

Meeting the Sexual and Reproductive Health Including HIV Needs of South Sudanese Refugees in Gambella, Ethiopia

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Abstract

Background: Sexual and reproductive health services are more often than not perceived as low in the hierarchy of needs during humanitarian crisis yet populations in crisis need and have a right to sexual and reproductive health (SRH) services. A project to meet the SRH needs of South Sudanese refugees was designed and implemented in Ethiopia.

Methods: A post emergency review was done to assess performance of the project. A desk review; 10 key informant interviews with project management staff, partners and beneficiaries; 5 focus group discussions (FGDs) with a total of 42 participants representing adult men/women and boys/girls was done. Thematic and content analyses approach was used for data analysis.

Description: United high commission for refugees (UNHCR) estimates over 190,000 people were displaced into Ethiopia during the 2013/2014 South Sudan crisis. A project was designed and implemented through a partnership between the international planned parenthood federation Africa Region (IPPFAR) and the International Medical Corp (IMC). The response was guided by five minimum initial service package (MISP) objectives; sector/cluster coordination, prevention of sexual violence, reduction of HIV transmission, prevention of excess maternal and neonatal mortality and morbidity and provision of comprehensive reproductive health (RH) services. The project reached 88,869 refugees.

Lessons Learnt: Timely and speedy implementation of MISP at the onset of crisis and sustaining it throughout the crisis is critical and saves lives. A transitioning plan to ensure continuum of care is important for this type of intervention. Understanding the HIV in crisis settings and providing it in an integrated package reduces stigma and ignorance and increase demand for services.

Conclusions: On commencement it is necessary to conduct a rapid assessment to establish the baseline. Provision of HIV services as part of the integrated package was not well covered largely due to stigma attached to the disease and ignorance. A better understanding of the implementation environment would have achieved a more meaningful intervention.

Keywords: Reproductive health; South Sudan; Crisis; Refugees; Ethiopia; MISP

List of abbreviations: ARO: Africa Regional Office; ARRA: Administration of Refugees and Returnees Affairs; CCT: Country Coordination Team; IMC: International Medical Corps; IPPF: International Planned Parenthood Federation; PEPFAR: US Government President's Emergency Plan for AIDS Relief; MSF Holland: Medecins Sans Frontieres; SPRINT: Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations; RCC: Refugee Central Committee; UNFPA: United Nations Population Fund; UNHCR: United Nation High Commission for Refugees; WHO: World Health Organisation

AIDS: Acquired Immunodeficiency Syndrome; ASRH: Adolescent Sexual and Reproductive Health; CDK: Clean Delivery Kit; CEmOC: Comprehensive Emergency Management of Obstetric Care; EP: Emergency Preparedness; BEmONC: Basic Emergency Management of Obstetric and Neonatal Care; FGD: Focus Group Discussion; FP: Family Planning; GBV: Gender Based Violence; HIV: Human Immunodeficiency Virus; IDP: Internally Displaced Persons; M&E: Monitoring and Evaluation; MISP: The Minimum Initial Service Package for Reproductive Health; PEP: Post Exposure Prophylaxis; PER: Post Emergency Review; PMTCT: Prevention of Mother to Child transmission; RH: Reproductive Health; SGBV: Sexual Gender-Based Violence; SRH: Sexual and Reproductive Health; STI: Sexually Transmitted Infections; SV: Sexual Violence; USD: United States Dollar

Introduction

Although sexual and reproductive health services are not highly prioritized during emergency settings, they are important and necessary for populations in crisis situations. At the very least providing the minimum initial service package (MISP) for reproductive health saves lives. IPPF uses the MISP model to provide reproductive health services during periods of crisis and/or protracted crisis. MISP has the overall goal of improving health outcomes of crisis affected populations by reducing preventable sexual and reproductive health morbidity and mortality. Its implementation is premised on five objectives; coordination for

implementation of MISP, prevention of sexual violence, reduction of HIV transmission, prevention of excess maternal and neonatal mortality and morbidity and a plan for provision of comprehensive RH services integrated into primary health care.

Between 2013 and 2014, thousands of South Sudanese citizens were displaced into the neighboring countries of Kenya, Uganda and Ethiopia. UNHCR reported that an estimated 192,724 refugees arrived by January 2015, of which, 43,177 refugees were registered pre 15th December 2013; majority were women and children. Refugees entered Ethiopia through Gambella at the Pagak, Akobo, and Tergol entry points. The Ethiopian government through the Ethiopian Administration of Refugees and Returnees Affairs (ARRA) opened three camps at Okugu, Lietchour, and Kule. As a response to this crisis, IPPFAR forged a partnership with the International Medical Corps (IMC) in Ethiopia to implement a complementary emergency response in these camps. ARRA subsequently commissioned the opening of health facilities; they took charge of one health centre and delegated the management of the other health centre and health post to MSF Holland. Each of the health posts was expected to cover at least two zones or more depending on the population size of the zones.

The project in Ethiopia was implemented using two approaches; capacity development and service delivery. Capacity development responded to two areas; human resource and infrastructure. During the project life cycle and on a need basis, specific trainings were designed to target the diverse stakeholders in the project. A total of 4 trainings and 6 community sessions for information and education were conducted: basic emergency management of obstetrics and neonatal care (BEmONC) for health workers; SRH and HIV/AIDS prevention for other health care providers and influential refugee community groups. Tea / coffee talks were held with young people especially young women and girls to provide information and education on SRHR. The project management team formed a camp level coordination committee that held weekly planning meetings; the committee developed a joint work plan and data collection tools. A strong referral system was developed as a result of this joint collaboration.

The project experienced an increased demand for services from the refugee community and as a result 88,869 people were reached with SRH services compared to 56,970 people target at the beginning of the project. The joint planning, trainings targeting the relevant stakeholders, on-going community education and availability of friendly SRH services contributed to increased understanding of SRHR issues and behavior change. It was instrumental in the demystification of sexual and gender based violence (SGBV) which was highly misunderstood. An enabling environment for service delivery was created, whereby 100 pregnant women received HIV voluntary counseling and testing, 2,795 deliveries were undertaken by skilled attendants, and 33,199 women of reproductive age received sensitization and education on SRHR.

This paper explores and examines the role of the project to the beneficiaries, the perceptions, significance and constraints of the partnerships forged. It also looks at the implementation environment and its effect on achievement of the project goals. This paper focuses on answering the following research questions; To what extent was SPRINT support for surge capacity and RH commodity procurement effective? To what extent did the project contribute towards progress in increasing timely access to life saving SRH services as outlined by the MISP checklist? To what extent did SPRINT support and funding enhance or strengthen the CCT led response? Conclusions are from the available literature on the project, interviews with beneficiaries, the project management team and the partners.

Post Emergency Review of the Emergency Response

Following the implementation of an emergency response project, an assessment of its intended outcomes was conducted. The PER was designed as an accountability tool for the beneficiaries as it examines the appropriateness and effectiveness of an emergency response. The PER specifically looked at the following objectives;

Objectives of the PER

Objective 1: To assess the extent to which SPRINT's support for surge capacity and RH commodity procurement (through funding, coordination, distribution, or technical assistance) was effective

Objective 2: To assesses the project's contribution to progress towards increasing timely access to life saving sexual and reproductive health services as outlined in the MISP/MISP checklist;

Objective 3: To determine whether, how, and to what extent SPRINT funding and support enhanced or strengthened the CCT led emergency response.

PER Methodology

At the end of the six month project implementation period, a post-emergency review was conducted. The PER documented the process and assessed the outcomes of SPRINT's support to country coordination team (CCT) and/or partner. The PER tool was revised and used for this exercise. The post emergency review tool collects secondary and primary data. A desk review of the existing literature on the South Sudan crisis and the response in Ethiopia was done prior to the field trip. A documentation of quantitative performance indicators (including service statistics) based on project proposals was done at field level.

5 focus group discussion (FGD) consisting of at least eight participants per group was done. The groups were segregated by age and gender. 3 of the FGDs were conducted in Tierkidi camp while 2 were conducted in Kule based on the population density in the camps. To be eligible for the FGD, a participant must have been in the camp for a minimum period of 6 months and accessed at least one SRH service from the project or the health center / post. The participants provided views on their experiences with the project, the challenges they faced as pertains to reproductive health in a camp setting and the recommendation they thought were best moving forward with a similar project. 10 key informant interviews were conducted with the project management staff at headquarter and branch level, partners (UNHCR, MSF Holland, and ARRA). KIIs were also conducted with 2 project beneficiaries to provide an in-depth analysis of the project. The interviews sought to establish whether the environment was supportive in the implementation of SRH in emergency settings, coordination, the role of partnership and its ability to deliver intended benefits to the beneficiaries. Thematic and content analyses approach was used for data analysis. Responses from key informant interviews and focus group discussions were triangulated and categorized into categorical variables and analyzed using thematic and content analyses to help understand people's perceived benefits of the project, challenges, the role of partnership and the overall coordination and performance of the project.

The review took place from 21st to 27th January 2015 and was done in two camps; Kule and Tierkidi. Due to security reasons the third camp at Leitchour could not be assessed. This assessment was conducted by the SPRINT team from Africa Regional Office (ARO) in collaboration with IMC staff. Initial planning meetings were held at the IMC head office in Addis Ababa, subsequent meetings were held at their field office in Gambella. All interviews and photos were taken with prior informed consent of all stakeholders.

Results

The project reached 88,869 people; a higher number of beneficiaries than targeted due to the high need for SRH services, increased understanding of their SRH and HIV issues, effective demand creation strategies, and availability of SRH friendly services (Table 1).

Month	Total number of people	Women of Reproductive Age (WRA) (15-49) provided with SRH assistance		Men	Adolescents		People sensitized
		Number of PLW provided with SRH services	Number of WRA (15-49) provided with SRH assistance (exclude PLW)		Number of female adolescents (10-19) provided with SRH assistance	Number of male adolescents (10-19) provided with SRH assistance	
Aug. '14	9,546	1,200	3,413	2,035	987	1,911	Total Number of people sensitized on SRH issues and/or services (through health information sharing (HIS), IEC session, etc.
Sept. '14	13,173	1623	4123	4677	1463	1287	16,509
Oct. '14	22,940	2312	6412	6231	2314	5671	18,320
Nov. '14	19,606	2812	4512	5456	2314	4512	21,671
Dec. '14	23,604	2913	3879	7368	3124	6320	20,093
TOTAL	88,869	10,860	22,339	25,767	10,202	19,701	86,688

Table 1: Services provided by SPRINT project implemented by IMC (Source: IMC SPRINT final report Dec, 2014)

The training component of the project was implemented successfully and was instrumental in increasing demand for services. Trainings related to SRH and HIV, prevention of GBV, ASRH, BEmONC were provided to health workers, clinical staff, young people and influential people in the community. The influential groups and young people trained acted as the change agents in the community.

"The training received was very important for the entire community and has impacted our ways for doing thing" (Male FGD Respondent, Kule Camp) (Table 2).

Expertise gained on implementation of MISP by key stakeholders earned IMC the confidence of other partners such as ARRA and UNHCR. In addition to trainings, community mobilization and awareness creation approach was used to create demand. It is worth noting that FP services were not available prior to the SPRINT project. At the end of the project, MSF reported an increased demand in FP and other SRH services "Before IMC started the FP program, Family planning services were reported at Zero, when the program started, people started demanding for FP and other SRH services. FP services increased and so did the ANC and PNC services" (Mid-wife-MSF, Kule Camp).

Using the community structures to create awareness and advocate for utilization of SRH services broke some barriers of access by increasing acceptability of these services. Responses from the FGD participants and health staff at MSF demonstrated that

increased awareness of HIV status and availability of the services motivated at least 100 pregnant women to undertake HIV voluntary testing and counseling.

Direct target beneficiaries - Adolescent girls and boys aged (10-19 years old), women in reproductive age group (15-49 years old); Adult men which appositely were 57,861 (5,413 men, 30,852 women & 21,596 adolescents) Beneficiaries of the project - 88,869 people		
Target	Training	No. of People
Clinical Health Workers	MISP	13
Health Providers	HIV counselling and prevention	24
Representatives of refugees' influential groups at community level	SRH and HIV/AIDS prevention	120
Midwives	BEmOC	21
Services Provided as a result of interventions		
Condoms Distributed	36,400	
HIV testing and Counselling	100 pregnant women	
Clean Delivery Kits distributed	1,500	
Sensitization & Education on SRHR	33,199 women in reproductive age	
Sensitization and Education on ASRH	6 tea/coffee session conducted with young people	
Obstetric complication treated	29 Women	
Deliveries by Skilled attendants	2,795 deliveries	

Table 2: Achievements of the project during the 6 month implementation period

“Nobody knows their HIV status because we did not take this tests before” (Male FGD Participant, Kule Camp)

“If STI infections are reduced the problems of the women will be taken care of” (Female Respondent, Tierkidi)”

“IMC has come out as an NGO that has concern for the health of the community. They provide clean delivery kits and condoms for STI/HIV prevention. They also handle GBV and rape survivors when they come for information and support” (Female Respondent, Tierkidi Camp).

Strong collaboration was established between implementing partners. The MISP/health coordination committee formed at the beginning of the project provided the necessary support and commitment required to achieve the project objectives and goals. The committee had representation from key groups such as the health partners at the camps, influential refugee groups; religious leaders, the refugee central committee (RCC), camp chairman, zonal leaders, women association representatives and youth representatives. Coordination and collaboration resulted to the development and implementation of a strong referral system by the project and its partners.

“IMC has a good referral system. During the home visits and community mobilization sessions, community health workers refer the clients to the health centre/post by giving referral cards, they then go to the clinic for services, the health clinic then hand over all the filled forms back to IMC for documentation” (Senior SRH Officer, Kule Camp).

The use of infotainment and recreational activities, coffee/tea sessions for young people worked well in creating interest and driving demand for ASRH services. Where youth and adult SRH friendly did not exist, IMC worked with partner to create a conducive environment for service uptake. The community felt that the services offered by IMC were important and timely given their circumstances.

Although the project was well received by the refugee community and partners, its implementation presented some minor challenges. Lack of a baseline survey at the beginning of the project meant that some of the interventions were not adequately informed to achieve the desired result. For example, although sexual and gender based violence was eminent in this community, it was a topic that was highly misunderstood and rarely discussed; therefore the interventions in this area were minimal.

“In our culture the only type of rape we know is gang rape, with the training I got from IMC I now know that there are different forms of rape such as marital rape. We are now empowered enough to report” (Community Agent, Tierkidi Camp)

While the project reached young people and had several interventions targeting them, overall, the number of young people seeking for SRH services as a result remained low. Young people interviewed during the FDG felt that the absence of youth friendly services at the health centers was the main hindrance. They also cited lack of privacy as a deterrent to accessing these services.

A good number of pregnant women interviewed reported that they preferred home deliveries compared to institutional deliveries. While some felt that the health centres lacked friendly services during the ante-natal visits most women cited; culture, and long distance to the health centres. Provision of clean delivery kits by the project was also not well received by the government which viewed them as being retrogressive towards the achievement of institutional delivery.

“I delivered at home because my place is very far from the health centre. When I came to the clinic, they denied me access” (Female Respondent, Kule Camp)

“For us delivery is not known only God knows. If it happens during the day, I might come to the health centre, if it happens at night, I will have my baby at home” (Female Respondent, Tierkidi Camp)

Although the project advocated for strong partnerships, the policy environment was not fully supportive of it. For example, the project had initially planned to procure post exposure prophylaxis (PEP) kits but was faced with government regulatory challenges. PEP is procured by the US Government President’s Emergency Plan for AIDS Relief (PEPFAR). Transportation and distribution is also done by PEPFAR on behalf of the Ethiopian government. Provision of services at the camp was only done on approval by ARRA and restricted to one provider. Therefore, the full range of SRH services such as family planning and HIV related services were not available at some of the health centres/posts. Partnerships would have allowed for service integration and linkages.

“Coming from a war torn country a lot of the people have mental health issues, it would really help if we received mental health services” (Female Respondent, Kule Camp)

The project was short and ended prematurely. Project management staff and beneficiaries felt that the project concluded at its peak. The project concluded without a clear transition plan; a great desire was expressed to upgrade MISP to comprehensive SRH services integrated into primary healthcare to sustain the demand created by the project.

Case study

Meet Deng*, a 22 year old young woman from South Sudan. She crossed over the Border into Ethiopia from the Upper Nile State due to the on-going conflict in South Sudan. She has been living in Tierkidi camp since March 2014. “I live here with my family. I’m married and have two children. My sister is here with me too. My parents don’t live here, they went back to South Sudan and I think they live somewhere near the border with Ethiopia. I had my first child in South Sudan but the second was born in the camp. I got pregnant when I was in this camp, during my pregnancy I went to the ARRA health center and got the necessary treatment (vaccination and supplements). Although I went to the health center during my pregnancy I delivered at home. I wanted to have my baby at the health center but my labour happened so quickly that I did not even know it was happening. It was very short. I had no time to get to the health center so my neighbors helped me to deliver at home. I took my baby to hospital a week after giving birth. So far she has received the necessary immunization. I learnt about health services through IMC. I learnt about IMC through other women in the community and I always see the IMC people around the camp wearing t-shirts. Once I learnt what they do, I started going to their compound to collect materials. Although I did not receive the kits they were giving to pregnant women in the community, I have received information on SRH which has been very useful to me.”

Discussions

Although the project forged successful working partnerships with implementing organizations, important lessons were learnt by the implementers on how to engage with partners for future projects. At the end of the project the government through the ministry of health in Gambella felt that such a project was important and it complemented its work in areas where its presence is weak. However, it was felt that not enough time was given for planning and mapping out the responsibility of each partners. Future projects should anticipate the nature of emergency projects and carry all partners every step of the way. In a typical scenario, the project is implemented using the country coordinating mechanism (CCT) which has representation from different stakeholders (government, organizations providing basic needs, relevant UN agencies and other community partners). In the case of Ethiopia, the national CCT exists but is not well aligned to the grass-root level, the project therefore engaged the willing partners who were already at the camp setting to implement the project. This was a short term project that did not provide adequate time to handover the services to the community structures that would sustain continuum of care for the community.

In order to execute a well informed and meaningful response, a baseline / rapid assessment is essential at commencement. Sexual and gender based violence for example was identified as a sensitive issue for the South Sudanese community which has spent years in war. An informed approach informed by the baseline assessment would have increased penetration into the community as well as yielded better results for SGBV survivors. The community also had little to no awareness about HIV. South Sudan being a relatively new country, has majority of its population coming from many years of crisis and may not necessarily understand the pandemic.

Due to the short nature of emergency response projects, on-going resource mobilization efforts are important to not only sustain demand but to also cater for emerging issues, and ensure continuum of care either at minimum capacity if crisis is ongoing or in providing comprehensive services through protracted crisis. Without the necessary funding for the project, this project ended prematurely.

To achieve the goals and objectives of MISP and intended outcomes for the beneficiaries, it is necessary to establish and strengthen linkages and service integration. In as much as food, shelter, and clothing are essential and fall high in the hierarchy of needs, populations in crisis also have to endure pregnancies, HIV and other STIs, other public health needs such as such as mental health.

From the camp setting, it was apparent that there was a high need for mental health services, a need that was not fully satisfied. A close collaboration with all partners would have ensured that all components of implementation were covered.

Provision of SRH services for young people remained low at both camps. There was lack of and/or perceived lack of youth friendly services. Although during crisis room for privacy is limited, there is need to create separate spaces for young people to access their services. In a bid to increase privacy and SRH friendly services, the beneficiaries of the project preferred to have more female community outreach agents. Empowering women to take charge of their issues was seen as a way to increase penetration to the camp.

Due consideration for availability and importance of SRH in crisis would have allowed better outcomes. Although the government was working with partners at the camp the policy environment is a hindrance when it comes to comprehensive service provision. Organizations can only provide services within the allowed restrictions of the Ethiopian government. For example, to increase the number of institutional deliveries, health facilities would have been decentralized to allow women living far from the available health centers to have increased access to health services. Women interviewed at the camp presented a strong preference for home deliveries as opposed to institutional delivery.

It was estimated by MSF and IMC that slightly over 40% of the deliveries were done at home. Systematically addressing the challenges that the pregnant women faced such as distance and breaking cultural barriers would be important in increasing institutional deliveries. A good number of women reported that the health facilities lacked SRH friendly services. The project was keen on improving SRH friendly services and in some cases intervened on behalf of the clients. A more meaningful collaboration by the government with the partners would have increased the possibility of not only increasing institutional deliveries but also providing having comprehensive and integrated SRH services at all the camps.

Conclusion

On commencement it is necessary to conduct a rapid assessment to establish the baseline. Provision of HIV services as part of the integrated package was not well covered largely due to stigma attached to the disease and ignorance. Provision of SGBV services was also weak due to confidentiality and cultural issues; a better understanding of the same would have achieved a meaningful intervention.

Potential Limitations

We would like to acknowledge a few limitations of these data. This was a project based paper, data collected was based on self-reporting and a post emergency review. The perceived benefits of the project were reported by the beneficiaries, program management staff and partners. In the absence of a full scientific research, all outcomes of the project cannot be fully attributed to the interventions of one partner.

The end of project implementation assessment was conducted by the managing organization on behalf of its donor, in this case IPPFAR, despite the fact that the tools and guidelines were followed for the assessment, we acknowledge some level of bias of either over reporting or under reporting during the interviews.

References

1. International Medical Corp (2014) End of project report. The Complementary Emergency SRH Interventions for South Sudanese Refugees living in Kule and Tierkidi camps in Gambella, Ethiopia.
2. UNHCR (2015) Population profile of camps in Gambella.
3. UNFPA (2013) women and girls at the centre.

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