Health in Humanitarian Settings:
Learning through case studies to inform programs and policies**

**Please note that the decision was made to limit the case study research to conflict or immediate post conflict settings, rather than the larger category of humanitarian settings

Executive summary

On 30-31 March, 2017 the Maternal Health Task Force, part of the Women and Health Initiative, at the Harvard TH Chan School of Public Health and the Centre for Global Child Health at the Hospital for Sick Children in Toronto co-hosted a technical discussion in Boston on health in conflict settings. Participants included individuals with varied experience and vast expertise addressing health issues among people displaced (and not displaced but affected) by war, conflict, famine, natural disasters, and epidemics. Specifically, the 23 participants discussed ways to understand better the situation of reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH&N) interventions for populations in crisis or affected by crisis through case studies.

The meeting objectives were to:

1. Brainstorm the kinds of questions the case studies will attempt to answer and agree to a core set;
2. Discuss and reach agreement on key methodological approaches to be used for the case studies; and
3. Examine and identify case study leads, timelines and next steps.

Together with representatives from the London School of Hygiene & Tropical Medicine, Stanford University, Johns Hopkins University, George Washington University, and Columbia University, as well as key non-governmental organizations and UN agencies, and select Harvard University faculty, the group discussed approaches to conduct case studies in order to gather important evidence to inform policies and programs. Participants agreed to conduct up to ten case studies (pending funding support) in the following eighteen months. Participants listened to presentations from the chairs of the workshop, humanitarian health experts, case study experts as well as several PIs, including one senior researcher who presented her potential work in Burundi.

The case studies will inform a critical evidence base that is part of a larger package of work that includes improving the current knowledge of the burden and epidemiology of conflict and synthesizing existing evidence from published and grey literature to understand better RMNCAH&N interventions in selected geographies and situations.

There will be a common set of research questions for all of the case studies that will be adapted based on the context as well as specific sub-research questions. The case studies will explore the process of determining and setting up the interventions put in place and where gaps remain. A closer understanding of coverage and access to services from the perspectives of both providers and users of the services, as well as existing facilitators and barriers to the interventions will be included. Quantitative and qualitative methodologies will both be used and may vary depending on data availability in a given location. Prioritized countries/situations include: Afghanistan; Pakistan; Syria/Lebanon; Yemen; Northern Nigeria/Chad; South Sudan/Uganda; Somalia/Kenya; Mali; and Colombia. Alternates may include CAR and DRC.

The target audience for whom these case studies will be written and to whom they will be disseminated include: (1) local implementation partners including smaller national groups and civic organizations; (2) UN Organizations, especially WHO and UNICEF, who are currently revising relevant guidelines; (3) international implementation partners including iNGOs; and (4) donors who are trying to determine how most efficiently and effectively to invest limited funds. In addition to stakeholder dissemination through meetings and conferences, case study findings will be published in a summary paper within a 5-paper Lancet series, with case study-specific papers collated in a journal supplement. Research teams will also take advantage of opportunities as they arise to share data gathered and to make program and policy recommendations.

A. Background: Overview of Case Study Project

In recognition of the current, global humanitarian crisis challenges, there has been a push to document the evidence for potential solutions to improve the health and save the lives of those affected. Despite important work underway, however, there remains a critical lack of knowledge on the effects of specific interventions to address the RMNCAH&N needs in selected situations and geographies. Although there is limited evidence available, the burden on women and children as a result of conflict is not well-defined or measured, with large differences based on type of conflict and regions. Meanwhile, there exist gaps in guidelines across the continuum of RMNCAH&N applicable to a variety of settings and types of conflicts.

Meeting participants discussed the fact that there is a need to look at the interventions implemented in more stable settings and how they can be applied in conflict settings in order to understand better how the interventions or the delivery mechanisms need to be adapted to address specific needs. One participant offered the graphic below to explain this phenomenon.

		Method of Delivery	
		As Normal	Intervention as normal Method of delivery needs to be modified
Intervention		Intervention needs to be modified Method of delivery normal	Intervention needs to be modified Method of delivery needs to be modified

A separate but linked work package within the overall consortium project is a systematic review of the effectiveness of RMNCAH&N interventions and of implementation and delivery strategies within conflict settings globally. The review will search comprehensively for data and information available in both the indexed and grey literature, including reports and other outputs from UN agencies as well as non-governmental humanitarian and implementation organizations. This review will begin in advance of the case studies, and will aim to produce some early findings to inform the case study planning.

Complementing the systematic review, the case studies will provide an opportunity to investigate assumptions about how interventions work and to examine the reality of implementation practices. They may also provide the opportunity to advocate for those whose voices are rarely heard, while recognizing that any investigation conducted will not create a broad archetype for implementation, but rather begin to fill in a picture of interventions addressing RMNCAH&N needs.

Questions raised in this discussion included:

- How to assess quality of data and whether some primary data collection is necessary

- How to address the issue of the actual burden given that the data available are variable with large ranges for estimates that include inter-country differentials
- How to consider the range of guidelines and guidance documents that exist given the limited evidence and consensus on what to do, when and how
- The kinds of audiences the case studies might target, including policymakers, practitioners, and donors
- How best to share data gathered with WHO and other UN agencies undertaking relevant guideline and development (or revisions) processes
- Whether a focus on implementation science is the most critical part of the case studies

Participants discussed the following proposed hypothesis:

Conflict-affected populations (i.e., populations affected by ongoing or recently subsided fighting, whether displaced or not, whether refugee or IDP, whether in camps or open settings) have differential access to and utilization of RMNCAH&N services. This results in lower coverage rates of interventions that have been proven to be effective in comparable populations unaffected by conflict and in worse health outcomes as demonstrated by increased morbidity and mortality rates.

In order to investigate this hypothesis, we propose to use a flexible mixed-methods approach to gather available data, generate relevant data where none is available, or document the non-availability of data (itself evidence of poor health system performance vis-à-vis the affected population). The objectives of this work are not to produce new policies or guidelines directly, but rather to add reliable information to a landscape in which donors, national authorities, and program implementers often work without clear, objective evidence. We will expose the barriers to providing these populations with effective health interventions, whether these are related to available resources, poor access of health providers to the population, or relative inflexibility in modifying the means by which these interventions are provided on a routine basis. We will do this by working with those most familiar with the situation being investigated to explore what programs worked to produce better health, what programs did not work, and the extent to which implementers were able to learn from both mistakes and successes to guide their programs.

B. Case Study Objectives, Research Questions & Methodology

In order for the case studies to gather data that are applicable across interventions, settings, and populations, participants agreed that it would be important to create a common vision, including discussion about core objectives and research questions. Additionally, there was discussion of sub-research questions that may be applicable in specific settings, but not relevant across settings. There was also recognition that, within the meeting participants' networks, there are a number of experts with experience working in specific geographies or situations whom it would be helpful to consult as planning evolves both for their knowledge of assessments and other data available, as well as their personal connections and understanding of specific situations. Triangulating available data while the systematic review is completed will also allow for moving ahead more efficiently.

Case Study Objectives

The **case study objectives** included the following:

- Improving the current understanding of the burden and epidemiology of RMNCAH&N-related morbidity and mortality in conflict settings
- Synthesizing available evidence (literature, policies, and data) on RMNCAH&N in conflicts and identifying key gaps
- Assessing the reality of using evidence in conflict situations to guide decision-making on implementation and funding
- Advocating for adolescents, women and children in conflict situations
- Making recommendations for the UN system and partners to inform and improve global guidance for RMNCAH&N in conflict settings

Research Questions

There will be a set of common, core research questions for all of the case studies that will be adapted based on context and the approach will incorporate specific sub-research questions. The case studies will investigate the process of determining and setting up the interventions or services put in place, as well as where gaps remain. A closer understanding of access to services both from the perspective of users and providers and existing facilitators and barriers to access will be included. Specific approaches and methodologies will be discussed further and may vary from case study to case study.

The agreed upon **core research questions** include the following:

- How were interventions chosen and how were they prioritized?
    - Minimum initial services package (MISP) + other RMNCAH&N interventions and packages?
    - Specific situational needs (Were needs assessments conducted? If so, how were key findings used to inform service delivery?)
    - Baseline services in context based on country standards?
- Which interventions were implemented?
    - What is the quality of these interventions (using key proxies?)
- What coverage has been achieved?
    - How will coverage (vs actual access) be noted?
- What/where are the gaps in provision?
- What/where are the barriers to implementation?
    - Coordination, coverage, etc.
- How have barriers been addressed?
- What has been the impact on the local health system? (cross-cutting)

Methodology

While **methodology** was only discussed briefly, participants agreed that a mixed methods approach would be utilized. Primary **qualitative** data will be collected via key informant interviews, focus group discussions, and potentially, direct observation and/or other methods. Primary (if possible) and secondary **quantitative** data may be gathered via health facility assessments, and desk reviews of existing documentation and data from the DHS, MICS, UNHCR's HAUS, and/or NGO surveys. Existing sources of data for each case country will be explored by and shared among the consortium teams to then refine the proposed data collection methods.

C. Country Selection criteria

The meeting participants agreed on the following **country selection criteria** for the case studies:

- Geographical representation (countries in Asia, Africa, Latin America, and the Middle East)
- A mix of acute, chronic/protracted and recovery phases
- Feasibility, as measured by
  - Security and access
  - Partners (availability and quality of local researchers and implementers)
  - Data availability (see note above regarding whether baseline data are essential, believable, etc.)
- A mix of conflict-affected populations: displaced and not displaced; IDPs and refugees; camp settings and open settings
- A mix of low income and middle income settings
- Relevance to agreed upon research questions
- A mix of of well-documented and poorly/un-documented conflicts

D. Prioritized Countries/Situations (see appendix for additional information on process used)

1. Afghanistan
2. Pakistan
3. Syria/Lebanon
4. Yemen
5. Northern Nigeria / Chad
6. South Sudan / Uganda
7. Somalia / Kenya
8. Mali
9. Colombia
10. Alternates: CAR and DRC

E. Target Audience

The participants discussed and agreed upon the need to disseminate information to various actors in the field for a variety of purposes which will shape the content of the case studies. They also agreed to the fact that those from whom the information/data were gleaned deserved to be the first to hear about the findings gathered, to vet and to help interpret them. In fact, hopefully, they will be involved in the process of designing and gathering the data so will be an extension of the research team working in a specific country or situation.

With this in mind, the target audience for whom these case studies will be written and to whom they will be disseminated include: (1) local implementation partners including smaller national groups and civic organizations; (2) UN Organizations, especially WHO and UNICEF, who are currently revising relevant guidelines; (3) international implementation partners

including iNGOs; and (4) donors who are trying to determine how most efficiently and effectively to invest limited funds.

In addition to stakeholder dissemination through meetings and conferences, case study findings will be published in a summary paper within a five paper Lancet series, with case study-specific papers collated in a single journal supplement, possibly in BMC Conflict and Health. Research teams will also take advantage of opportunities as they arise to share data gathered and to make program and policy recommendations.

F. Next Steps

1) Principal investigators will explore and share the work of partners in key geographies and any data collected and opportunities for site visits
2) Principal investigators will also share personal networks and contacts in order to begin to gather prospective data informally that will assist the planning process
3) Sick Kids colleagues will consult with the PIs and start to plan for a meeting on 6 June in London with selected NGOs (e.g., Red Cross, IRC, Save the Children, World Vision, ICRC, IMC, ACF, IFRC, CARE, Women's Refugee Commission)
4) Sick Kids colleagues will also consult with the PIs to plan for a meeting after the NGO meeting 7 June with UN organizations (e.g., UNICEF, UNHCR-RH, WHO, UNFPA-Humanitarian Response, IOM, OCHA, WFP)
5) Discussions will continue about dissemination which will include a 5-paper Lancet Series supplement in 2018, as well as major symposia and convenings such as the 2019 International Congress of Pediatrics
6) Sick Kids colleagues will update the group about current and future fundraising efforts and engage them, as necessary.

Appendices:

A. Program agenda
B. Participant list
C. Sick Kids' Country list that shares details about countries
D. Group 1 and 2 Country prioritization matrix

A. Program agenda

Health in Humanitarian Settings

Learning through case studies to inform programs and policies

MEETING OBJECTIVES

Over the course of two days (March 30-31), the Maternal Health Task Force at the Harvard TH Chan School of Public Health, together with the Centre for Global Child Health at The Hospital for Sick Children, will convene a technical consultation in Boston to address the following objectives:

1) Brainstorm the kinds of questions the case studies will attempt to answer and agree to a core set.

2) Discuss and reach agreement on key methodological approaches to be used for the case studies.

3) Discuss and reach agreement on case study leads, timelines and next steps.

DAY 1, THURSDAY, MARCH 30		
Time	**Event**	**Session leader**
8:30–9:00	*Registration and breakfast*	
9:00–9:20	Welcome on behalf of MHTF and Harvard Chan School of Public Health and introductions	Ana Langer
9:20–9:45	Brief overview of the project • Progress to date • Basic timeframe • Plan for how case studies will be used • Dissemination	Zulfiqar Bhutta
9:45–10:15	Mike VanRooyen, Harvard Humanitarian Health Initiative Jackie Bhabha, FXB Center for Health and Human Rights Offer insights from their current work in humanitarian settings and how they envision our case studies complementing the body of knowledge and critical work underway Q and A	Ana Langer
10:15–10:30	*Tea and coffee break*	
10:30–11:00	Candidate case study countries • Conceptual framework/working typology of crises • Case selection criteria • Shortlist of candidate case countries	Michelle Gaffey
11:00–12:00	Discussion on case study objectives and potential research questions Given emerging questions, how will our case studies contribute to a better understanding of the RMNCAH+N crises in humanitarian settings, gaps in knowledge and coverage, and the most effective policies and programs to address them? What questions might the case studies answer that will complement the systematic review?	Ron Waldman to lead discussion Karl Blanchet to help extract from discussion and begin to draft list of case study objectives and potential research questions
12:00–1:00	*Lunch*	
1:00–3:30	Introduction to types of case studies and what each offers. Discussion on relevance for our case studies, best potential methodologies, and pitfalls to avoid. • Rebecca Weintraub, Global Health Delivery Project at Harvard University • Susan Madden, Department of Health Policy and Management, Harvard TH Chan School of Public Health • Sara Casey, IAWG on RH in Crisis, Columbia University • Jennifer Requejo, Countdown to 2030, Johns Hopkins	Paul Wise to lead discussion Discussion to continue after coffee and tea break
3:30–4:00	*Tea and coffee break*	

4:00–4:30	Continued discussion from above	Paul Wise

DAY 2, FRIDAY, MARCH 31		
Time	**Event**	**Session Leader**
8:00–9:00	Co-investigators' meeting	Zulfiqar Bhutta
8:45-9:15	*Breakfast*	
9:15– 9:20	Country matrix overview and background	Michelle Gaffey
9:20–9:30	Presentation of 2 by 2	Ron Waldman
9:30-10:30	Discussion and agreement on core research questions to be explored in all case studies	Karl Blanchet
10:30–10:45	*Tea and coffee break*	
10:45–12:00	Group 1: For first half of core research questions, discuss and decide on: sub-research questions; methodological approaches to be used; most appropriate countries or sites (Select rapporteur to report out) Group 2: For second half of core research questions, discuss and decide on: sub-research questions; methodological approaches to be used; most appropriate countries or sites (Select rapporteur to report out)	Group 1 leader: Paul Spiegel Group 2 leader: Zulfi Bhutta
12:00–12:30	*Lunch*	
12:30-1:00	Report out from groups 1 and 2 followed by brief discussion to combine ideas and shortlist countries Discussion and filling in of matrix collectively (?)	Karl Blanchet

1:00 –2:00	Key considerations and potential partnerships
	• Consideration of individual countries
	  ○ Who will lead implementation?
	  ○ Local stakeholders – academics, gov't, CSOs
	  ○ International stakeholders – INGOs, UN agencies
		Bob Black

2:00–2:30	Next steps • Confirming country cases and committing case leads • Protocol development by case leads, and co-investigator review	Zulfiqar Bhutta
2:30–3:30	Working tea and coffee break Next Steps (continued) • Meeting in London in June • AOB	
3:30–4:00	Wrap up	Ana Langer

B. Participant list

Name		Organization
Anushka	Ataullahjan	The SickKids Centre for Global Child Health; University of Alberta School of Public Health
Valerie	Bemo	Bill & Melinda Gates Foundation
Jackie	Bhabha	FXB Center, Harvard TH Chan School of Public Health
Zulfiqar	Bhutta	The SickKids Centre for Global Child Health; University of Toronto
Bob	Black	Johns Hopkins Bloomberg School of Public Health
Karl	Blanchet	London School of Hygiene and Tropical Medicine
Sara	Casey	Columbia University Mailman School of Public Health
Nancy	Dale	The SickKids Centre for Global Child Health; University of Toronto
Jocelyn	Finlay	Harvard TH Chan School of Public Health
Michelle	Gaffey	The SickKids Centre for Global Child Health; University of Toronto
Elizabeth	Gibbons	FXB Center, Harvard TH Chan School of Public Health
Ana	Langer	Women & Health Initiative, Harvard TH Chan School of Public Health
Susan	Madden	Case-Based Teaching & Learning, Harvard TH Chan School of Public Health
Imran	Mirza	UNICEF
Meg	O'Connor	Women & Health Initiative, Harvard TH Chan School of Public Health
Jennifer	Requejo	Johns Hopkins Bloomberg School of Public Health
Paul	Spiegel	Johns Hopkins Bloomberg School of Public Health
Mike	VanRooyen	Harvard Humanitarian Initiative, Harvard TH Chan School of Public Health
Linda	Vesel	MHTF/Women & Health Initiative, Harvard TH Chan School of Public Health
Ron	Waldman	George Washington University Milken Institute School of Public Health
Mary Nell	Wegner	MHTF/Women & Health Initiative, Harvard TH Chan School of Public Health
Rebecca	Weintraub	Global Health Delivery Project at Harvard University
Paul	Wise	Stanford University Medical School

C. Country data table

	Country	Income Level	MMR	IMR	Population	Displacement (UNHCR 2015)	Camps/ Non-camps/Both	Phase / Duration
1	Afghanistan	Low	396	66	32,526,000	Incoming refugees: 237,069 Outgoing refugees: 2,662,954 IDPs: 1,1074,306		
2	Bangladesh	Lower Middle	176	31	160,995,000	Incoming refugees: 31,958 Outgoing refugees: 12,172 IDPs: ?		
3	Colombia	Upper middle	64	14	48,228,000	Incoming refugees: 226 Outgoing refugees: 90,836 IDPs: 6,939,067		
4	Chad	Low	856	85	14,370,000	Incoming refugees: 369,540 Outgoing refugees: 14,940 IDPs: 51,999		
5	CAR	Low	882	92	4,900,000	Incoming refugees: 7330 Outgoing refugees: 471,104 IDPs: 216,392		
6	DRC	Low	693	75	77,266,000	Incoming refugees: 383,095 Outgoing refugees: 541,291 IDPs: 1,555,112		
7	Iraq	Upper Middle	50	27	36,423,000	Incoming refugees: 277,701 Outgoing refugees: 261,107 IDPs: 4,403,287		
8	Jordan	Upper Middle	58	15	7,594,000	Incoming refugees: 664,118 Outgoing refugees: 1841		

						IDPs: ?		
9	Lebanon	Upper Middle	15	7	5,850,000	Incoming refugees: 1,070,854 Outgoing refugees: 4369 IDPs: 19,700		
10	Mali	Low	587	75	17,599,000	Incoming refugees: 15,917 Outgoing refugees: 154,211 IDPs: 61,920		
11	Myanmar	Lower Middle	178	40	53,897,000	Incoming refugees: ? Outgoing refugees: 198,685 IDPs: 451,089		
12	Nepal	Low	258	29	28,513,000	Incoming refugees: 32,667 Outgoing refugees: 8865 IDPs: up to 50,000		
13	Nigeria	Lower Middle	814	69	182,201,000	Incoming refugees: 1395 Outgoing refugees: 152,136 IDPs: 2,172,532		
14	Pakistan	Lower Middle	178	66	188,924,000	Incoming refugees: 1,561,162 Outgoing refugees: 277,344 IDPs: 1,146,108		
15	Palestine	Lower Middle	45	18	4,442,000	Incoming refugees: ? Outgoing refugees: ? IDPs: ?		
16	Somalia	Low	732	85	10,787,000	Incoming refugees: 8081 Outgoing refugees: 1,123,022 IDPs: 1,133,000		
17	South Sudan	Low	789	60	12,339,000	Incoming refugees: 263,214		

						Outgoing refugees: 1,259,036 IDPs: ?		
18	Sri Lanka	Lower Middle	30	8	29,966,000	Incoming refugees: 784 Outgoing refugees: 121,435 IDPs: 44,934		
19	Syria	Lower Middle	68	11	18,502,000	Incoming refugees: 21,113 Outgoing refugees: 4,850,792 IDPs: 6,563,462		
20	Uganda	Low	343	38	39,032,000	Incoming refugees: 477,187 Outgoing refugees: 6316 IDPs: 29,800		
21	Yemen	Lower Middle	385	34	26,832,000	Incoming refugees: 267,173 Outgoing refugees: 15,896 IDPs: 2,532,032		