Call for papers on prevention of non-communicable disease in humanitarian settings

BMJ Global Health, in collaboration with the International Rescue Committee, the Conflict and Health Research Group at King's College London and the College of Health at Lehigh University, have announced a call for papers on *Non-Communicable Disease (NCD) Prevention in Humanitarian Settings*. Today's conflict-affected countries have some of the highest prevalence of NCDs globally. The World Health Organization (WHO) estimates that diabetes, for example, affects 12% of adults in Syria, 13.7% of adults in Libya and 7.7% of adults in Yemen. Many refugee camps and settlements have been home to displaced people for three or four decades, such as Kakuma and Dadaab in Kenya and Mae La in Thailand. In those settings, NCDs are the leading cause of death and must be addressed. In addition to the four main risk factors – unhealthy diet, physical inactivity, smoking and alcohol – WHO recently added a fifth leading NCD risk factor: air pollution. Notably, poor air quality could be responsible for up to a quarter of strokes and heart disease, a third of lung cancers and almost half of chronic obstructive pulmonary disease cases.

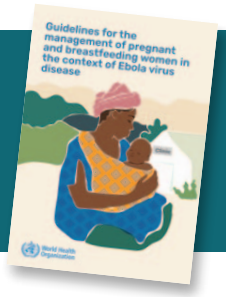
Despite these challenges, preventing NCDs through aggressive monitoring and policy interventions is still not prioritised in these countries and settings. Primary prevention is not a priority during acute emergency and conflict situations, but secondary prevention measures are important in such scenarios. Patients with existing diagnoses of NCDs require continuity of care to prevent acute exacerbations and complications of their disease, and ultimately prevent premature deaths. Conversely, in long-standing and more stable contexts, such as refugee camps, primary prevention initiatives are possible. A 2015 systematic review highlighted the dire lack of research on NCDs in humanitarian contexts and ELRHA (Enhancing Learning and Research for Humanitarian Assistance)[1] has listed NCDs as a priority research area.

BMJ Global Health invites submissions for a special issue on this subject, including case studies, qualitative research, evaluations of interventions, quantitative analysis and prevalence studies, papers on commercial determinants of NCDs, and systematic reviews. Abstracts of one to two paragraphs must be submitted by 17 April 2020 to **info.bmjgh@bmj.com**

For more information please see:
https://blogs.bmj.com/bmjgh/2020/02/13/call-for-papers-ncd-prevention-in-humanitarian-settings

[1] www.elrha.org

Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease



The Democratic Republic of Congo (DRC) is currently experiencing the second-largest Ebola outbreak in history, following a 2014-2016 outbreak in western Africa that had an estimated 28,000 cases. Investigational treatment and vaccination trials are ongoing, but data in the context of pregnancy and breastfeeding are limited. There is a paucity of scientific evidence on how best to treat pregnant or breastfeeding women with suspected or confirmed Ebola virus disease (EVD). Historical reports suggest that, among women who acquire EVD during pregnancy, there is increased mortality and morbidity, and a near 100% rate of adverse pregnancy outcomes. To save the lives of mothers and their babies, mitigate complications and limit the spread of disease, it is critical that recommendations are made on the prevention, treatment, and surveillance of women who are exposed to EVD, acquire EVD during pregnancy or breastfeeding, or survive EVD with ongoing pregnancies.

In response, the World Health Organization (WHO) recently released guidelines for the management of pregnant and breastfeeding women in the context of EVD.[1] These guidelines are the first to provide such recommendations. They also cover the surveillance and management of ongoing pregnancies and adverse pregnancy- related events, the handling of bodily and pregnancy-related fluids during acute maternal infection and following recovery, and the management of subsequent pregnancies in Ebola survivors. These guidelines will be of interest to health policy makers, emergency preparedness and response teams, and healthcare providers who work with pregnant or breastfeeding women in the context of Ebola.

Specific recommendations cover six topics: (i) the management of acute EVD in pregnant women; (ii) the management of pregnancies in women who develop EVD during pregnancy and those who survive EVD with an ongoing pregnancy; (iii) infection prevention and control (IPC) measures for pregnant women with acute EVD or who have recovered from EVD with ongoing pregnancies (with conception prior to EVD); (iv) IPC for women who become pregnant after recovering from EVD (with conception after EVD); (v) breastfeeding women with acute EVD or who have recovered from EVD (see Table 1); and (vi) vaccination recommendations for pregnant women who are at risk of acquiring EVD.

Download the full guidelines from:
https://apps.who.int/iris/handle/10665/330851

[1] Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease. Geneva: World Health Organization; 2020.

Table 1 Breastfeeding recommendations – extract from the WHO guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease (2020)

Recommendation #9: Breastfeeding should be stopped if acute EVD is suspected or confirmed in a lactating woman or in a breastfeeding child. The child should separated from the breast feeding woman and provided a breastmilk substitute as needed. Recommendation strength: strong. Very low quality evidence.
Recommendation #10: Children without confirmed EBOV infection who are exposed to the breastmilk of women with confirmed EVD should be considered contacts. The child should stop breastfeeding and should undergo close monitoring for signs and symptoms of EVD for 21 days. The child should be given a breastmilk substitute as needed. Post-exposure prophylaxis for EVD can be considered for children exposed to the breastmilk of EBOV-infected women on a case-by-case basis and in accordance with existing research protocols. Recommendation strength: strong. Very low quality evidence.
Recommendation #11: If a lactating woman and her breastfeeding child are both diagnosed with EVD, breastfeeding should be discontinued, the pair should be separated, and appropriate breastmilk substitutes should be provided. However, if the child is under six months of age and does not have save and appropriate breastmilk substitutes, or the child cannot be adequately cared for, then the option to not separate and continue breastfeeding can be considered. Recommendation strength: strong. Very low quality evidence.
Recommendation #12: A woman who has recovered from EVD, cleared viremia, and wants to continue breastfeeding should wait until she has had two negative RT-PCR breastmilk tests for EBOV, separated by 24 hours. During this time, the child should be given a breastmilk substitute. Recommendation strength: strong. Very low quality evidence.