SEXUAL & REPRODUCTIVE HEALTH

A medical and political approach based on public health and human rights
Every day in the world, around 800 women die of complications related to pregnancy or delivery (WHO, 2012). Yet almost all these deaths could have been avoided, using simple means. 13% of these deaths are a result of complications related to abortions carried out in poor conditions. 215 million women would prefer to delay or avoid pregnancy but do not always have access to safe and effective contraception.

In 2012, more than 200 million women worldwide have an unmet family planning need.

Médecins du Monde (MdM), the international medical and humanitarian organization, provides care to the most vulnerable populations in the world, and victims of armed conflict and natural disasters caring for those whom the world is forgetting. As an independent non-governmental organisation, Médecins du Monde is engaged in action beyond the provision of medical care. It denounces situations in which human dignity is in danger and works alongside populations in their struggle to improve their situation. For thirty years, MdM has been active in projects related to Sexual and Reproductive Health (SRH). By the term SRH we mean “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes […]”

Over the last twenty years, both governments and international institutions have eventually given the needed political priority to SRH. Several agreements, adopted by a number of countries, bear witness of this commitment and provide a strategic framework in which SRH projects can be implemented. MdM relies on this framework to bring about the recognition of sexual and reproductive rights, in the areas where they intervene.


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WHAT IS IT ABOUT?

An Approach to Public Health based on Respect for Human Rights

In an international context where women’s rights come increasingly under threat, certain fundamental principles, such as those set out in the Beijing Declaration and Platform for Action Programme (1995), appear to have been challenged. A great majority of women have no access to quality healthcare (either because they are unavailable, inaccessible or even illegal), with terrible consequences in terms of public health.

MdM advocates that these founding agreements and protocols on human rights and in particular those related to sexual and reproductive health, be brought into application. In this respect, MdM actively supports the right of women to dispose of their bodies as they wish, to choose whether or not to have children, and decide on how many children they want and at what intervals.

SRH is not limited simply to maternal health, rather “[it] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.1"

MdM’s commitment is centred on two main areas of activity: providing holistic, fair, accessible and quality medical care and advocating for sexual and reproductive rights.

These are in keeping with the 5th Millennium Development Goals (MDG), which aim to reduce maternal mortality ratio by 75% and ensure universal access to reproductive health by 2015. MdM’s action also contributes in part to the Muskoka Initiative (taken at the G8 Summit in 2010), which sets out the objective of reducing the number of deaths among mothers, newborn children and children under the age of five in developing countries, by strengthening national health systems and making quality healthcare available.

1. International Conference on Population and Development, Cairo, 1994; program of action adopted by 179 countries
An Approach founded on the Reduction of Gender Inequality

"Gender is a constitutive element of social relationships based on perceived differences between sexes, and gender is a primary way of signifying relationships of power."
Joan W. Scott, 1988

Gender inequality is manifest in the disparity of access to education, healthcare, work opportunities and a decent salary, and to positions of responsibility and political office. Fighting these inequalities means calling into question the distribution of roles and activities taken on by men and women, with the aim of reaching a balance in the relationship between the sexes. MdM aims to reduce the inequality between the sexes, in particular where access to healthcare services is concerned, but also to promote the freedom of women to make decisions that will affect their health and the health of their families.

"...the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields."
The Convention on the Elimination of All Forms of Discrimination against Women (United Nations Assembly General, December 1979)

Gender inequality is a major obstacle to the respect of sexual and reproductive rights and in the access to healthcare. Recognising these rights implies gender equality, the recognition of the existence of different sexual orientations, the participation in the fight against gender-based violence, people trafficking and sexual exploitation. Sexual and reproductive healthcare offered as part of MdM’s healthcare projects are considered a privileged way to be able to identify abuse early, providing victims with the necessary treatment, and referring women to appropriate care.

The three-tiered gender approach consists of:

- **A concept:** the gender approach analyses the power relationships between men and women based on the roles that have been designated and constructed by society according to sex;
- **An objective:** it promotes equal rights, as well as the fair sharing of resources and responsibilities between men and women;
- **A methodology:** it produces a comparative analysis of men and women's situations, as much from an economic point of view as a social, cultural and political one. It is a cross-cutting approach and deals with all fields of development.
INTERVENING WITHIN WHAT FRAMEWORK?

A Continuum of Care within Time and Space

MdM supports the notion of an inclusive long-term Continuum of Care, which can allow patients to receive follow-up care, in the community- and local health facilities and referral services. For this, an efficient system of referrals needs to be in place. Over time, this system allows both preventative and curative care, leading to a reduction in mortality and morbidity rates. It provides guidance and follow-up to women and their families and promotes life-long health.

Enabling easier access to healthcare services and encouraging a respect for rights to healthcare are essential for reinforcing the Continuum of Care. For this purpose, three aspects have to be taken into consideration: geographical barriers (distance to services, absence of means of transport); financial barriers (prohibitive cost of services); sociocultural determinants (little or no decision-making powers, no freedom of movement or financial management by women, etc.), which could impede access to healthcare services. For this reason MdM favours initiatives that could lead to these barriers being removed.
Setting up Partnerships and Community Participation

The different SRH services have to work closely both between themselves and with the primary healthcare services. In this way, MdM can intervene to support and reinforce public healthcare systems and guarantee access to the right to health.

In order to ensure the Continuum of Care as a whole: MdM works to mobilise and promote regular contact between all the different actors by working in partnership with local organisations – run by women and professionals – together with community-based organisations and health authorities.

Moreover, the active participation of the community is an essential element in guaranteeing that projects are accepted, remain accessible and maintain standards of quality. Community participation in SRH services is key to promote and bring about long term change. Joint actions help to guarantee a response that is adapted to the needs of the target population and lead to the removal of the various barriers to access to healthcare. It also guarantees that these activities not only become sustainable but also help to empower the population, in particular women, so that they can gain greater control over their health.

Diagram of the SRH answer taking barriers to health care access into account

- Social and cultural barriers
- Economic barriers
- Geographical barriers

Referral Hospital ➔ Quality Healthcare
Primary-level health facilities ➔ Quality Healthcare
Community/family ➔ Quality Healthcare

In Nepal, many groups are organized to discuss sexual and reproductive health matters.
Nepal © Stéphane Lehr

SEXUAL AND REPRODUCTIVE HEALTH (SRH)
WHAT ARE THE BATTLE LINES?

In addition to the medical response on the ground, MdM’s action focuses on two main advocacy areas:

Prevention and Care of Unwanted Pregnancies

In 2008, it was estimated that 40% of pregnancies were unwanted. Around 42 million abortions are carried out every year, of which 22 million are carried out in unsafe conditions, most of them in developing countries. Médecins du Monde actively supports the right of women to choose whether or not to have children, the number of children and the spacing between births. Every woman should be able to have access to contraceptive methods to avoid an unwanted pregnancy and to a legal, safe voluntary termination of pregnancy, if needed. This goes hand in hand with a reinforcement of health services and advocacy campaigns in favour of these rights.

In Latin America, 97% of women live in a context in which the laws governing abortion are very restrictive. MdM works in close association with various actors (civil society and health professionals) in seven countries in the region in order to share experiences and advocate “access to safe and legal abortion”. MdM would like to extend this campaign beyond the continent of South America and Caribbean, particularly in Africa and Asia.

Removal of the Financial Barriers to Healthcare

In low-income countries, being able to afford healthcare represents a heavy obstacle to access to healthcare, particularly for the most vulnerable families. The cost of a Caesarean section or even emergency transport to hospital in the case of obstetrical complications is often unaffordable for the majority of households and justifies the setting-up of fairer and solidarity-based financing mechanisms.

Conscious of the need to support functional and accessible healthcare systems for the most vulnerable, MdM is in favour of removing these financial barriers and recommends the adoption of public policies which would establish free access to primary healthcare at the point of use. In particular, the organisation supports policies which exempt payment for healthcare by pregnant women and children under five. These so-called “free targeted healthcare” policies have been developed to a great extent over the last ten years in developing countries and constitute an important first step in the gradual establishment of universal health coverage.

In Mexico, MdM works with migrant sex workers women on the prevention of unwanted pregnancies.

Mexico © Michel Redondo
In France, the facilities for the prevention, treatment and care in the area of sexual and reproductive health exist already, and are in theory free of charge and available to everyone. However, the healthcare, advice and referral clinics run by MdM receive a number of women with worrying socio-economic indicators.

In 2011, only a third of women who came to the 21 MdM’s clinics were living in stable housing, 96% had no medical insurance coverage, 45% of pregnant women who received their first consultation were late starting their antenatal follow-up and 40% had already experienced or were still experiencing problems related to their pregnancy. The women, when they come to MdM, are already in a vulnerable situation due to their situation of deprivation, have little or no knowledge of the rights or entitlements available to them, and find it difficult to find their way around this health system.

MdM’s mediation programmes, (in Nantes), enable women to be informed and be given assistance in finding a suitable health facility, whether this may be for pregnant women to get some follow up care or for delivery, or for patients requesting contraception or termination of pregnancy. Consultations by gynaecologists and/or midwives are available in the clinic in Saint Denis (Paris) or are conducted as home visits (as in Bordeaux). The clinics also offer health education either individually or in small groups regarding pregnancy, breast-feeding, abortion, family planning and sexually-transmitted infections (STIs).

SRH activities have also been developed in projects to support sex workers, both men and women (as in Nantes or Paris), as part of a harm reduction policy (through preventive measures against STIs, AIDS and hepatitis, handing out condoms and giving information on what to do if a condom breaks during intercourse etc.). Information is also given on the risk of unwanted pregnancy, on termination of pregnancy and so on.

Through its projects MdM advocates a more equitable system of health that consists of:

- Developing the network of professionals (in maternity clinics, family planning centres, networks for perinatal care etc) in order to give patients access to a suitable-reception, guidance and quality healthcare.
- Building up teams which can reach out to women where they live (in squats, rough housing areas etc) or at their place of work (in the case of sex workers);
- Making the complete package of healthcare (information, prevention, screening, follow-up and treatment) available to the wider public.
Implementing a Continuum of Care in a Post-Conflict Situation

In a context of political and social reconstruction, the current health system in Côte d’Ivoire has to overcome a considerable number of obstacles to be able to offer quality healthcare to every member of the population. After ten months of free healthcare for all, the government decreed in February 2012 that free healthcare would only target pregnant women and children under the age of five. These policy decisions, although welcome as part of the effort to lower the financial barriers to healthcare, have not been supported by adequate funding to be fully implemented.

In the south east of the country MdM is supporting the health authorities at the district and regional level to improve the implementation of these targeted exemptions.

The main objectives are to reinforce and improve the quality of care all along the continuum of care, with a special focus on maternal death audits at the hospital level and pilot activities for referrals of emergency obstetric complications.

At the national level, MdM is carrying out lobbying activities not only to make sure that the current policy is adequately supported but also in the future to include new SRH services in the free package.
SAHEL

REINFORCING WOMEN’S FINANCIAL ACCESS TO HEALTHCARE

Health indicators for the three countries of the region covered by MdM’s regional programme, Mali, the Niger and Burkina Faso, show that little progress has been made and that the Millennium Development Goals (MDG) are unlikely to be reached by 2015. Limited access to primary healthcare is the main cause of this, notably due to the economic barriers in place.

The principal areas of MdM’s work lie in the improvement of access to care in both financial and geographical terms; the improvement of the quality and organisation of services; and the promotion of new and fairer policies in terms of financing healthcare. Pilot projects have been developed in Burkina Faso and the Niger to allow patients access to free deliveries; and in the Niger, to develop innovative financing mechanisms based on solidarity for emergency referrals, which are not currently covered by the national policy of exemptions. To guarantee the sustainability, the central role in terms of financing and managing these solidarity based funding mechanisms has been given to the local authorities.

As a result of this experience led by MdM, the health authorities are looking to scale up the policy of access to medical care, for which progress has been reported in the Niger and Burkina Faso. In 2012, basic and emergency referrals showed encouraging signs of being on the rise, up by 41% and 53% respectively in Koro and Keita, two of the districts in Mali and the Niger where MdM is active.

However, MdM’s activities remain vulnerable to the increasing decline in the security which has led to heightened vigilance in this respect and some activities having to be adapted, without having to compromise, in being able to carry out its activities.

NIGER ILLÉLA

ADVANCING FAMILY PLANNING THROUGH RELIGIOUS LEADERS

In Niger, the total fertility rate per woman is above 7 and the unmet needs for family planning remain high. If women had wider access to FP services, the maternal mortality, which is still very high, would be considerably lower. The country introduced a system of free FP services in 2006. Nevertheless, efforts are still needed to support the supply side (outreach activities, supply chain, training health professionals…) and to increase the demand by working with the population, in a context where there are a lot of misconceptions regarding family planning included to be contrary to religious principles.

MdM works to support the district health systems of Illéla, in the Tahoua region, thanks to an innovative project, which involves identifying and raising awareness among 275 local community leaders, broadcasting programmes on birth-spacing and skilled care at every birth and producing a series of religious-based arguments to highlight the risks of underage pregnancies, preaching caravans etc. In this context, religious leaders have become the inevitable actors in the process, not only in the promotion of family planning and nutritional practices, but also on the subject of health and rights for women and children. Working with religious leaders also means involving men, who are more often the decision-makers, even in areas concerning family health.

This work is carried out by the ‘School for Husbands’, an initiative put in place by UNFPA and the NGO Songe-ES-Niger, and taken on and supported by MdM.
The current health system in Chad has to face up to a chronic shortage of human resources in the health sector which, together with economic difficulties and cultural factors, explains the under-use of health services and particularly in the area of sexual and reproductive health. The women of Chad have very little access to antenatal and obstetrical care. Poor care or the absence of adequate care of complications during labour are important contributing factors that explain the appearance of obstetric fistula, generally associated with prolonged labour. This condition leads to chronic incapacitating incontinence which can be easily prevented if labour takes place in the presence of qualified staff, but which, if allowed to develop, will require high tech surgery to be treated. MdM has been present in the semi-desert region of Kanem since 2009, and works in support of the health authorities at the regional and district levels. While offering support to 10 health facilities both in the rural areas and at the hospital in Mao, the regional capital, the project’s activities aim at reinforcing knowledge amongst the population as to the causes of these fistulae and of the importance of SRH services. The goal is also to improve the quality of maternal and postnatal healthcare within the Continuum of Care as a whole. This includes setting up antenatal follow-ups, a system of referrals for obstetric emergencies as well as the training of Chadian doctors to be able to treat emergency obstetric care and obstetric fistula.

**PREVENTION AND TREATMENT OF OBSTETRIC FISTULA**

**PROVIDING QUALITY CARE IN AN EMERGENCY SETTING**

MdM provides quality care in an emergency setting. The aim of the project is to improve the access to maternal and child healthcare both for the vulnerable among the host population and for internally displaced. MdM supports five mother and child health centres, (through renovation, setting up a system of referrals for obstetrical emergencies as well as providing quality care in an emergency setting). All five centres are located in the semi-desert area of Kanem and in the camps for the displaced population in the surrounding areas. MdM works in partnership with the Ministry of Health and a local NGO, Integrated Services for Displaced People (ISDP). In January 2013, MdM renovated the maternity wing of the general hospital of Bossasso and built a sixth health centre. The challenge is to put in place quality SRH activities without being affected by the constraints brought about by the prevailing emergency situation (dysfunctions in delivering medicines especially contraceptive methods, inadequate or insufficient infrastructure, lack of human resources; and the rapid turnover of medical teams).

**SOMALIA/BOSSASSO PUNTLAND**

Laos

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**PROVIDING QUALITY CARE IN AN EMERGENCY SETTING**

MdM intervenes in the State of Puntland in the north-eastern part of Somalia, in an environment which is as unstable as it is difficult to project. The aim of the project is to improve the access to maternal and child healthcare both for the vulnerable among the host population and for internally displaced. MdM supports five mother and child health centres, (through renovation, setting up a system of referrals for obstetrical emergencies as well as providing quality care in an emergency setting). All five centres are located in the semi-desert area of Kanem and in the camps for the displaced population in the surrounding areas. MdM works in partnership with the Ministry of Health and a local NGO, Integrated Services for Displaced People (ISDP). In January 2013, MdM renovated the maternity wing of the general hospital of Bossasso and built a sixth health centre. The challenge is to put in place quality SRH activities without being affected by the constraints brought about by the prevailing emergency situation (dysfunctions in delivering medicines especially contraceptive methods, inadequate or insufficient infrastructure, lack of human resources; and the rapid turnover of medical teams).

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HAITI

REINFORCING THE LINK BETWEEN THE COMMUNITIES AND HEALTHCARE FACILITIES

The healthcare system in Haiti faces a number of challenges, as much by the size and extent of health problems as by the capacity to be able to respond to them. The maternal mortality ratio remains the highest across the continent, which can be explained in part by the high number of unwanted pregnancies and the frequent recourse to illegal abortions (in itself the cause of 30% of maternal deaths). In response to these problems, the Ministry of Health has decided, along with its partners, to establish free healthcare for pregnant women and children under five in a certain number of facilities. However, implementing this policy has been hampered by a number of difficulties (medicine stock outs, limited capacities at the various levels of the health pyramid, etc.).

MdM contributes to strengthening and improving the access of women and new-borns to quality healthcare by their action in the department of Grand’Anse. MdM has been present here since 2009, working with the Ministry of Public Health and the Haitian population, through a constant mobilization of community networks and support to various health facilities. Traditional birth attendants and community-based health workers have been trained to promote the importance of family planning, antenatal care and safe delivery by skilled birth attendants. These networks help to raise awareness among households, guide pregnant women towards health structures at the time of delivery and mobilise communities to allow women in more isolated areas to be transferred to a healthcare structure. This reinforcement of the Continuum of Care has brought about a considerable increase in the number of facility-based births (multiplied by 2.3 from 2011 to 2012) and in the number of antenatal consultations in those supported maternity clinics (thanks to staff training, monitoring, and upgrading the medical equipment).

In addition, MdM assists the authorities in setting up the free healthcare policy and more specifically, has drawn the attention of the health professionals to the importance of guaranteeing access to post-abortion care.

MEXICO

WORKING ALONGSIDE MIGRANT WOMEN, SEX WORKERS

Since January 2011, MdM has been developing a project in the region of the Chiapas to enable migrant women from Central America to have access to SRH care. 44% of the women targeted by the project are sex workers. These women are stigmatised both by their status as migrants and by their professional occupation. As such, they are particularly exposed to sexual violence, unwanted pregnancies and addictions.

MdM works to raise awareness amongst health professionals to improve the healthcare given to these women and reduce discrimination against them. They can then be referred and accompanied if needed to gynaecological services.

URUGUAY

SUPPORTING ADVOCACY IN FAVOUR OF SAFE AND LEGAL ABORTIONS

Uruguay is a pioneer country in that it has developed a strategy to reduce the risks related to unwanted pregnancies, within the restrictive environment that prevails, voting a law in 2012 which has decriminalized abortions. Since 2010, MdM has supported two Uruguayan organisations, who work in the defence of sexual and reproductive rights: an organisation of healthcare professionals called Iniciativas Sanitarias, with whom MdM improve the training and the follow-up of health professionals; and the feminist organisation, Mujer Salud en Uruguay (MySU), whose campaign for the legalization of abortion, MdM supports. The legal obstacle has been partially lifted but a number of barriers still remain to be able to guarantee an actual access to voluntary termination of pregnancy. This project in Uruguay also initiates a dynamic of regular exchanges across the region between women’s organisations, health professionals’ organisations, and MdM projects, about prevention and care of unwanted pregnancies. This is important in a region which is particularly marked by the high rate of unsafe abortions.
In 1994, the Cairo Conference marked a decisive turning point by introducing and defining the concept of sexual and reproductive health. It was no longer a question of maternal health but of "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

GIVEN ITS IMPACT ON PUBLIC HEALTH AND OUR WILL TO PROMOTE RESPECT FOR SEXUAL AND REPRODUCTIVE RIGHTS, SEXUAL AND REPRODUCTIVE HEALTH IS ONE OF MÉDECINS DU MONDE’S PRIORITIES.

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