforts, and systematic, comprehensive clinical management remains limited (Chynoweth Conflict and Health 2015)
- 2013 review found extremely limited research (LSTMH, 2013)

http://gbvguidelines.org/
Summary of SRH in Humanitarian Settings

• SRH awareness, funding and programme provision 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