



Inclusion of Sexual and Reproductive Health in Managing Humanitarian Emergencies in Senegal

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Abstract

Introduction: The humanitarian emergency (HE) management requires coordination that often integrates insufficiently sexual and reproductive health (SRH). The objective of this study was to assess the incorporation of SRH in managing HE (SRH/HE) in Senegal.

Method: The evaluation focused on the past 15 years. Interviews with key informants were conducted at three ministries (Health and Social Welfare, Interior, Armed Forces), the Executive Secretary of the National Council for Food Security, three UN agencies (WHO, UNICEF, UNFPA), and three health districts. The review analyzed nineteen national planning and/or programming documents.

Results: Senegal has faced various emergencies: floods, locust invasions, climate change (back to shore), sinking of the boat *le Joola*, and explosion of an ammonia tank in Dakar. In the management of these emergencies, the SRH was considered only for floods. Staff trained on the minimum initial service package (MISP), moved, was not replaced. Preparatory activities were insufficient, and community approaches weak and misdirected. National planning and programming documents neither took into account the preparation of the actors nor the establishment of procedures and forecast resources. Decentralized contingency plans in the regions have neither planned mobilizing additional resources nor training on the topic.

Conclusion: The preventive logic requires taking a definitive account of the SRH in HE management in Senegal. Recommendations were, especially but not exclusively, well targeted for the Government and the civil society, technical and financial partners, as well as institutions and training schools.

Keywords

Humanitarian emergency (HE), Sexual and reproductive health (SRH), Minimum initial service package (MISP), Evaluation, Senegal

Introduction

During humanitarian emergencies, deliveries often take place outside of health facilities. Because of the lack of obstetric and neonatal emergency services, the number of preventable maternal and neonatal deaths increases. Sexual violence is more frequent. Women and girls are particularly vulnerable to rape, which can cause, not only early and unwanted pregnancies, but also spread sexually transmitted infections (STI). Thus, in any emergency, it is important to implement, as soon as possible, the minimum initial service package focused on sexual and reproductive health (MISP/SRH) [1]. The MISP/SRH is a limited set of services essential to the immediate management of priority needs. It has five objectives: 1. Coordinate the implementation, 2. Prevent violence and provide assistance to victims, 3. Reduce the transmission of STI/HIV, 4. Prevent excess morbidity and maternal and neonatal mortality, 5. Plan the integration of complete RH services into primary health care.

Sub-Saharan Africa regularly deal with humanitarian emergency issues which vary by country (Figure 1). Senegal, politically stable with a young population (51.4% under 20 years old), remains exposed to potential risks (unemployment, migration, terrorism). Successive humanitarian emergencies have been managed. There are national planning and programming documents. However, the level of integration of SRH in the management of these emergencies remains unclear. This could negatively impact the effectiveness of the management of problems associated with SRH during future humanitarian emergencies (HE).

The objective of this evaluation was to make a critical assessment of the degree of integration of the component "sexual and reproductive health in humanitarian emergencies (SSR/HE)" in all stages of the planning cycle of health services, projects and programs, to formulate recommendations focused on its improvement in Senegal.

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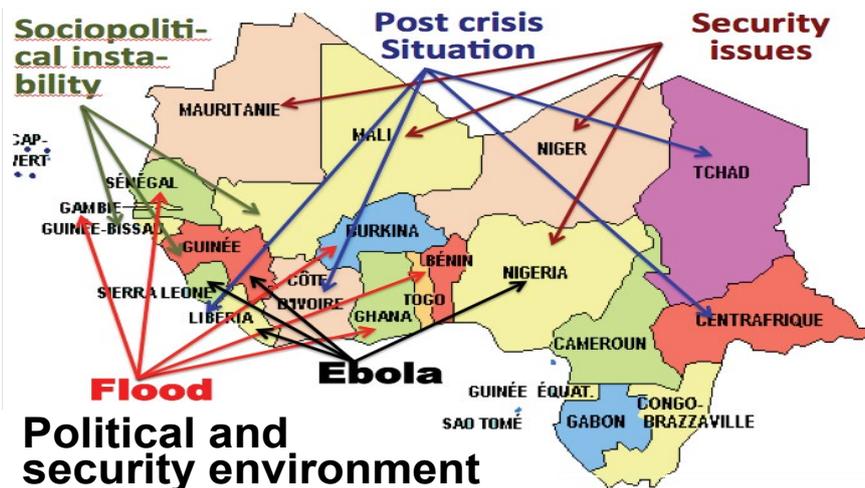


Figure 1: Major problems related to the environment in Sub Saharan Africa.

Box 1: Semi-structured interview guide.

1. The place of the structure in crisis management
 - Missions of the structure
 - Structure's activities
 - Organization of the structure
 - Interventions of the structure in humanitarian emergencies
 - Work plans and procedures of the structure
2. Knowledge of the standards and recommendations on SRH
 - Training of actors of the structure on the management of the SRH in humanitarian emergencies
 - The place of SRH in the work plans and procedures of the structure
3. Experience in emergency management and integration of SRH
 - SRH problems experienced during interventions in humanitarian emergencies
 - Management of SRH issues
 - Lessons learned
 - Prospects for improving the integration of SRH in the interventions of the structure in humanitarian emergencies

Box 2: List of interviewees.

Mbour's Deputy Prefect
 Health Programme Manager, Directorate of Health Service, Chief of General Staff of the armed forces
 Responsible for reproductive health programs UNFPA
 Head of the Division of Child Survival - Acting Director of DSRSE
 Head of the health and child survival section at UNICEF country office
 Establishments bureau head classified in the Directorate for Civil Protection
 Head of the Monitoring Office (measles elimination) / EPI WHO
 Commander of the 42nd Company of the National Fire Brigade
 Advisor to the DGS General Manager providing technical coordination
 SRH technical advisor of the General Director of Health
 Councillor MNCH / Gender at WHO
 Coordinator of the Emergency Operations Center
 Joal's Health District reproductive health Coordinator
 Thiadiaye's Health District reproductive health Coordinator
 Joal's Health District Midwife mistress
 Joal Health District Chief Doctor
 Thiadiaye's Health District Chief Doctor
 SRH Focal point in humanitarian crisis of UNFPA country office
 Executive Secretary of the National Council for Food Security

Framework and Survey Methodology

Framework

Senegal, the western most country on the African continent, covers 196,722 km². The health system has a pyramidal structure with three levels. At the top, the central (The Minister's office, departments and other domestic services) formulates guidelines and health policy. At the intermediate level, the medical region reflects the national policies in regional strategies. Basically, the operational level, called health district (a health center and satellite posts) runs health programs. The country is divided into 14 regions and 76 health districts. In 2014, the fertility rate was 5.0 per woman and the population growth of 2.56 %. The population increased from 6,896,000 in 1988 to 14,354,690 in 2015 and will reach 32,932,000 in 2050 and 58,180,000 in 2100 [2].

Survey

The approach combined a survey and a literature review.

The objective of the survey was to determine the experiences concerning the integration of SRH/HE in the management of humanitarian emergencies. It was conducted through semi-structured interviews with key informants identified beforehand at different levels (Box 1). The Ministry of Health and Social Action, the Directorate General of Health, the Department of Reproductive Health and Child Survival, as well as the emergency operations center were visited. At the interior Ministry, the Civil Protection Department and the National Fire Brigade were visited. At the Ministry of the Armed Forces, it is the Directorate of the Armed Services that was visited. Furthermore, the investigation team went to the Executive Secretariat of the National Council for Food Security, at three UN

agencies (WHO, UNICEF and UNFPA) and at three health districts (Joal, Mbour and Thiadiaye). Interviews with key informants were based on a semi-structured guide, specially prepared for the occasion (Box 2).

The literature review had two different objectives. One was to make an inventory of major emergencies that Senegal has experienced over the past 15 years. The other was to investigate aspects related to Sexual and Reproductive Health (SRH) and then to extract, in the context of Humanitarian Emergency (HE), the components of this theme in collected working papers [3-21].

Limitations

Data collection has not covered all ministries. It was hampered by the unavailability of certain authorities and officials, due to short schedule. This was offset, in part, by analyzing the documents collected on the occasion. Similarly, some surveyed institutions were not in conditions to share their activity reports, their annual work plans and procedural manuals. These deficiencies have been diminished by a discussion of the content of these documents during interviews that were not referenced here.

Results

Major emergencies in the last 15 years

In Senegal, the story is punctuated by various accidents, calamities and disasters. The floods of 2003, 2004 and 2013 affected several areas

Table 1: Donation to the Mbour hospital, the health centers of Joal, Mbour and Thiadiaye (Thiad.), and the counseling center for teenager(s) and youth(CC/TY).

Kits	Mbour Hospital	DISTRICTS			CC/TY	TOTAL
		Joal	Mb.	Thiad		
Simple deliveries	5	15	15	15	0	50
Sexual + transmitted diseases	0	1	1	1	2	5
Complicated deliveries	1	1	2	1	0	5
Complication of abortion	1	1	2	1	0	5
Traumatism of cervix/vagina	1	1	2	1	0	5
Caesarean	1	0	0	1	0	2
TOTAL	9	19	22	20	2	72
Dignity	0	300	400	300	0	1000

Table 2: Services offered at Mbour's hospital, Joal, Mbour and Thiadiaye (Thiad.) health centers, and at the counseling center for teenager(s) and youth (CC/TY).

Offered Services	Mbour Hospital	DISTRICTS			CC/TY	TOTAL
		Joal	Mbour	Thiad.		
Simple deliveries	0	344	36958	1429	0	38731
Complicated deliveries	738	0	2905	38	0	3681
Caesarean	295	0	0	14	0	309
Condoms	0	1000	36000	576	24000	61576
Consulted youth	0	125	630	98	1970	2823

and caused more than 250,000 victims, with serious damage to people and property. Locust invasions (1988 and 2004) caused considerable damage to thousands hectares of crops. The sinking of the ship “*le Joola*” in 2002 resulted in the death of nearly 2000 people. In 1992, the explosion of an ammonia tank in Senegal’s oilseeds national marketing company, left 30 dead and hundreds injured. Fires in markets, between 1993 and 2005, caused more than 10 billion of losses on traders’ goods. Unseasonal rain, in January 2002, caused over 30 billion CFA francs of losses on agriculture and livestock. Cholera epidemics have caused, in 2005, 4838 cases including 64 deaths (1.32%) and in 2007, 2231 cases including 12 deaths (0.53%).

Sexual and reproductive health consideration

In Senegal, the SRH is not yet taken into account by the National Health Development Plan. The need to transition curative actions towards preventive strategies has been the source of several institutional reorganizations. Thus were established, different plans (national contingency plan, food resilience plan) and organs such as the health emergency operations center. SRH/HE hasn’t been specifically mentioned in any of these plans. The missions essentially revolve around four general points: defining preventive and curative support measures, coordinating the actions of various stakeholders involved in emergency management, supervising field operations focused on the management of HE, liaising between stakeholders for a better efficiency of operations.

The only specific actions were carried out with the support of UNFPA in response to the floods; what is perceptible to all three phases of humanitarian emergency.

Pre emergency phase: The primary scope of SRH in an emergency situation was not taken into account in the management plans, neither in the Ministries, nor at the UN agencies, and even less in the health districts. Half of the staff trained on the issue was moved and not replaced.

Emergency phase: The rescue organization plan provides for adjustments, in the new decree of organization and in the procedural manual, for better involvement of relevant sectors, including SRH, following the establishment of a “mother-child emergency cell”.

Resettlement camps for flood victims had not taken into account the SRH component, so the MISP was not in place. Mobilized soldiers, policemen and firefighters received any specific training on detection and management of sexual violence to which they happened to face.

Post emergency phase: After the floods (2003 and 2004), 11 districts (Bakel, DiankéMakhan, Fatick, Goudiry Kidira Koumpentoum, Maka Coulibantan, Mbour, Tamba, Thiadiay, and Thies), were supported by UNFPA on account of four workshops intended for the training of reproductive health coordinators on MISP. The program consisted of five (5) modules: 1. Sexual and reproductive health and humanitarian emergency (SRR/HE), 2. Coordination of the Minimum Initial Service Package (MISP), 3. Gender-based violence, 4. HIV & STI prevention, 5. Maternal, newborn, and child health. In support, kits were given (Table 1). Different services were provided (Table 2). However, decentralized contingency plans had neither foreseen mobilizing additional resources or training nor capacity building for health stakeholders in the management of SRH/HE problems.

Discussion

External and internal environment

The relative stability of Senegal should not overshadow the risk of humanitarian emergency emergence or import. Accidents, calamities and disasters have as risk the insecurity and displacement of populations, thus facing more unmet needs for sexual and reproductive health. They are serious threats that may, in case of occurrence, compromising the expectations of the demographic dividend and development efforts, and push the affected populations (particularly women and children) in vulnerability.

Evolution of interventions: The need to move from curative actions towards preventive strategies has been the source of several institutional reorganizations. Thus were created, various plans (national Contingency plan, food resilience plan) and organs such as the Center of Health Emergency Operations [3-5]. The missions, essentially, focused on four points: 1. Define preventive and curative measures; 2. Coordinate the different actors involved in emergencies management; 3. Supervise field operations focused on the humanitarian emergencies; 4. Liaise between actors for better operations’ efficiency.

Answers provided

The inclusion of SRH component was observed only for floods. It is limited to three actions: kits donations to affected districts; capacity building of some players; and service offering. Donations have targeted a single hospital (Mbour), three health centers (Joal, Mbour, and Thiadiaye) and an advice center for teenagers and youth [6]. It was the same for the supply of services. The gaps identified in the management focused on each of the three phases (before, during, and after) of humanitarian emergency.

Pre humanitarian emergency phase: At the Ministry of Health and Social Action (MHSA), the General Health Directorate is mainly based on the National Health Development Plan. SRH/HE was not taken into account in the guidelines. At the Department of Reproductive Health and Child Survival (DRHCS), documents and work plans (multispectral road map to accelerate the reduction of maternal and neonatal morbidity and mortality from 2006 to 2015, strategic plan for reproductive health 2012-2015, annual work plans 2015 and 2016) didn’t take SRH/HE into account. In health districts, Annual Work Plans, developed since 2013, have not included the preparation and implementation of activities integrating the MISP to SRH. Training activities on the MISP were carried out in 2010. However, over 50% of trained actors are assigned elsewhere [7-14].

Preparatory activities are insufficient. Interventions of DRHCS are mainly related to routine services. They focus on the managerial capacities of actors in the SRH, service availability, and ownership of the SRH by the community. In case of emergency, these activities will certainly have an effect, but services could be overwhelmed

and precariousness may emerge, if any preparation for a better consideration of the SRH/HE is previously made. The Center of Health Emergency Operations represents the body of the Ministry of Health and Social Action responsible for defining the emergency measures, coordinate actors and supervise field operations to any health emergency. It had not yet taken into account the SRH in developing its health emergency management procedures.

Humanitarian emergency phase: The Relief Organization plan has trigger, implementation, and lifting conditions set by the Interior Ministry. It is planned, prepared, implemented and coordinated by the Civil Protection Department. The inclusion of vulnerable groups (children, women, the disabled) among the victims is provided in the new organizational order and the procedural manual. These adjustments also provide for better involvement of different sectors involved in field operations, including the SRH with the establishment of a “mother-child emergency” cell [3-5].

So far, planning and programming documents didn't take into account, neither the preparation of the actors, nor the establishment of procedures and projected resources to deal with any humanitarian emergencies. The Civil Protection Department has developed several documents (including contingency plans). However, none of these documents has addressed the distinction of vulnerable populations among the victims, much less specific aspects to SRH. At the the Ministry of Health and Social Action, actors of the General Health Directorate have not been trained in SRH/HE. Thus, during the floods, the resettlement camps for the victims have not integrated SRH, so the minimum initial service package (MISP) was not in place. The organization of these camps has not integrated mobile interventions strategies as part of SRH for women and children. In emergencies, the national police ensure safety and security of the affected areas, the National Fire Brigade (NFB) performs interventions (emergency assistance and rescue operation) and militaries are deployed in several theaters. However, mobilized agents received no specific training on detection and early treatment of sexual violence, which they sometimes face [15-17]. At WHO as at UNICEF, SRH/HE training hasn't been made for any member country offices. Emergency management, in aggregate form, is mostly limited to the acute stage and does not take into account the priority dimension of the MISP. SRH/HE has not been taken into account, neither in plans, nor in training, much less in the strategic device. The establishment of committees for outbreak management didn't take into account the SRH so that the DRHCS was not represented. The last major actions focused on the Ebola virus disease and E hepatitis. Ebola virus disease prevention and control strategies against hepatitis E have offered no specific support for the SRH / HE [18].

Community-based approaches are weak and misdirected. In the health districts of Mbour, Joal and Thiadiaye, the 2013 floods have led to the outbreak of the Relief Organization Plan. Interventions were mainly oriented to the drainage and the resettlement of victims. The floods were interspersed with an increase in health problems related to sexuality and reproduction. Indeed, isolation and inaccessibility of some areas have hampered access to health facilities, and prevented outreach activities. This caused an increase in home deliveries, under-utilization of antenatal consultation services, maternal and child morbidity (or even on mortality). Several cases of raped women and girls were also noted in affected areas. No report has documented the effect of the floods on SRH, no strategy has been adopted to act, on the one hand, against sexual violence in general, rape in particular, the spread of STIs and HIV/AIDS infection and to reduce, on the other hand, the frequency of home births and the morbidity and maternal and infant mortality [19,20]. The Executive Secretariat of the National Council for Food Security coordinates the fight against vulnerabilities related to food safety. It is organized by national, regional, departmental, and local committees; each of them has a participatory and inclusive approach based on gender, taking into account the SRH dimension [21].

Post humanitarian emergency: An even lower number of workshops on the MISP, four in total, allowed the training of some

reproductive health coordinators for some districts. Some of these districts were then drawn up action plans to better prepare for a new emergency. However, none of these plans has been integrated with an annual work plan. New medical officers were affected, but none of them were aware of the existence of these action plans. Contingency plans are decentralized to the regions. Each region, thus, has the opportunity to plan its interventions in perspective. However, no plan for mobilizing additional resources, or training and capacitating health actors on SRH/HE has been developed [6,8].

Recommendations

The management of humanitarian emergencies must go beyond coping responses to focus more on prevention strategies, taking into account the minimum initial service package for sexual and reproductive health (MISP/SRH). The recommendations in this regard, targeted primarily, but not exclusively, the Government and the civil society, the technical and financial partners, institutions and training schools.

To the Government and the civil society: concerning the pre emergency phase: advocate for the integration of sexual and reproductive health in humanitarian emergency (SRH/HE) in different national programs during the meetings with policymakers and in the Ministries; Advocate for the introduction of the MISP in basic training programs; Integrate SRH/HE in the priorities of services in charge of preparing the response to crises and disasters at national level. Regarding the emergency phase: Involve health actors in the preparation and the response to crises and disasters, even unsanitary, at the operational level; and document the inputs, outputs and impacts of the implementation of the MISP/SRH.

As for the post emergency phase: share experiences on the MISP/ SRH with declining humanitarian emergency management with stakeholders; take the lessons learned to be more successful for SRH consideration in the subsequent management of other potential humanitarian emergencies.

To the financial and technical partners: For the pre emergency stage, support the mobilization of resources for taking SRH/HE preventive and curative problems. For the emergency phase, strengthen collaboration between partners for joint interventions focused on collecting data on SRH in HE management. For the post emergency phase, develop, with civil society, a partnership based on experiences, for a better management of any other humanitarian emergencies.

To universities, schools and training centers: Insert the MISP in basic education programs, train health actors on MISP/SRH SSR at all levels of the health pyramid.

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