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

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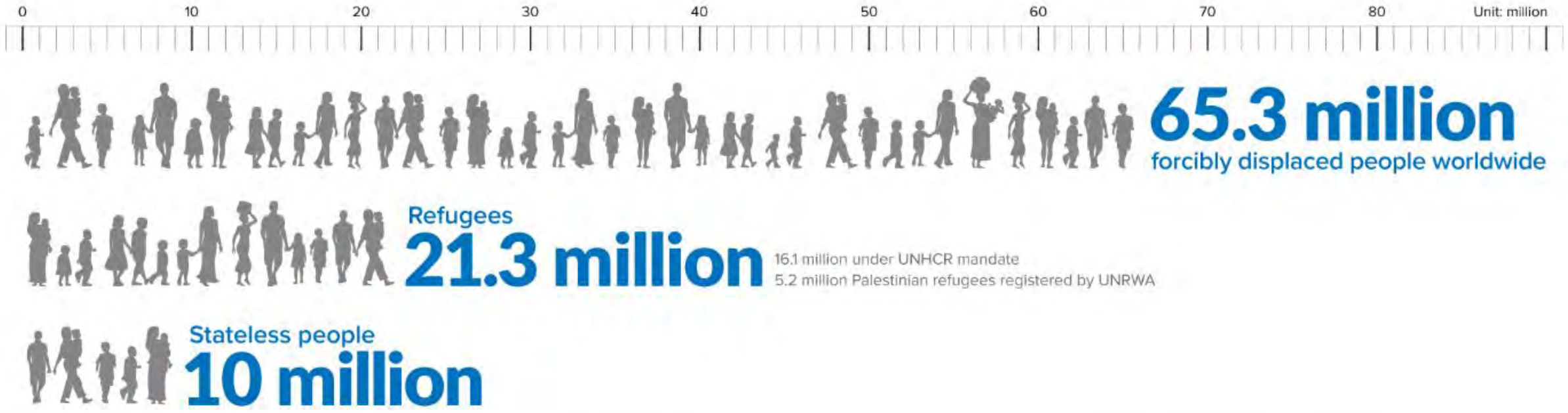
Global Trends 2015 Statistical Yearbooks



UNHCR
The UN Refugee Agency

Johns Hopkins
Center for
Humanitarian Health

The Humanitarian 'Norm' <u>was</u>… (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

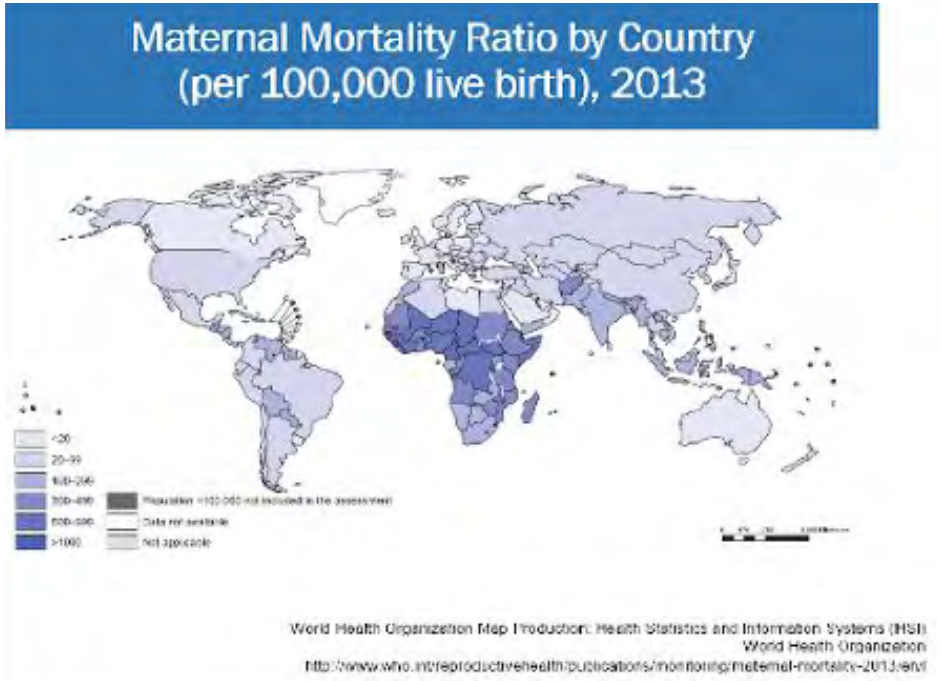
Key Questions for SRH in Humanitarian Settings

- How do we interpret and apply evidence in multitude of different and evolving contexts?
- How valid is it to use existing evidence, mostly 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[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?*



Michelle Hynes, CDC, 2015

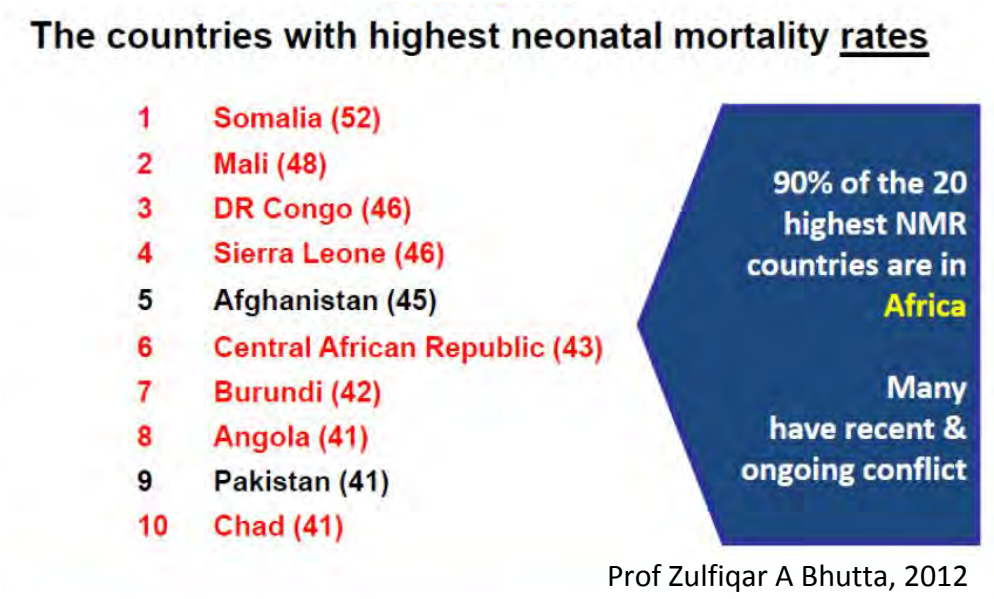
1. Organisation for Economic Co-operation and Development. States of fragility 2015: meeting post-2015 ambitions. Paris: Organisation for Economic Co-operation and Development, 2015.
2. WHO, UNICEF, UNFPA, World Bank, United Nations Population Division. Trends in maternal mortality: 1990 to 2013. Estimates 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:

- >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 <u>emergencies</u> than non-emergency settings; can one always assume increase in these statistics?*



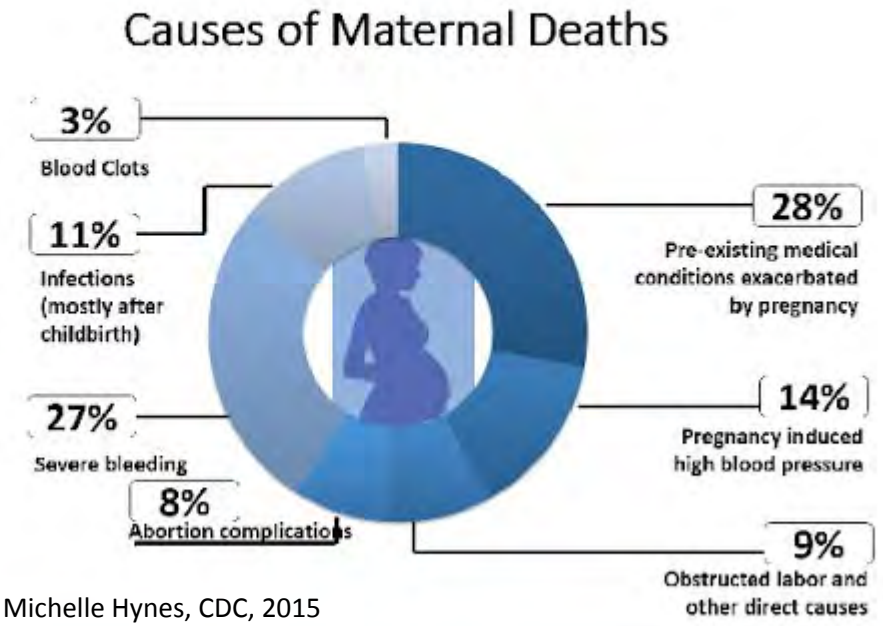
Prof Zulfiqar A Bhutta, 2012

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
  - 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 ($p < 0.0001$)
    - *Whitmill et al. Retrospective analysis of repro health indicators in the United Nations High Commissioner for Refugees 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*



Michelle Hynes, CDC, 2015

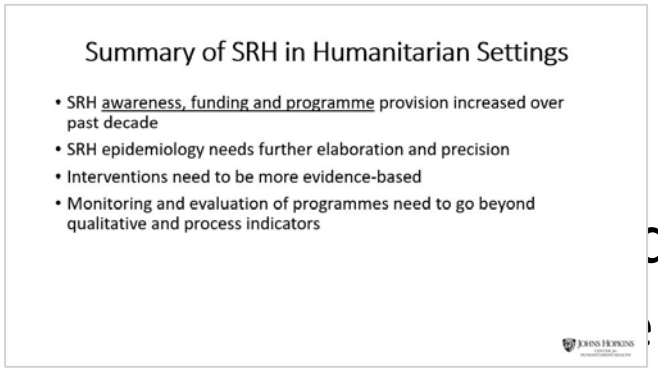
Evidence: Review of SRH Interventions in Humanitarian Crises

- Of 7,149 citations reviewed (1980-2014), 15 met inclusion critieria[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

[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

Neonatal Health in Humanitarian Settings Cont

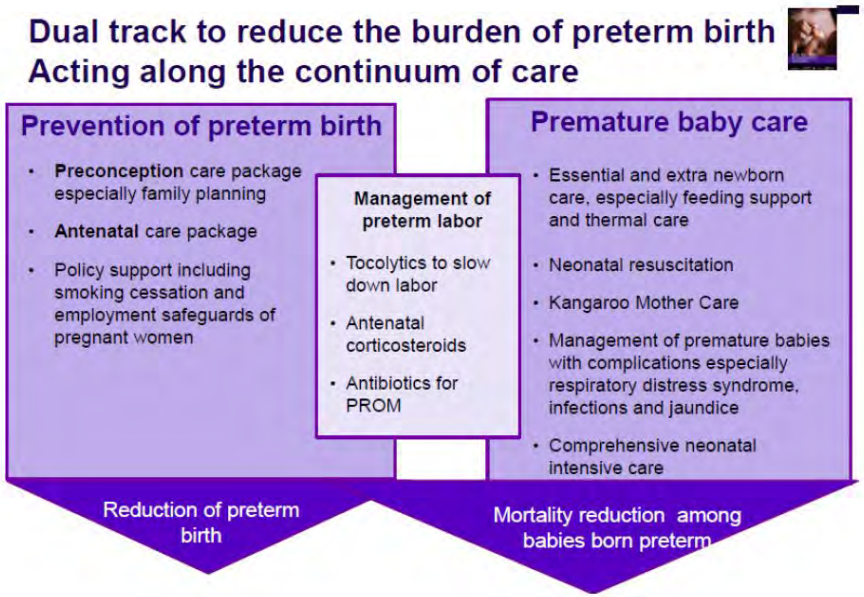


technical consultation, Wash DC, June 2012:

d neonatal interventions

nded that basic resuscitation be provided universally in all humanit 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)

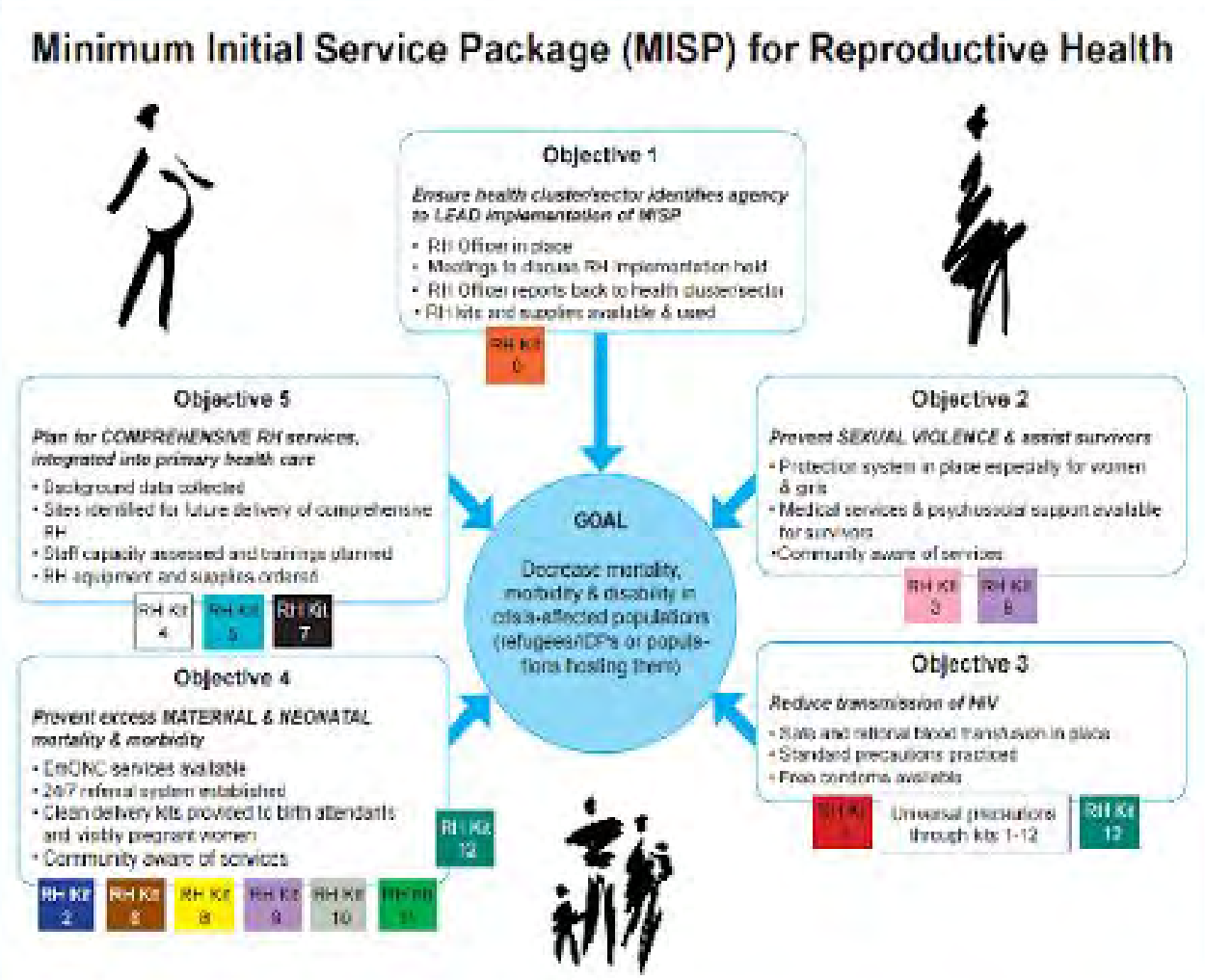


How valid is it to use existing evidence gathered outside of humanitarian settings and apply it to these settings?

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 assessmen
- Service: Health care for the populatior
- Package: Activities and supplies, coordination and planning



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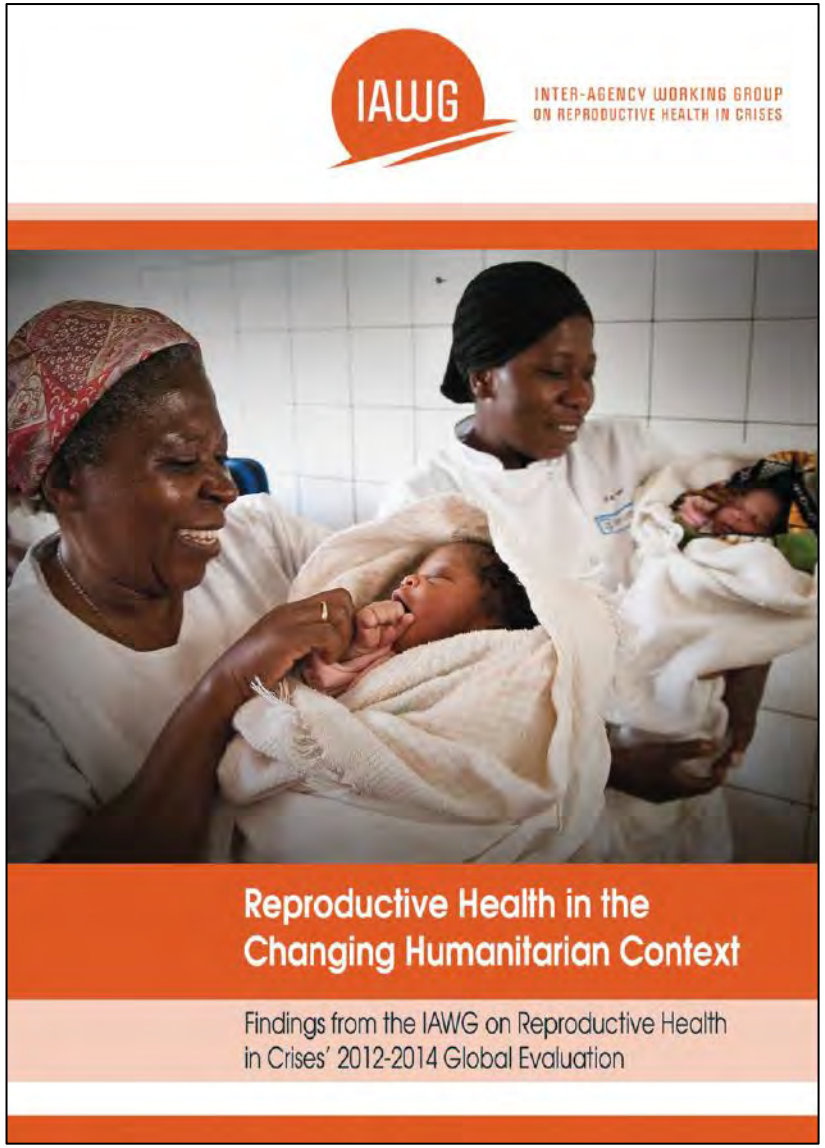
Findings from IAWG on RH in Crises' 2012-14 Global Evaluation

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

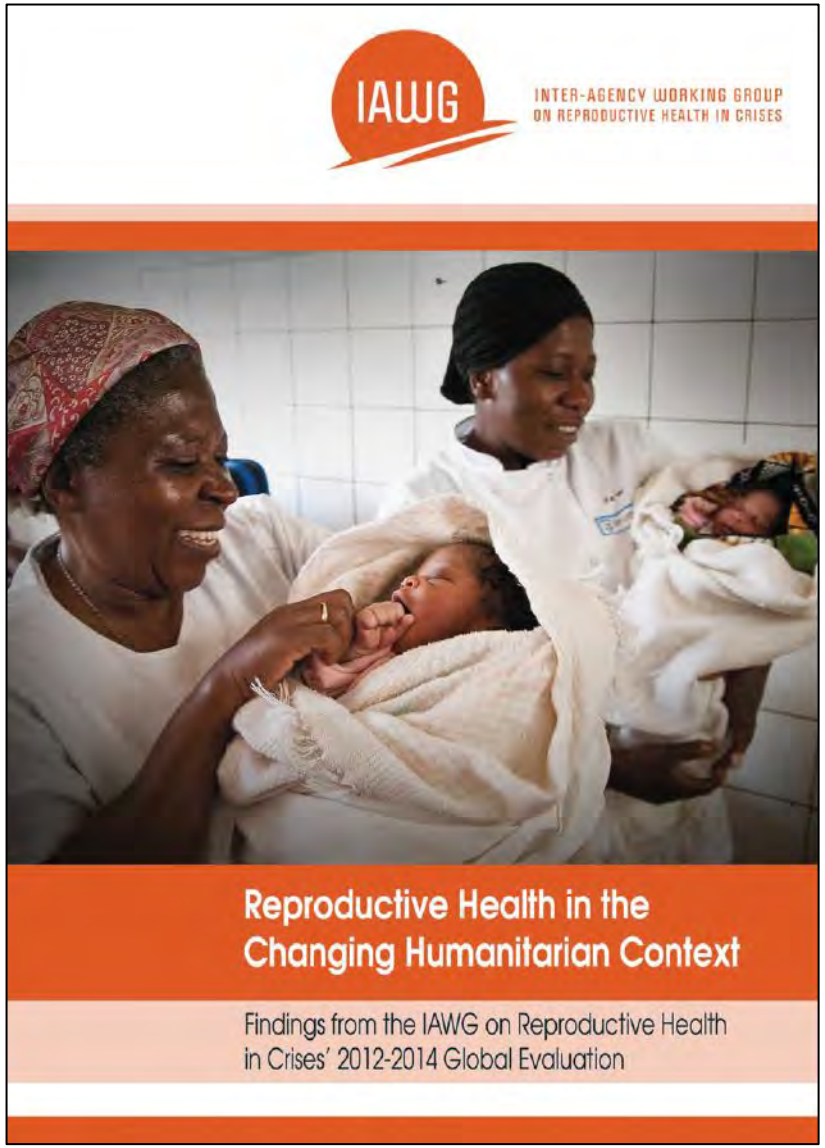
Findings from IAWG on RH in Crises' 2012-14 Global Evaluation

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*

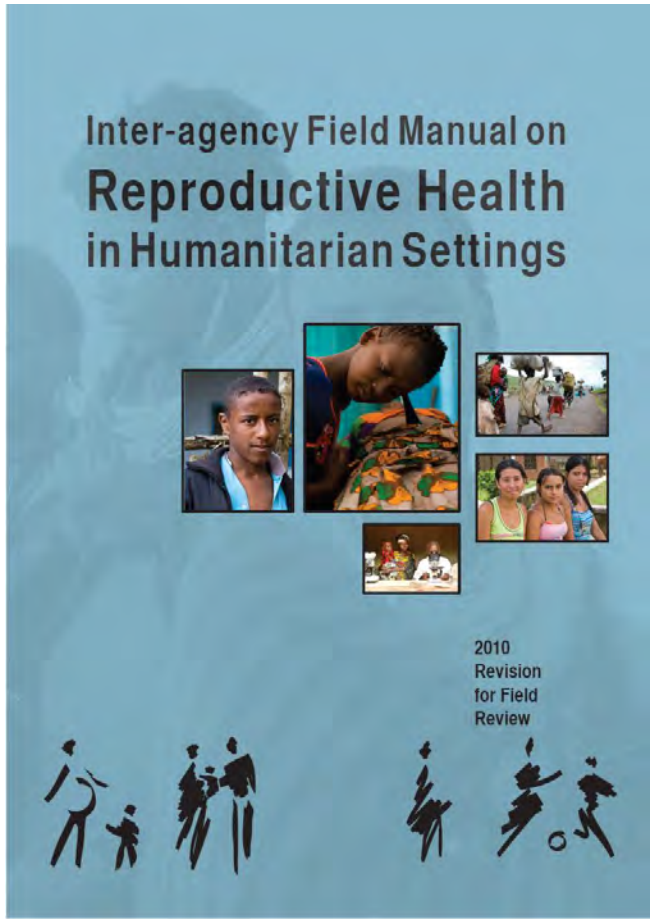
Chynoweth. *Conflict and Health* 2015, **9**(Suppl. 1):I1 http://www.conflictandhealth.com/content/9/S1/I1



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

Other Key Areas in SRH in Humanitarian Settings

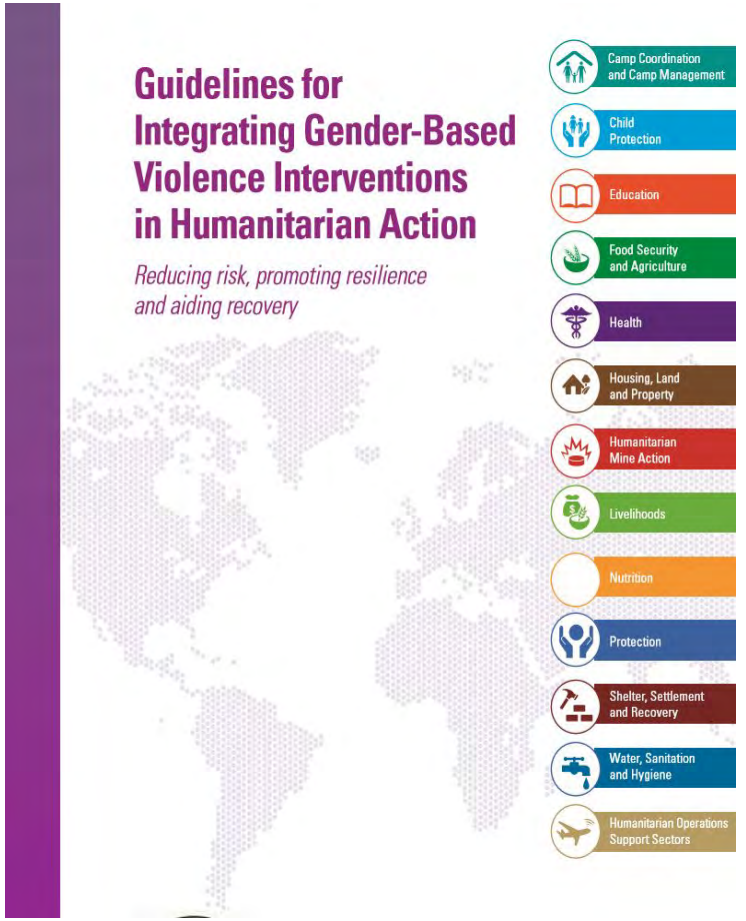
- Adolescent health
- Family planning
- Post-abortion care
- HIV and other sexually transmitted infections



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 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