SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

GUIDELINE
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In 2010, Médecins du Monde (MdM) made access to sexual reproductive health rights and services one of its priorities for action. Ten years later, the maternal mortality and morbidity indicators show noticeable progress however the challenges remain huge, advances are uneven and weak, and conservative opposition groups are still as fierce against women’s and girls’ freedom to decide over their own body and over their sexuality.

Nonetheless, the lines are shifting, mentalities are changing, stakeholders of civil society, health, research, politics, funders are acting towards guaranteeing respect of sexual and reproductive rights around the world for each and everyone. In 2015, the Sustainable Development Goals (SDG) represent a shift from the Millennium Development Goals (MDG) by giving a central importance to the fight against gender inequalities in access to SRH, as per the action programs of Cairo and Beijing. In 2017, the SheDecides global movement is initiated in reaction to the reactivation by the American administration of the global gag rule. A few months later, the Family Planning 2020 global partnership is reaffirmed and widened to new stakeholders including Médecins du Monde. In 2019, the right to abortion finally becomes a reality for women in Ireland and becomes an item of the legislative agenda in the Democratic Republic of Congo as a result of the official ratification of the Maputo Protocol.

This revised version of the Sexual and Reproductive Health and Rights Guidelines, a first version of which was published in 2013, aims at mirroring the structuration of technical and medical expertise, as well as MdM’s political voice in this changing environment, with a constant concern in mind: the quality of our actions for services users and partners. Our vision is based on the belief that access and availability of quality and comprehensive SRH services implies a global approach, integrated in the continuum of care, founded on promotion, respect, and guarantee of human rights, reduction of gender-based inequalities, and empowerment of individuals and communities.

Our expertise and political fights revolve around 3 strategic areas that remain prominent topics given the health indicators and impediments to human rights, in particular those of women and girls in vulnerable and precarious situations:

- Prevention and management of unwanted pregnancies
- Response to needs for SRH services in crisis situations
- Prevention of cervical cancer

Ten years. Our commitment is clear, strong, and sustainable. For each woman and each girl, and more generally for each person, regardless of their gender or sexual orientation to be able to freely decide on their own sexuality, health, and life.

SANDRINE SIMON,
Head of Health & Advocacy Department,
Médecins du Monde

PHILIPPE DE BOTTON,
President, Médecins du Monde
Médecins du Monde (MdM) implements many projects associated with sexual and reproductive health and rights (SRHR). The scope of intervention and approaches provided by our teams to this day are varied. Thus, this guideline document aims at supporting projects in a quality approach by bringing together in a unique document the operational aspects of MdM’s positioning on the topic of SRHR, adapted to contexts of intervention and taking into account international recommendations.

The objectives of this document are:
- To raise awareness on the issues at stake in that field;
- To disseminate and bring to light MdM’s good practices and skills in that area;
- To suggest ideas for reflection and intervention towards the development and implementation of projects or parts of projects in that field.

However, this guide does not provide ready-made solutions to implement activities nor does it provide a response to a lack of access to sexual and reproductive health; those interventions need to be adapted to each context.

A first version of this guide was elaborated in 2013. Given the evolution of the international context in terms of SRHR as well as the operational experience of the organisation with regards to implementation of SRHR strategies, a revised version of this guide was developed in 2019. This version integrates more recent technical recommendations, as well as MdM’s expertise, which has developed through various projects in the recent years. Many actors of MdM were involved in writing and editing this document, so as to include the diversity and richness of experiences that were gained through different intervention contexts with various publics in France and abroad. Specifically, this guide was read and corrected by an expert panel of the topics at hand.

The first part of this document introduces the commitments made by MdM regarding SRH, its principles of action, and the topics of advocacy defended by the organisation. Then, the document suggests a reflection on the barriers to access to healthcare, and how to lift them. Those barriers are then analysed through an intervention context diagnosis which must take into account the specifics of SRH, including the public health impact and the respect of fundamental rights in SRH.

This document contains several thematic sections presenting the continuum of care in SRH as well as certain types of cross-sectional interventions, such as prevention and management of gender-based violence, prevention of cervical cancer, or prevention of vertical transmission of HIV. We also present SRH interventions for populations that require specific attention, such as adolescents, sex workers, LGBTQ+, or migrants.

Throughout the chapters, key concepts for understanding are brought forward, a recommended minimum package of interventions is defined, and examples of planning and implementation frameworks are provided. The MdM list of SRH indicators is provided, and a catalogue of essential generic medications, consumables and equipment are listed in the appendices.

Finally, detailed chapters are dedicated to the specificities of emergency situations and the specificities of our approach regarding reinforcing capacity of action for individuals, communities and partners.

The guide is punctuated with examples from MdM projects in order to illustrate possible intervention strategies and underlining the diversity of contexts and publics that are the focus of our intervention.

The body of documents cited in this guide is available on the Health and Advocacy Department (HAD) intranet page.

This guide is intended for all actors, in France and worldwide, who participate in the initiation and implementation of projects dealing with the issues of sexual and reproductive health and rights. Medical practitioners will find practical recommendations on services to provide as well as tools to facilitate implementation. Staff specialised in advocacy will find key elements in terms of commitment and organisation positioning, as well as examples of implementation strategies for advocacy in various contexts. Moreover, people participating in defining and coordinating interventions (employees and volunteers, in the field or at the headquarters, etc.) may find inspiration in the elements of reflection and support in diagnosis, planning, implementation and monitoring of SRH projects that take into account the overall issues as per a health promotion approach.

With regards to writing throughout this guide, unless specified otherwise, all reference to human beings must be understood as both feminine and masculine.
CHAPTER 1

MEDECINS DU MONDE’S PRINCIPLES OF INTERVENTION
Médecins du Monde asserts its wish to work in favour of universal access to sexual and reproductive health services, which is in line with international and regional texts defining human rights, specifically those relating to sexual and reproductive health and rights (see information box below). Given the values that it defends, the organisation focuses its actions towards vulnerable populations, acknowledging that the notion of vulnerability encompasses various realities depending on context.

MdM commits to developing and implementing interventions that tackle different health inequalities, and fight through these actions against all types of discriminations whether they are based on gender, sexual orientation, gender identity, or those based on social class, age, handicap, ethnicity, religion, or political opinion. Therefore, in projects led by the organisation, MdM aims at taking account of specific needs of individuals, and to fight against discrimination and inequalities. Traditionally, the responses in terms of health are designed looking at the needs of adult men as a universal norm that can be applied to all people, making invisible the specific characteristics of women and LGBTQ+ people, thus reinforcing health inequalities and gender stereotypes.

Gender inequalities accentuate health inequalities, therefore MdM commits to including an intersectional gender approach to all its actions in order to contribute to health equity.

Moreover, regarding SRH, adolescents are a vulnerable group for which particular attention is requested to improve access to sexual and reproductive healthcare services. Indeed, their status as minors adds to their vulnerability and they present an increased risk of developing complications during pregnancy and birth which must be considered; healthcare services must be adapted to this age group. Sex workers also represent a group with specific SRH needs that are often overlooked.

In addition, migrants often face adverse sanitary conditions due to low levels of access to services. As a consequence, MdM works at collaborating with...
people for whom health services are least accessible and works in partnership with existing actors to reinforce healthcare provision in order for isolated populations to benefit from holistic and quality care in sexual and reproductive health.

In areas where crisis or conflicts are punctual or chronic, populations are affected by an impeded access to care through lack of security, disruption of the health system, and/or other barriers to quality healthcare. In these situations, women and children are often the first to be excluded from health systems. As a consequence, MdM considers interventions in the context of a crisis or conflict as priority areas for action.

Médecins du Monde defines its action and its priorities with regards to SHR in accordance with these realities.

Médecins du Monde recognises the importance of holistic care which allows the follow-up of people through the continuum of care, from the community level to referral facilities, and accompanies people throughout the course of their life in the spheres related to sexuality and reproduction.

The identification of the elements of this continuum and the healthcare provision is underpinned by the definition of sexual and reproductive health and rights introduced by the Guttmacher-Lancet commission\(^2\) (see Chapter 1. II. Definitions of key concepts).

Médecins du Monde recognises that, in order to strengthen the continuum of care, an essential aspect is the promotion of access to healthcare services and respect of the right to health.

There are three aspects that must be taken into account to achieve this: geographical barriers, financial and administrative barriers, and sociocultural determinants\(^3\) which can all impede access to services.

For this reason, projects offering sexual and reproductive healthcare services must consider how to promote and strengthen, where appropriate, initiatives that operate to remove these barriers.

With regards to financial barriers, preference will be given to initiatives that allow services to be delivered free of charge at the point of care\(^4\).

Concerning geographical barriers, it is essential to consider the options for referrals between the community, the local healthcare facilities and the referral services.

Regarding legal barriers, advocacy approaches will be taken to implement respect of sexual and reproductive rights.

As for sociocultural barriers, attention given to those barriers will reinforce the adequacy between offer and demand for care. Reflection regarding accessibility of healthcare services should be undertaken jointly between local authorities and local stakeholders, in order to work in synergy and avoid creating parallel, or even contradictory methods of operating.
REFERENCE TEXTS PROMOTING THE RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH

The right to survive pregnancy and childbirth is implicit in the right to life, a fundamental right of women (and of any human being) enshrined in all international and regional texts concerning women’s rights. The exercise of this right by women relies on their capacity to exercise three other fundamental human rights: right to healthcare, right to non-discrimination, and right to freedom of choice in reproduction.

In practice, to have access to SRH, you must first achieve the individual human rights to:
- Freely define one’s own sexuality, including sexual orientation, gender identity, and gender expression
- Decide if and when one wishes to be sexually active
- Choose one’s sexual partner(s)
- Enjoy a pleasurable and safe sexual experience
- Decide if, when, and who to marry
- Decide if, when, and how to have children, and how many
- Have lifelong access to information, resources, services, and guidance in the realisation of the above, without discrimination, constraint, abuse or violence.

All those rights are written in commitments taken by the international community and ratified by the States. Whether they are treaties, conventions or declarations, these texts are the legal international and regional framework for protection in relation to sexual and reproductive rights. The State parties commit to do what it takes to make that right substantive. They must therefore fulfil some obligations. Hence, monitoring and control mechanisms are there to ensure the States respect their commitments. In addition to this, for some States, there are possibilities to file individual complaints. To make governments accountable for the realisation of those rights is a powerful mean to overcome the acceptance of death during pregnancy and childbirth as an inevitable risk associated with the feminine condition.

The international conventions on protection of human rights do not specifically refer to Sexual and Reproductive Rights, but the latter are rooted in imperative and universal human rights.

Sexual rights have emerged little by little at global conferences on human rights and development, with the aim of protecting women. Human rights must be respected, protected, and achieved. They are universal, inalienable, indivisible, and interdependent.

INTERNATIONAL LEGAL INSTRUMENTS FOR PROTECTION HUMAN RIGHTS (WWW.OHCHR.ORG):

§ The United Nations Charter of 1945 acknowledges and advocates equal rights between men and women

§ The Universal Declaration of Human Rights of 1948 is the foundation of international law in human rights. It is not legally binding. Therefore, it is a text that is essentially moral, building on the authority conferred by the fact that it is signed by a majority of world States.

§ The International Covenant on Civil and Political Rights (1966), the right to life, freedom, and safety. It also prohibits any discrimination based on gender and sexual orientation.

§ The International Covenant on Economic, Social and Cultural Rights (1966) states the right to enjoy the best possible state of physical and mental well-being.


§ The Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1984). The Committee Against Torture has stated that a complete abortion ban is contrary to the Convention’s principles.

The main United Nations treaty that concern human rights possesses a committee to monitor implementation of provisions by the States that have ratified the treaty. Those treaties are legally binding, which means that the States are legally obliged to follow them.
INTERNATIONAL LEGAL INSTRUMENTS
CENTRED ON WOMEN’S RIGHTS

This convention is a legally binding tool that defines discrimination against women, enumerates different types of discriminations, and presents an action plan to enable State Parties to eliminate ‘discrimination against women in the field of health care in order to ensure […] access to health care services including those related to family planning’ (article 12.1) and on the universal access to ‘appropriate services […] in connection with pregnancy, confinement, and the post-natal period’ (article 12.2). Finally, it promotes the right to ‘decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to exercise these rights’ (art. 16.1.e)

§ The Vienna World Conference on Human Rights of 1993 asserts that violence against women constitutes a human right violation. The Declaration and Plan of Action adopted at the end of the conference called for the designation of a Special Rapporteur on violence against women (Mrs. Rashida Mangoo since 2009). The conference participated in the adoption of the Declaration on the Elimination of Violence Against Women.

§ International Conference on Population and Development - ICPD (1994, Cairo) reasserts the link between violence against women, their health, and their sexual and reproductive rights. The Program of Action adopted during that conference signalled a major turning point by defining sexual and reproductive health, sexual and reproductive health rights, and setting universal access to SRH as an objective alongside reducing maternal and child mortality.
It also clearly states all women should have access to family planning services and post-abortion care regardless of abortion’s legal status (art.8.25).

§ Fourth World Conference on Women, Beijing (1995) reasserts the principles stated in Cairo. The Platform for Action defines a set of priority measures to reinforce women and girls’ power in 12 critical areas (health, violence against women, development). It acknowledges the right of women to have ‘control over their sexuality’. It is the first time an international text refers to women’s sexual rights without systematically linking them to reproduction. In particular, the Beijing Platform for Action reminds the States to revise the laws penalising women who have undergone an illegal abortion.
The United Nations Commission on the Status of Women (UNCSW) monitors and evaluates the progress achieved and problems encountered in the implementation of the Beijing’s Declaration and Platform for Action.
The texts resulting from by the Cairo and Beijing conferences also emphasize the importance of developing interventions and policies that involve boys and men in the field of SRH, towards their health and that of their partners when they are in a couple.

§ The United Nations Sustainable Development Goals (2015-2030). They follow the Millennium Development Goals (MDG). The SDGs are a new set of objectives, targets and universal indicators that should underpin the UN State members’ programs and policies in the next 15 years. The UN members validated the proposal with 17 SDG at the New York Summit in 2015. Those came into effect in January 2016 and apply to all countries whether they are developed or in development.
Regarding SRH, 2 objectives are of particular interest to us:
SDG 3 To ensure health lives and promote well-being for all ages
Target 3.7 By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.
SDG 5 Achieve gender equality and empower all women and girls
Target 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
Target 5.3 Eliminate all harmful practices such as child, early and forced marriage and female genital mutilation
Target 5.6 Ensure universal access to sexual and reproductive health and reproductive health rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.
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REGIONAL LEGAL INSTRUMENTS APPLICABLE TO SRHR

THE EUROPEAN SYSTEM:
§ The European Social Charter of 1961.
§ The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence of 2011. This is the second legally binding instrument on violence against women.

THE INTER-AMERICAN SYSTEM:

LATIN AMERICA:
§ The American Convention on Human Rights (1969)
§ The Additional Protocol to the American Convention on Human Rights on Economic, Social, and Cultural rights (Protocol of San Salvador - 1988) that states the right to health, social protection and education. The Protocol was only signed by Haiti and is still to be ratified to become legally binding.
§ The Inter-American Convention on the Prevention, Punishment and Elimination of Violence Against Women (Convention of Belém do Para – 1994)
§ The Declaration on Violence Against Women, Girls and Adolescents and their Sexual and Reproductive Rights (2014), Committee of Experts of the Follow-up Mechanism to the Belém do Para Convention (MESECVI). The Declaration calls for the States to guarantee women’s sexual and reproductive health and their right to life, by the elimination of unsafe abortions, by establishing the legal possibility of pregnancy interruption, and by enabling immediate and affordable access to contraceptive methods, including emergency contraception.
§ The Montevideo Consensus on Population and Development (2013) was adopted by all countries of Latin America and the Caribbean during the first regional conference on population and development in August 2013. This document includes a set of measures aiming at reinforcing the Cairo plan of action in the Latin American and Caribbean region. It specifically advocates guaranteed access to medicalised abortion services, underpinned by a rights and public health approach, and calls for States to amend existing restrictive policies.

THE AFRICAN REGION:
§ The Protocol on the Rights of Women in Africa, also known as the Maputo Protocol (2005) comes as an addition to the African Charter of Human People’s Rights. Its main objective is the promotion and the protection of African Women’s fundamental rights, including the right to health and more specifically to sexual and reproductive health. It is the first international legal instrument to explicit the right to medicalised abortion, in the case of sexual abuse, rape, incest, and when the pregnancy puts the mother’s physical and mental health, or the life of the mother or the foetus in danger. It guarantees other rights for women among which the right to participate to political life, social and political equity with men, and improved autonomy in their decisions concerning health, and the end of female genital mutilation. It was adopted by the African Union in Maputo, Mozambique on July 11th, 2003, to enter into force on November 25th, 2005. The African Commission for Human and People’s Rights ensures its implementation. The protocol was signed by Madagascar and ratified by Burkina Faso, the Republic of Ivory Coast, and the Democratic Republic of Congo.
§ The Maputo Plan of Action for the operationalization of the Sexual and Reproductive Health and Rights Continental Policy Framework (2016) defines the priority areas of intervention to achieve universal access to sexual and reproductive health by 2030. In article 14 on the right to health and control over reproductive functions, the Maputo Protocol states the following:
1) The states ensure respect and promotion of women’s rights to health, including SRH. These rights include:
   a. the right to control their fertility
   b. the right to decide whether to have children, the number of children, and the spacing of children
   c. the right to choose any method of contraception
   d. the right to self-protection and to be protected against sexually transmitted infections including HIV/AIDS
   e. the right to be informed on one’s health status and on the health status of one’s partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices
   f. the right to have family planning education
2) The States take all appropriate measures to:
   a. Provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas
   b. Establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding
   c. Protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.
II. DEFINITIONS OF KEY CONCEPTS

In order to harmonise terminology and create a common language between different stakeholders, we suggest a definition of key concepts used throughout this document.

1. SEXUAL AND REPRODUCTIVE HEALTH

Since the 1994 International Conference on population and development in Cairo, definitions of sexual and reproductive health, and of sexual and reproductive rights have evolved towards a more holistic approach. The concepts of health and rights are intertwined, and sexual and reproductive rights are an essential premise to achieve sexual and reproductive health. Thus, in 2018, the Guttmacher-Lancet Commission called for all the stakeholders involved in this topic to adopt a new integrated definition of sexual and reproductive health and rights (SRHR):

‘Sexual and reproductive health is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right’.

In order to guarantee sexual and reproductive health and rights, essential intervention packages must be available: comprehensive sexuality education, counselling and services in efficient contraceptives, antenatal, childbirth and postnatal care, including emergency obstetric and newborn care, comprehensive abortion care, prevention and treatment of HIV and other sexually transmitted diseases (STIs), prevention, detection, and management of gender-based violence (GBV), prevention, detection and management of cervical cancer (CC), information, counseling and services for sexual health and well-being and subfertility and infertility. Those interventions are essential and a part of MdM’s approach in the continuum of care in SRH (see figure on continuum of care in Chapter 1. III.

2. Provision of care: health promotion, prevention, and curative care)

Because sexual and reproductive rights are an essential premise to sexual and reproductive health, MdM decided to adopt the term of SRHR as defined by the Guttmacher-Lancet Commission.

2. SEXUALITY

The concept of sexuality can be understood differently depending on people and contexts. Two types of interpretations or visions exist: the one that analyses and understands sexuality as a biological fact, that would answer to people’s instincts or pulsions; and the one that understands sexuality as a sociocultural fact, which is a social construct that varies depending on society, historical and political context. In this document, we will adopt the definition used by the WHO, according to which sexuality can be defined as ‘a central aspect of being human throughout life and encompasses sex, gender identities and roles, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced

FIGURE 1: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

5. Guttmacher-Lancet Commission, Accelerate Progress - Sexual and Reproductive Health and Rights for All, 2018

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or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. 

3. GENDER AND SEXUALITY

The term ‘sex’ refers to the biological and physiological differences that exist between men, women, and intersex people (people who are born with biological and physiological characteristics specific to male sex and specific to female sex). The sex does not determine the roles and different position that men, women and intersex people occupy and the society where they are born, raised, and evolve. The term ‘gender’ refers to the way that a given society, at a historical and political point in time attributes different roles and expectations to people depending on whether they are considered men, women, or transgender. People learn and are socialised to become woman or man depending on the expectations of their contexts and social environment. Men were traditionally socialised into undertaking roles that are more socially valued and enable access and control over more important type of resources. This social differentiation was fed with gender stereotypes and discrimination that are at the origin of gender inequalities and GBV. Given that this is a social construct, it can be modified and questioned. For further information on definitions relating to sexual orientation and gender identity, see Chapter 6. IX Providing appropriate care to the LGBTQ+ people.

4. MATERNAL AND NEONATAL MORTALITY

One of the objectives of our SRH activities is to reduce maternal mortality. This means reducing the number of maternal deaths or deaths of women during pregnancy or within forty-two days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but neither accidental nor occurring by chance. Interventions to reduce maternal mortality are also associated with reducing the number of neonatal deaths, which are those occurring within the first 28 days of life of a child. Neonatal deaths are characterised as follows: very early (≤24 hours), early (≤7 days), and late (from 9 to 28 days).

5. ABORTION

Given the diversity of terminology that refers to the issue of abortion, and the difficulties encountered in differentiating the concepts, the following definitions are suggested here. Those concepts are used in MdM practical sheets: Management of unwanted pregnancies and comprehensive abortion care. Confidentiality and the difficulties encountered in providing appropriate care to the LGBTQ+ people.

Abortion: the term abortion means the termination of a pregnancy, for whatever reason, before the foetus is capable of extra-uterine life (before the end of 22 weeks of amenorrhoea or weighing less than 500g).

Spontaneous abortion (also referred to as miscarriage): occurs without intervention, whereas and induced abortion indicates that an intervention has been carried out with the aim of terminating the pregnancy. In the case of induced abortion, the several terms listed below represent different situations that can occur:

Therapeutic abortion: it is performed when a pregnancy endangers the physical and/or mental health of a woman. In cases where therapeutic abortion is considered a criterion for legally authorised abortion, countries tend to specify a list of illnesses included under this heading. These lists are essentially intended to illustrate scenarios that may be found to endanger the life of a woman, but they are not intended to obstruct the clinical decision of a doctor as to what is or is not dangerous for a particular woman.

Safe abortion: it is a pregnancy termination procedure carried out by a skilled person in safe conditions. Safe abortion is opposed to unsafe abortion, which is an abortion practiced in unsafe conditions i.e. by unqualified personnel and/or in an inappropriate environment with regards to minimal medical standards. Safe abortion can be conducted at different stages of pregnancy. Where States accept the practice of safe abortion, they tend to fix a time-limit for terminating pregnancy. In such cases, later abortions may be authorised in certain specific situations (most commonly therapeutic abortion or in the case of foetal deformity).

Unsafe abortion: this term refers to abortions that are conducted in poor conditions. In 2017, the Lancet presented estimates on safe or unsafe abortion on a global scale, and for the first time introduced a three-tiered categorisation of abortions in which unsafe abortions are divided into ‘less safe’ and ‘least safe’. This distinction enables a more subtle understanding of the conditions of abortion for women who cannot access safe abortion by a

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1. WHO, Brief sexuality-related communication: Recommendations for a public health approach, 2015
3. Ibidem
5. WHO, Global, regional and sub regional classification of abortion by safety, 2010-2014: estimates from a Bayesian hierarchical model, 2017
6. MdM, Factsheets: Management of Unwanted Preganancies and Comprehensive Abortion Care, 2019
7. The Lancet, Gender, and the difficulties encountered in providing appropriate care to the LGBTQ+ people.
8. The Lancet, Global, regional and sub regional classification of abortion by safety, 2010-2014: estimates from a Bayesian hierarchical model, 2017

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Médecins du Monde’s commitments with respect to sexual and reproductive health are implemented via two types of complementary interventions: provision of holistic, accessible and quality care for the most vulnerable populations, and advocacy to promote respect for the right of these populations to access appropriate healthcare services. The issue of partnerships is central to the way in which these interventions are implemented, not only from the perspective of the types of partnership sought but also the values shared.

Before essential interventions can be identified, the principles underpinning them must be identified, and it is the latter that will be set out here first.

1. CHOSEN APPROACHES

The interventions developed by Médecins du Monde, whether directly or in partnership, must consider the following principles:

a) A Public Health approach

By virtue of the prevalence, severity and consequences on the individual and society, sexual and reproductive health problems are a significant public health issue. Every year, 303,000 women die from causes linked to pregnancy; over 357 million new cases of sexually transmitted infections are recorded every year; 214 million women wanting to avoid pregnancy use no form of contraception; 89 million unwanted pregnancies occur in those countries, a quarter of which lead to unsafe abortion. Each year, these unsafe abortions cause the death of 22,800 to 31,000 women, which represents 8 to 11% of maternal mortality, whilst 8 million others suffer from temporary or permanent impairments.

In the light of this situation, there appears to be an urgent need to provide holistic, quality care that is accessible and that reduces the impact of sexual and reproductive health problems, which are even more prevalent among vulnerable populations. This care must be provided in line with the ethical principles relating to medical practice.

6. QUALITY CARE

Ensuring quality treatment and care throughout the continuum of care is crucial for reducing maternal and infant morbidity for reducing maternal and infant morbidity and mortality, as well as to respond to specific needs of people building on the principles of non-discrimination and autonomy.

The quality of the care is both the quality of the care provided and the quality of the care as experienced by those receiving it. The quality of the provision means a provision that corresponds to defined standards in terms of safe, accessible care, available in a timely and continuous manner and patient centred. In particular, this implies the availability of skilled practitioners as well as the respect by such practitioners of the patients’ right to informed consent, privacy and confidentiality.

Comprehensive abortion care (CAC): this is the care provided by a skilled health professional and includes: pre-abortion consultation, safe abortion (medical or surgical), post-abortion care, and post-abortion contraception.

Management of unwanted pregnancies: this relates to the care provided to a woman or adolescent who faces an unwanted pregnancy. Depending on the woman’s choice, it can be the continuation of pregnancy and therefore encompass antenatal care and psychosocial support, or it can be the option of terminating the pregnancy. In some contexts, it can consist in a safe abortion with a health professional, and in others where the legal constraints are restrictive, it may be the self-administration of misoprostol within the framework of a harm reduction strategy. It can also be the implementation referral system to another partner.

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III. AN ACTION-ORIENTED POSITION STATEMENT


15. WHO, Maternal mortality, Key Facts, 2019

16. WHO, Sexually transmitted infections, Key Facts, 2019

17. Guttmacher Institute, Abortion Worldwide 2017: Uneven Progress and Unequal Access

18. Dromer C. et al., For ethics in the field: Sensitive personal data management, MdM, 2010
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To achieve this, sexual and reproductive health services should not be isolated or conceived in a vertical way but must be integrated into primary healthcare services.

b) A human rights-based approach

Health is a universal human right to which every person is entitled, and which must be guaranteed by the States. For MdM, this means supporting and strengthening public health systems to guarantee accessibility of care and respect for the right to health. The individual capacities of members of the population also need to be increased so that individuals are aware of and are able to exercise their rights. More particularly, for everyone’s sexual and reproductive rights to be recognised without discrimination, the following elements should be taken into consideration: gender issues, diversity of sexual orientations, impact of inequalities on health and sexuality, and opposing all forms of gender-based violence.

c) A gender-based approach

The WHO acknowledges gender as one of the most important social determinant of health inequalities19. In the area of SRH, gender is a transversal element of people’s sexuality and element of analysis that helps bringing forward the persisting gender inequalities in that area. For example, unequal access to health services, and failure to account, in medical diagnosis and response, for specific characteristics and needs of all people depending on their gender identity and biological sex, as well as the implementation of actions that reproduce discriminatory discourses and practices and failure to recognise SRHR, etc.

The integration of a gender approach in health programmes therefore appears as a compromise towards equity and social justice and is complementary to a rights-based approach which it reinforces and supports.

MdM, as health actor, affirms this approach in its principles, so that our actions enhance equity and respond to specific needs of individuals and communities with which we work. Towards that venture, MdM promotes the integration of a gender approach in all its actions and programmes. Gender analysis will be cross-sectional in all stages of the project (diagnosis, planning, budgeting, monitoring and evaluation), so as to conduct a contextual analysis that enables the understanding of various gender inequalities with an impact on populations and the issues targeted and permit to provide a person-specific response to individual needs that can overcome those inequalities. Thus, the responses will enable the integration of methodologies that look at promoting individual and/or collective changes such as empowerment, and/or community work and/or work around positive and egalitarian masculinities.

d) An approach based on individual and community empowerment

Inequalities in terms of exercising and accessing SRHR are mostly the consequence of imbalances in power that prevent some people or groups to exercise their rights fully regarding their life, their sexuality, their body and their future, and impede their capacity to act on their environment and the determinants of their health. The imbalances in power are the consequence of inequalities based on gender, sexual orientation, age, handicap, ethnic origin, religious origin, and social background.

Thus, any intervention aiming at improving SRH must be integrated in a wider more holistic framework of the fight against inequalities and must contribute to the development of marginalised individuals and communities’ empowerment so that they truly become the actors and actresses of their life and health. Without that underpinning, those interventions are likely to be inefficient at best, if not they might contribute to perpetuate those inequalities. Therefore, developing empowerment is one of MdM’s core principles (see box below).

e) A cross-sectional approach with mental health and psychosocial support

SRH and mental health and psychosocial support (MHPS)20 present joint themes: indeed, MdM’s programmes target potentially vulnerable or fragile populations, whether it be for contextual or structural reasons. Thus, despite the fact that the majority of our programme users do not develop mental illnesses21 in relation to these situations (anxiety disorders, depressions, post-traumatic stress disorder for example), and even if the prevalence of severe mental disorders rises from 3 to 4% and that of moderate disorders from 10 to 15-20% in emergency humanitarian...
situations 10 à 15-20%, a number of them present psychological distress22. This impacts their capacity to adopt positive behaviours regarding prevention and management of their health. It is therefore crucial to integrate this element to our project development strategies, within the scope of the medical care as well as in the community action, for a better involvement, identification and compliance. SRH refers to intimate issues: not only corporal but also psychological (and more generally socio-political). Any medical act that is carried out without the necessary tact may be perceived as violent. Any care without listening can be hard to live through and distressing. To date, MHPS is mainly integrated in MdM’s programmes on GBV, and more specifically programmes relating to sexual abuse. However, an expertise still needs to be developed, as we only offer a basic psychosocial care, undifferentiated depending on situations and time of care. We can further reinforce the partners in the field to lead to a substantive psychological and psychosocial management of those situations.

Some issues are specific to SRH for which MHPS must be further developed: postnatal care, emergency obstetric care, gender-based violence, abortion (in some cases), accompaniment of unwanted pregnancies that are carried out through to full term for example. Each of these situations involves complex psychological mechanisms for the person who receives care, but also for the person who provides it. Each of these situations is ‘at risk’ from a psychological perspective and requires care to be adapted to these issues. Finally, the practitioners involved in SRH programme must understand that people suffering from mental health disorders are more exposed to gender-based violence, and, as a consequence, to unwanted pregnancies. Their inclusion and protection in the programme frameworks must be reinforced.

2. Provision of care: health promotion, prevention and curative care

MdM works at a holistic care so that adolescents, women and men may have access to quality services at every step of their life, thus being accompanied in their choices and decisions. This implies the guarantee of a continuum of care from community to expert services, as well as primary care centres - and therefore an efficient referral process.

The provision of care must be a part of a holistic care and must take place within the existing sexual and reproductive health services when possible. The elements of care will be described in detail in chapter IV. Elements of the continuum of care. Whenever possible, care should be offered by the services supported by the project, or the teams will have to ensure its availability dispensed by other stakeholders. In the latter case, strengthening of referral procedures should be considered.

Teenage pregnancy and the specific risks encountered by this target population are often a crucial issue that is given little consideration in our areas of intervention. The risks include unwanted pregnancy, vulnerability to STIs and increased risk of complication in the event of pregnancy. It is therefore important to pay particular attention to this population group. This can be achieved by adapting the services to the specificities of treating and caring for adolescents and especially by promoting access to information, sex education, contraceptive methods and prevention and curative services and care. Similarly, MdM recommends the provision of care in SRH be adapted to the specific needs of migrants, LGBTQ+ people and sex workers.

3. Advocacy23

The right to health is the establishment or reestablishment of access to healthcare and effective exercise of this right through: (i) the implementation or strengthening of basic integrated care and prevention services; (ii) combined with social protection systems based on multi-sector approaches that take the socio-cultural and economic determinants of health into account; (iii) participation by the population in decision-making processes concerning health issues, at both community and national levels; (iv) support or advocacy action for more efficient and rational policy which includes the issue of resources.24

MdM acts and strives in order to achieve the right of individuals to have control over their body and make free and informed decisions about the sexuality, their health and their life. Whether it be in Kinshasa, Madagascar, Ivory Coast, Uganda, Palestine or Bulgaria, MdM works alongside communities and stakeholders of the civil society and public institution to enhance the availability and quality of services, accompanying in improving their knowledge of their rights and their capacity to act as well as challenging policy makers and make them face their shortcomings and their responsibilities. MdM stands in favour of access to safe abortion care and fights to have the laws that penalise women and young girls or health practitioners in case of abortion repealed.

The interventions that we have developed and the practical realities we have faced during those interventions make us legitimate to testify and are the basis of our advocacy in favour of SRHR. Communicating and discussing available healthcare provision, barriers to healthcare, possible levers of these barriers and the values that underpin our action, with services users, communities, health practitioners

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22. Psychological distress occurs when a person is confronted to a source of stress that he/she cannot cope with, which leads to feeling overwhelmed. This state can then have a negative impact on one’s capacity to manage everyday life, and on the quality of one’s relationships, for example.

23. For MdM, advocacy is ‘An activity that consists in using a number of different channels to influence decision-making bodies. It aims to bring about long-lasting changes in policy and practice having a direct impact on the health of population groups, targeted by [its] programmes.’ Board meeting, November 2007.

Figure 2: The lifelong continuum of care in SRH

**Community**
- Comprehensive sexuality education
- Counseling and services for a range of modern contraceptives
- Information, counseling and services for sexual health and well-being

**First level health care facility**
- Prevention and treatment of HIV and other sexually transmitted infections
- Prevention, detection and management of reproductive cancers, especially cervical cancer
- Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care
- Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence
- Information, counseling and services for sexual health and well-being
- Safe abortion services and treatment of complications of unsafe abortion

**Referral**
- Referral

**Counter-referral**
- Counter-referral

**Important:** SRH actions are not only for women but must include men, LGBT and intersex people.
and health authorities in particular, are essential pre-requisites to making practices and policies evolve towards better access to health.

One of the necessary and useful steps to the advocacy is conducting surveys (qualitative in majority concerning the topic of unwanted pregnancies). Beyond providing a sharp analysis of context, it enables to point out the barriers, to involve communities and civil society, and to legitimate recommendations to policy makers.

With regards to the specific barriers preventing complete and universal access to SRHR and to the points of rupture of the continuum of care, each project identifies one or several priority advocacy themes. Defining themes means to identify priorities for change. Indeed, the advocacy strategy aims at achieving political or practical changes, whether it be locally, regionally, nationally or internationally. This practice takes time, a diagnosis, and acute knowledge of context and constraints.

It may rise from the convergence of several factors beyond the analysis of legal and practical barriers, whether it be locally, regionally, nationally or internationally. This practice takes time, a diagnosis, and acute knowledge of context and constraints. It may rise from the convergence of several factors beyond the analysis of legal and practical barriers: a political agenda presenting opportunities (for example a ‘reproductive health’ strategy being revised on a national level), a civil society that is strongly involved on one theme, a strong regional dynamic that is a catalyst for change, etc.

Depending on each project and each context, an advocacy strategy is defined in co-construction with civil society movements that are in line with the values that we defend.

The contexts in which we intervene have restrictive regulations regarding SRHR. Thus, it is appropriate and particularly useful to begin the ‘advocacy diagnosis’ by an analysis of the legal environment. In that venture, a tool for analysis of the legal framework was developed, that is available to all projects, and is available from the legal department of the MdM headquarters. Beyond the results, conducting this analysis is particularly interesting to deconstruct prejudices on what the law permits or not, to take onboard the teams in this participative process, to create a sense of ownership of the issues at stake in SRHR, informing and building awareness in accordance with the law, etc.

Alongside this, it is possible to conduct analysis of operational risks for the implementation of one or another advocacy theme (for example: to what extent is conducting advocacy for the right to abortion in DRC risky?). To achieve this, it is possible to adapt MdM’s risk analysis assessment tool25.

4. PARTNERSHIPS AND COLLABORATION, COMMUNITY INVOLVEMENT

All projects work to identify the local, regional and national stakeholders involved in the field of sexual and reproductive health or who may have a positive or negative influence on the project. This stakeholder analysis is carried out regularly. MdM recognises the importance of establishing partnerships and alliances and facilitating community participation, not only to ensure the relevance and sustainability of projects but also to pool the efforts to achieve certain objectives. In the 2016-2020 strategic plan, MdM recommends prioritising resource allocation for organisation of operational and political partnerships and alliances, and to (systematically) develop a partnership strategy taking into account context and levels of partnership. This is about supporting partners to strengthen their visibility in the societal, institutional, political and mediatice environment and to promote direct access of partners to institutional funds. To achieve this, it is important to determine, for each advocacy theme, the alliance(s) that may be most efficient to reach the targeted stakeholders at each level (local, national, regional - specifically European and global).

Partnerships may be considered within the implementation of a project in SRH but also in its initiation or in its evaluation. The initiation of partnerships will take into account the values and ethical principles shared between the different stakeholders.

MdM is committed to supporting existing local stakeholders, and especially health authorities, in order to strengthen the development of sexual and reproductive health services offering quality treatment and care. The term ‘local stakeholders’ refers to local NGOs and community organisations, etc. These stakeholders bring another perspective to the context and needs of the population. They often enable the project to be more firmly rooted in the context and can ensure that the activities are more sustainable. In addition, MdM recognises the importance of any existing women’s organisations and professional associations (in particular midwives’ associations) as defenders of the right to health. These organisations usually have a good understanding of the context and can be important de facto allies for the adaptation and acceptance of an intervention in the area of sexual and reproductive health.

25 Document included in the security package, on MDM intranet / Direction des Opé Internationales / Secu / Documents / Pack Sécu / Documents de Base
Since some aspects of the continuum of care are stigmatised and neglected, despite the fact that they have a strong impact in terms of public health, the organisation identified 3 priority strategic themes that concur with breaking points in the health and rights continuum. The development of Médecins du Monde’s expertise on these 3 themes enables to cover forgotten health needs, to be innovative, to create a collective knowledge and to strengthen our visibility as an important stakeholder in SRHR. This also permits to feed a strong and well-argued advocacy strategy based on these key themes.

In 2014, building on the previous years’ achievements, Médecins du Monde developed an intervention strategy26 that describes the organisation’s ambitions for the future and defines the priority themes to develop.

1. OBJECTIVES

MdM’s intervention strategy’s final aim is a universal access to SRH services, the main objective being to strengthen the capacities to exercise sexual and reproductive rights and to implement integrated and quality comprehensive SRH services in our countries of intervention. The following principles of intervention of the organisation are reaffirmed as a part of the strategy:

- Strengthening the continuum of care in SRH at different stages of the project and in partnership with the existing stakeholders
- Strengthening service users’ capacity to exercise their rights in SRH
- Strengthening the exercise of SRH rights and reducing gender inequalities through the involvement of community stakeholders and users at different stages of the projects
- Participating in social change and contributing to public policy change in order to strengthen knowledge on sexual and reproductive rights for all and to guarantee universal and effective access to SRH services.

2. FRAMEWORK OF DELIVERY

MdM recognises the importance of holistic care that enables following individuals throughout the continuum of care in SRH from community to expert services including primary health centres and accompanies individuals along their course of care as an adolescent, an adult and potentially a parent. This implies that each SRH project evaluates the gap in the continuum at diagnosis, planning and implementation stages, examining the possibility of responses by other stakeholders involved. To strengthen the continuum of care, it is essential to enhance access to services and to rights, taking into account all barriers to access, and to include men and adolescent boys in each stage of the process.

CHAPTER 1: PRINCIPLES OF INTERVENTION

a) Prevention and management of unwanted pregnancies

214 million women and girls who would prefer to postpone or avoid a pregnancy in the world still live in countries where there is no access to a safe and efficient contraceptive method. According to estimates, around 89 million unwanted pregnancies occur in those countries and more than a quarter of these pregnancies leads to unsafe abortion. Each year, unsafe abortion causes the death of 22,800 to 31,000 women, representing 8 to 11% of maternal mortality, whilst 8 million others suffer from temporary or permanent impairments. Unsafe abortions are the 3rd cause of maternal mortality; nonetheless they are easily preventable deaths.

To date, the issue of unwanted pregnancy is still a topic that leads to strong oppositions at international level, making progress in that matter still fragile and limited, and the achievements are never to be taken for granted. Nonetheless, unwanted pregnancies represent an important public health issue and are stated as the principal determinants of maternal morbidity and mortality. This is illustrated in practice by an increase in high risk pregnancies, an important number of abortions carried out in unsafe conditions or breaking points in young girls’ or women’s life trajectory as they had not planned their pregnancy or did not wish to welcome a child at that point in time. There are many obstacles impeding the access to quality Comprehensive Abortion Care (CAC). It is crucial that those barriers are taken into account and that the issue of the care of unwanted pregnancies and access to CACs are integrated into the global response to needs in SRH that MdM tends to bring by implementing its projects.

Thus, the working angles that Médecins du Monde adopts are the following:

- Strengthening our project-based knowledge of legislative, regulatory and extra-legal barriers as well as sociocultural barriers to access to abortion
- Access to services and comprehensive sexuality education in particular for adolescents
- Diversity of contraceptive methods (long-term methods, emergency contraception, etc.) and enhancing knowledge with regards to their action and eligibility criteria
- Adequacy between service provision and needs, which implies improved information, improved understanding of needs. To achieve this, quality counselling, adaptation of the modes of transmission, diffusion at community level (including to men and adolescent boys) are some of the ideas that deserve further exploration
- Service provision in CAC in our projects

b) Responses to SRH needs in a crisis context

Crisis contexts unsettles health systems and can increase gender inequalities, thus reinforcing women’s difficulty to access health care services and to get appropriate care for their needs. Indeed, given the economic, social, and security challenges that they face, women and young girls can be in a difficult position for decision making. Moreover, they can be confronted to isolation through movements of population which increases the experience vulnerability. Promiscuity, loss of means of support, lack of access to prevention methods are additional determinants that can lead to a higher prevalence of gender-based violence, transmission of sexually transmitted infections (STIs), including HIV, and unwanted pregnancies. The sense of impunity is also an important factor to explain the increasing number of GBV. GBV have severe consequences on physical and mental health, and on the socio-economic environment.

As a medical stakeholder, Médecins du Monde commits to take charge of the needs in SRH and to report violence experienced by populations as a result of a crisis. The organisation aims at reinforcing the integration of the Minimum Initial Service Package (MISP) in SRH from day 1 of the response, and to bring a more holistic, pluridisciplinary response to GBV centred on the survivors.

Therefore, Médecins du Monde takes the following working angles:

- Working at coordinating and strengthening of partnerships with existing actors
- Strengthening the integration of the MISP at the beginning of the response:
  - Provision of emergency obstetric care (including a 24/7 referral system)
  - Provision of contraceptives
  - Prevention of HIV transmission
  - Prevention and care of GBV
  - Provision of Comprehensive Abortion Services when possible, or at least post-abortion care
- Training for teams and use of adequate tools for evaluation and quick response
- Systematically addressing the issue of GBV, which implies:
  - Identification and care of survivors, access to medical certificate
  - Implementation of a referral network for care that is not available in our structures
  - Monitoring and operational research in order to alert on experienced realities and evaluate intervention strategies.

27. Guttmacher Institute, Abortion Worldwide 2017: Uneven Progress and Unequal Access
28. Women commission for refugee women and children, Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations, 2011
29. IAWG, Inter-agency Field Manual on Reproductive Health in Humanitarian settings, 2018
2. Universal access to SRHR in humanitarian contexts (crisis/conflicts), with particular attention to prevention and care of gender-based violence.

3. Liberalisation of the right to abortion in French-speaking Africa, through signing, ratifying, and implementation by all States of the Maputo Protocol (see Maputo Protocol in chapter 1. I. Commitment of Médecins du Monde)

Alongside these, MdM aims at engaging by 2021 in advocacy for prevention and care of cervical cancer. The priority theme of this advocacy tool is still to be defined.

CHAPTER 1: PRINCIPLES OF INTERVENTION

C) Prevention of cervical cancer

Over 311 000 women die each year of cervical cancer (i.e. one death every two minutes); a pathology mainly caused by a viral infection, the human papillomavirus (HPV), sexually transmitted, preventable in most cases thanks to an adequate screening test. Over 85% of deaths occur in countries with low or intermediate income and where access to prevention, screening and treatment is insufficient. In addition to this impact on mortality, the human, social and economic impact represent a real burden for those countries. Prevention and detection of precancerous lesions along with appropriate treatment, when necessary, are essential to prevent new cases of cancer. It has already been several years since the WHO acknowledged the importance of prevention and screening of cervical cancer.

Médecins du Monde’s working angles on that topic are the following:

- Developing experience and technical expertise of the organisation on that topic
- Integrating screening and treatment of precancerous lesions in SRH services
- Implementing partnerships and referral pathways to guarantee the continuum from community level to primary care centres and then secondary care centres in the case of uterine cancer.
- Developing activities in operational research to encourage the implementation of a screening and care algorithm that is efficient and adapted to intervention contexts, so as to influence international recommendations regarding prevention of cervical cancer.

3. A PROVISION OF CARE THAT FEEDS AN INSTITUTIONAL ADVOCACY

The 3 chosen themes structure a political voice for respect of sexual and reproductive rights that are taken into account in each project but also cross-sectionally in regional and international spheres of influence:

- Advocacy developed in a global context where sexual and reproductive rights, in particular the right to safe abortion, are points of opposition between the States and where attempts from conservative groups to diminish women’s rights are constant. This makes MdM’s fight for access to rights and services in SRH all the more essential.

- A more general framework for advocacy which makes sexual and reproductive rights the cornerstone of progress towards equality and sustainable development.

At the time of writing (2019), 3 key themes for advocacy were given priority on the pathway to complete and universal access to SRHR:

1. Maintaining the influential role and leadership of France with regards to SRHR, specifically through the development of a feminist diplomacy on the European and international scene.

2. Universal access to SRHR in humanitarian contexts (crisis/conflicts), with particular attention to prevention and care of gender-based violence.

3. Liberalisation of the right to abortion in French-speaking Africa, through signing, ratifying, and implementation by all States of the Maputo Protocol (see Maputo Protocol in chapter 1. I. Commitment of Médecins du Monde)
CHAPTER 2

BARRIERS TO ACCESSING HEALTHCARE
A person’s state of health is characterised by complex interactions between several individual, social, cultural, environmental, economic, legal, administrative and political factors. These determinants of health explain inequalities in health within one country or between different countries. It is therefore important to take them into account and act on those different factors to improve the health of populations.

These factors have an impact on the availability of adequate and quality healthcare provision, but also on access to services. Taking into account sociocultural, economic, legal, administrative and geographical determinants, Médecins du Monde wishes to strengthen the links between the different levels of care of individuals in terms of SRH.

Having an available health service does not necessarily mean that it is used in practice. Indeed, while the quality of care is improved at all levels of care, this does not provide any information as to the effective access of individuals; for this, it is necessary to strengthen the continuum of care and to ensure the effective and continuous link between levels of care.

In addition, it is to be reminded that maternal mortality and morbidity can be explained by the ‘three delays’ model:

1. Delay in deciding to seek care and in identifying healthcare services;
2. Delay in going to a health facility (inability to find a mode of transportation, cost of transportation, distance, state of the roads, insecurity, checkpoints, etc.);
3. Delay in dispensing appropriate care at health facility level (absence of skilled practitioners, absence of adequate equipment or treatments, payment before treatment, late referral or impeded referral towards the next level of care, etc.)
II. SOCIOCULTURAL FACTORS

1. DEFINITION/CONCEPT

’Sociocultural determinants (SCD) of access to healthcare may be defined as all popular norms, values, knowledge and practices associated with health and governing actions and thinking about health, illness and also care.’

Reflection around SCD is more and more present and is an important theme for new aid policies. The WHO, some governments and NGOs have started to include considering of sociocultural contexts in their health projects to improve populations’ access to healthcare. For MdM, it has been a cross-sectional topic for many years: a guideline as well as theoretical and methodological documents, and various workshops on how to apprehend SCDs have already been developed. Taking into account SCDs enables to enhance the dialogue between actors of health projects and service users and therefore improves the quality of the projects, taking into account users’ needs, values, norms, and integrating them in the development and implementation of the project.

2. HOW TO REDUCE THOSE BARRIERS TO ACCESS TO HEALTHCARE?

Adolescence, marriage, pregnancy, and childbirth are life steps that are rich in representations, norms and values in each community.

Therefore, it is important to understand:

- The representations linked to adolescence, sexuality, pregnancy, abortion, illnesses, GBV, the body, treatments (stigmatisation of some illnesses, etc.);
- The interpretation of the symptoms and causes of illnesses;
- The language (words used to speak of pregnancy, abortion, illness, understanding and interpretation of messages);
- The key role of society, groups, family in the therapeutic path (role of husbands, fathers, mothers, peers, traditional birth attendants, religious leaders, etc.);

Reducing inequalities in access to healthcare is a constant concern that MdM gives particular attention to.

The model evidences the importance of the existence of health facilities providing adequate and quality care, but also raises the question of access to those facilities that can be endangered by determinants that influence access to care.

The figure illustrates the different barriers that can impede the geographical continuum of care.

CHAPTER 2: BARRIERS TO ACCESSING HEALTHCARE

- Medical pluralism with a variety of care options (traditional and biomedical medicines);
- The patient-carer relationship;
- The economic, social, legal, administrative and political issues;
- The gender-based roles, relations and inequalities that may influence the experience and representation of an illness but can also put men and women in different positions within the community with unequal access to resources and unequal control of resources.

It is advised to undertake a sociocultural diagnosis with a gender approach at the beginning of each project, so as to identify the key people in a community, understand the barriers to access to healthcare, the therapeutic pathways and understand the representations around sexual and reproductive health.

Data collection using qualitative methods (observation, interviews and focus groups), along with data analysis by triangulation of these three methods enable to bring into light the social determinants of access to healthcare (these methods are explained in the guide ‘Data Collection - Qualitative Methods’ by Médecins du Monde). It is then essential that the data analysis takes into account geographical, social, economic, political and legal contexts.

These various elements have a strong impact on SRHR. Centering the analysis of SCDs on representation of illnesses and health is at risk of encouraging the development of programmes that over-responsabilise individuals without taking into account the fact that their ability to act is limited by their environments. Similarly, it will be important to include, in the data collection and in the context analysis, aspects of gender and in particular the role of men and women in the community, access to and control of resources by men and women as well as the analysis of different factors of influence (political, economic, cultural, training, legal, international etc.) which have an impact on and in gender relationships.

Once collected and analysed, it is important that this information is integrated in the planning and implementation of a project. Indeed, from an ethical perspective, it is important to consider SCDs in a non-judgmental and respectful manner but also by questioning them, which enables to improve the quality, the effectiveness and the sustainability of the projects. It is also essential to have particular attention and questioning on SCDs throughout the project to adjust our approach if necessary (see chapter 3. II. 7. Social and anthropological study).

Availability and quality of services in SRH are no use if patients do not seek them, do not understand the care or treatment that is offered, or if the service does not answer their needs or is discriminatory. Sociocultural adaptation of procedures, languages, norms, values, relationships practices with carers are crucial to ensuring access to healthcare. Activities for health education adapted to needs, representations and practices of the population are essential in improving knowledge in SRH, to strengthen capacities and encouraging healthier practices.

Moreover, the social and anthropological studies conducted by MdM show that among the various determinants of access to healthcare, the quality of interaction between patient and carer, the confidentiality in this relationship, the opportunity of a dialogue, the quality of reception provided in a health facility are crucial to the choice of beginning a therapeutic pathway. The trust in the medical relationship also increases adhesion and compliance to treatments as well as preventative behaviours. Thus, to achieve a better social acceptability of projects, it is essential to take into account patients’ voice in the conception of operational strategies and throughout the project cycle. In that context, it is essential to give particular attention to patient satisfaction. For that reason, MdM has developed a Practical guide to satisfaction surveys. In this guide, MdM insist on the multidimensional nature of patient satisfaction. Different criteria must be taken into account including the following: health practitioners’ technical skills, interpersonal aspects and relationship between patients and carer, accessibility and continuity of care and consideration of families. Measuring satisfaction should be a core part of projects so that we can adapt interventions depending on individuals’ needs and satisfaction criteria.

In addition, it is crucial to give specific attention to the patient-carer relationship. Some studies have shown that in many contexts, this relationship is dysfunctional and leads to situations of violence in care. More recently, organisations have described, in many countries, situations of ‘obstetric and gynaecological violence’. This violence can be defined as a set of unjustified gestures, words and medical acts impacting more or less severely on the physical and mental integrity of women. These acts can occur throughout the continuum of care in SRH, including births or abortion. They can be carried out by different practitioners in healthcare facilities and can constitute an important barrier to healthcare.

It is therefore paramount to analyse the factors that underpin the patient-carer relationship and the power dynamics at stake. As part of the support to health facilities, particular attention must be given to reception, communication with patients, implementation of respectful support care; this concerns not only knowledge and technical skills but also soft skills for healthcare professionals. For that purpose, the organisation of awareness-raising sessions, training, and formative supervisions on issues
of medical ethics and patient-carer relationship is an important activity to take into account when conducting projects.

On the other hand, when talking about patient-carer relationship, it is also important to know that in many situations, the acts are not conducted with the intention of being mistreating. The dysfunctional state of some health systems, lack of information and management, lack of equipment, and excess workload may lead to a state of exhaustion of practitioners that will impact their interaction with patients. To prevent this type of situation, particular attention must be given to working conditions and respect of international standards in terms of workload (in particular the Sphere standards regarding the number of consultations per day per practitioner).

Gender inequalities linked to the control of financial resources and time resources may also impact geographical access. In general, women have less control over financial resource, thus limiting their ability to pay for transportation to the health facility. In addition, women carry out tasks in the areas of reproduction, production, and community in an unequal manner with men, and have less time to spare for a long journey for example.

2. HOW TO REDUCE THOSE BARRIERS TO ACCESS TO HEALTHCARE?

Reducing geographical barriers means dealing with their different causes:

Service availability and quality:
- Some populations are particularly distant geographically from the nearest healthcare centre, with urban and rural areas contrasting sharply. Certain criteria govern the setting up of health facilities, namely four centres offering basic emergency obstetric and neonatal care (BEmONC) and one centre offering comprehensive emergency obstetric and neonatal care (CEmONC) to cover

1. DEFINITION/CONCEPT

The geographical barriers are the physical distance between care provided and demand for it. Geographical accessibility depends on how close the patient is or how far from the health facility delivering the care needed. This accessibility can also depend on the specifics of the zone: checkpoints, conflict, no-man’s land, etc.

A geographical barrier is often determined by the distance and the time taken to travel, which in turn depend on the method of transport available (on foot, by donkey, horse, boat, car, bus etc.), and the difficulty of the journey (condition of the roads, rainy/monsoon season, relief of the terrain, ferry crossing, etc.).

Geographical accessibility also depends in particular on the availability of sexual and reproductive health services at health facilities close to communities. Other factors, such as cost of transport, frequency of provision of care have an impact on geographical access to care.

III. GEOGRAPHICAL BARRIERS

1. DEFINITION/CONCEPT

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A geographical barrier is often determined by the distance and the time taken to travel, which in turn depend on the method of transport available (on foot, by donkey, horse, boat, car, bus etc.), and the difficulty of the journey (condition of the roads, rainy/monsoon season, relief of the terrain, ferry crossing, etc.).

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the needs of 500 000 inhabitants (Sphere standards)9. However, the criteria specify that, in rural areas with dispersed populations, a larger number of facilities may be created to reach a greater proportion of the population. The only conceivable option in some areas may be to create additional (and/or itinerant) healthcare facilities. This needs to be discussed with the authorities responsible for mapping healthcare provision:

➡️ It is essential that populations can be cared for whatever the divisions into sectors of provision and whatever their place of residence;

➡️ Decentralising certain forms of care to peripheral facilities can also facilitate access to more comprehensive, quality care. For example, decentralising services offering PMTCT has enabled greater number of pregnant women to be tested for HIV and to have access to antiretroviral treatment. Delegation tasks is also an interesting option to facilitate access to healthcare. Similarly, when a primary facility provides BEmONC, women can be more readily treated in the event of obstetric complications. The quality of care (and reception) provided is an additional argument to encouraging populations to travel, even where the journey is long and/or difficult;

➡️ Outreach activities may also reduce geographical barriers while helping establish a bond of trust between healthcare practitioners and the population. These activities may be particularly encouraged when women have difficulty travelling (postnatal consultation in the 48 hours following birth) or where regular treatment or care is required;

➡️ Healthcare services may be organised within the community and by the community itself or by community workers. For example, distributing contraceptives via community health workers is increasingly common.

➡️ Opening hours that are adapted to women’s needs, and childcare services can also be an option to enable women with families to travel according to their available time.

**Improving referral systems:**

➡️ Referring births and emergencies (haemorrhage, eclampsia, etc.) from the community to primary healthcare facilities is often problematic. Such referrals must be done quickly, and women and their families are often not in a position to organise transport. Community-based initiatives to pool means of transport or emergency funds may exist, be reinforced or initiated by MdM to facilitate referral. These initiatives must always be set up and developed in close collaboration with the communities benefiting so that the people concerned take ownership of them;

➡️ In situations where referring births from the community to primary healthcare with the minimum of delay is not an option, one possibility may be to propose and discuss moving pregnant women closer to healthcare facilities towards the end of their pregnancy (staying with family, in special temporary accommodation centres, etc.); these solution should be discussed during antenatal consultations;

➡️ Referral between primary and secondary healthcare facilities is also a crucial aspect of reducing maternal and neonatal mortality. It is therefore important that referrals are made by ambulance service for emergencies and complications during pregnancy or delivery that need to be managed at CEmOC centres. Healthcare personnel must also be trained in directing women and newborns to appropriate facilities in a timely manner. Clear referral criteria must also be drawn up for both emergency and non-emergency care for cases that need to be dealt with at a higher health service level (e.g. definitive methods of contraception). An effective system of communication is required to ensure referrals are made within acceptable timescales.

**Financial aspects of transportation:**

➡️ Geographical access also depends on financial access and modalities of financing transportation for the most in need. The cost of transportation, specifically in the case of an emergency can be very high. It is important that the question of financing this transport be discussed with communities and couples beforehand.

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"In the district of Djibo in Burkina Faso, an analysis of the causes of maternal death pointed out the geographical barriers and delay in accessing a health facility. To address this situation, MdM set up a community referral system through the donation to remote villages of tricycle ambulances to transport patients towards health centres. This support is a part of the management of emergency obstetric care. Communities are the only managers of these tricycles that enabled to achieve satisfactory results. Today, tricycles are used at all levels of the health system in a context where security is decreasing and where four wheeled ambulances are often targeted by attacks."

Dr Hyppolite Gnamien, Medical Coordinator, Burkina Faso
IV. FINANCIAL BARRIERS

1. DEFINITION/CONCEPT

In numerous countries, the policy of user fees (or direct payment) in healthcare facilities constitutes an obstacle to accessing healthcare. The costs of care are often high and impossible for households to budget for. In addition, households often have little capacity to pay for care. Gender inequalities regarding control over financial resources also impact women’s capacity to face certain costs.

Every year, more than 100 million people are pushed into poverty as a result of expenditure on health. Hundreds of millions of others simply abandon the idea of treatment due to a lack of money.

Maternal health represents an average expenditure and impoverishment of between 1% and 5% of household income. Maternal mortality between the lowest and highest quintile of the population is four-fold.

Financial barriers may therefore also have social and health consequences. Delays in accessing care may lead to a greater risk of mortality and morbidity. There is a four-fold difference in maternal mortality between the lowest and highest quintile.

Financial barriers to accessing care comprise not only direct costs, that is the fee for the consultation and the cost of drugs and tests, but also indirect costs, namely transport to the healthcare facility (which increases with the distance), food for those accompanying the patient and also tips which are sometimes demanded for nurses. In addition to direct and indirect costs, using healthcare services often implies a loss of earning as a result of disruption to income-generating activities (selling, harvesting, etc.).

2. HOW TO REDUCE THOSE BARRIERS TO ACCESS TO HEALTHCARE?

On May 24th, 2011, the World Health assembly adopted a resolution (64.9) inviting States Parties ‘to ensure that health-financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoid catastrophic healthcare expenditure and impoverishment of individuals as a result of seeking the care needed’.

Healthcare costs paid by service users - user fees - reduce the use made of healthcare services, result in financial stress for households and lead to inefficient and inadequate use of healthcare services. The direct payment policy has removed populations from the capacity to protect themselves effectively against the risk of illness. The right to benefit from social security in the event of illness is an important component of the right to health.

Some countries have deployed considerable resources to reduce the financial barriers for pregnant women and children:

- National policies of free healthcare for pregnancy women and/or children
- Fixed obstetric fee (Mauritania)
- Conditional cash transfers (India and Nepal)
- National health insurance scheme for mothers and children (Bolivia)
- Voucher system (Cambodia and Laos)
- Micro-insurance (Guinea, Ghana, Mali, Burkina Faso, Niger, Sierra Leone, Ivory Coast etc.)

Exemption from payment has generally had a positive impact on improving the health of women and children. Nevertheless, the success of such an enterprise depends largely on real political determination and advance planning that takes into account the long-term funding of free care, as well as the technical aspects relating to managing its impact on the population, human resources in healthcare facilities, and the supply in drugs. It is also essential that beneficiary populations are generally made aware of these health policies.

In 2012, MdM adopted a clear position on the financial accessibility of healthcare in a document entitled ‘Improving financial access to primary healthcare’.

MdM’s approach involves introducing or extending free access to primary healthcare and relies in particular on policies of selective ‘free’ healthcare that favour pregnant women and children under the age of 5.

13. Available on request from Health and Advocacy Directorate (DSP)
1. DEFINITION/CONCEPT

Obstacles to accessing SRH services, and especially access to contraception, care for victims of GBV, post-abortion care, or safe abortion care can be induced by a restrictive political and legal environment regarding these issues. On the topic of abortion, it is known that abortions tend to be safer when they are legalised as opposed to contexts where restrictive legislations are in order. According to the Guttmacher Institute, in 2018, 6% of the 1.64 million women of childbearing age in the world live under jurisdictions where abortion is completely forbidden, and 37% under legislations without restriction depending on motivation. Most women live in countries where the law is somewhere between these 2 extremes. It is estimated that 25 million (45%) of the 56 million yearly abortions over the period of 2010-2014 were carried out under unsafe conditions.

Moreover, several contexts exist where access to contraception, in particular for minors, is impeded by restrictive legislation. Finally, with regards to care of GBV, the obligation of some health practitioners to report sexual abuse to the police represents a major barrier to access to medical care for survivors. Similarly, inappropriate administrative processes can impede the exercise of SRHR. This refers for example to the case where it is necessary to have multiple practitioners’ diagnosis or a ‘cooling-off’ period in the case of abortion, the obligation to obtain consent from the spouse or legal guardian before accessing some services, complex and cumbersome administrative procedures in terms of social security, or the necessity of proving numerous supporting documents, etc.

In the specific case of migrant populations, the absence of firewalls between the healthcare provision and immigration control, as well as social exclusion are some of the factors that prevent women to seek medical assistance during pregnancy for example, thus increasing the risk of complications leading to possible maternal death.

2. HOW TO REDUCE THOSE BARRIERS TO ACCESS TO HEALTHCARE?

Believes that removing financial barriers is an essential step towards universal access to care. This strategy contributes to achieving the Sustainable Development Goals 1 and 3.

The introduction of free care must not be carried out at the expense of the quality of care provision. MdM also supports free care policies that cover all aspects of the continuum of care in SRH. Finally, MdM wishes for the indirect costs such as food and transportation for patients and their families to be considered in the national policies of free care.

For further information on Médecins du Monde’s experience regarding lifting financial barriers, please consult the document: Atelier sur la levée des barrières financières à l’accès aux soins [Workshop on lifting financial barriers to health care], March 2012.

Ivory Coast has a 22% prevalence rate of modern contraceptives. Through its adhesion to the regional partnership of Ouagadougou, and through the global partnership of FP2020, the Ivory Coast set itself a double aim by 2020 in enhancing family planning: achieve a target of 514,000 additional users of modern contraceptives and reach a prevalence contraceptive rate of 36%. To achieve this, the government allocated 400 million CFAF for the purchase of contraceptives for the year 2016. This amount was not reallocated in 2017. Facing that situation, MdM launched and coordinated an advocacy with organisations of the civil society, destined to the minister of health. We encouraged effective participations of all main stakeholders, including the ivorian Association for Family Well-Being, Acting for Family Planning, and the Health Policy Plus Project. This advocacy action contributed to the allocation of 500 million CFAF to purchase contraceptives in 2018. This should increase of 10% each year, which should enable an unprecedented stability of funding for the following years, thus improving the availability of quality contraceptives.

Yvan Kotchi, SRHR Advocacy Officer in Soubre, Republic of Ivory Coast

14. Available on request from Health and Advocacy Directorate (DSP)

15. Guttmacher Institute, Induced abortion: incidence and trends worldwide, 2018
So as to reduce legal and administrative barriers to SRH services, setting up an analysis of the legal framework in intervention contexts is essential. Those frameworks influence the quality and nature of the healthcare provision, and the way in which SRHR are respected. It is therefore crucial to analyse the legislation to understanding the conditions of access to some rights, and the obstacles to their exercise in the context of an MdM intervention (chapter 3. III. 3. Legal framework).

To lift these legal barriers and permit the exercise of sexual and reproductive rights, advocacy activities are the main levers to develop. Advocacy is an essential component of the projects, and aims at achieving political or practical changes, whether it be at local, regional, national or international level. Action will consist in supporting the adoption of new policies in favour of improving access to SRH, questioning and encouraging the amendment of policies with negative impact on SRHR, and enhancing the implementation of existing legislation that are not applied. Ideally, advocacy strategies will be set up in partnership with movements of civil society when those are in line with the values that we stand for.

Advocacy strategies may also be used to lift administrative barriers through simplifying access to one service or the other, facilitating administrative procedures. Moreover, legal advice activities can also be set up in order to improve individuals’ information on their rights. Finally, the appointment of health mediators who will assist individuals in their administrative endeavours concerning access to healthcare will constitute a major lever. These mediators will also have a role in raising awareness and informing health practitioners on the specific needs of some people (for example migrant women).
CHAPTER 3
DIAGNOSIS IN SEXUAL AND REPRODUCTIVE HEALTH
The health diagnosis aims at gaining a global understanding of the context, to better understand an aspect of health and its determinants, and to question each person’s behaviour and representations. It helps identify the chosen public health problem, objectives and options for intervening. It consists in understanding the SRH needs of a given population, in confronting them to the response provided by the health system and identify barriers to access and potential gaps.

The health diagnosis is a precondition for Médecins du Monde setting up an intervention whether in France or abroad, in emergency or long-term situations. It may be carried out at the beginning of the project (initial diagnosis) or during the course of the project (intermediary diagnosis) to make adjustments.

The diagnosis comprises three stages:
- **Context analysis:**
- Identifying, prioritising and analysing collective health problems;
- Identifying public health problems and potential interventions.

These stages are briefly described in the following chapters. For further information, you are strongly advised to refer to the Médecins du Monde *Health Projects Planning* guide.

### 1. CONTEXT ANALYSIS

Context analysis involves collecting and evaluating data concerning factors influencing a given situation. These factors are:
- **Demographic and health factors;**
- **Geographic and environmental factors;**
- **Historic, political, regulatory and security factors;**
- **Socioeconomic factors;**
- **Sociocultural factors;**
- Factors linked to health policy and organisation of the health system.

It is also essential to identify stakeholders who are likely to have a positive or negative impact on a health initiative, analyse issues of power and influence and pinpoint potential partners.

Compiling and analysing data must be carried out using complementary
CHAPTER 3: DIAGNOSIS IN SRH

quantitative and qualitative methods. Data analysis and compiling must be carried out simultaneously so that gaps are identified and filled. It is important to catalogue information and retain only what is relevant. Data retained and its analysis must be transcribed into the fact-finding mission report.

Contexts change and so the process must be dynamic with the data being reviewed and updated during the subsequent stages and phases of the project.

2. IDENTIFYING, PRIORITISING AND ANALYSING COLLECTIVE HEALTH PROBLEMS

A health problem, whether individual or collective represents a gap between the physical, mental and social state of health that is observed and expressed and the state of health that is considered desirable and expected, as defined by medical experts, set out in legislation, or established by social norms.

It is essential to identify, prioritise and analyse collective health problems even when the public health problem, which is the subject of the intended intervention, has already been identified, so that the choice can be validated and compared to realities in the field.

Collective health problems are identified using two complementary diagnoses - epidemiological and perceptual. The ideal situation is where both diagnoses converge.

The epidemiological diagnosis is an overview of health problems and their determinants based on quantitative data, how frequently the data appears and its distribution within the population, as well as related risk factors and consequences. At initial diagnosis stage, information is gathered and analysed using secondary sources (national health information system, community records, study reports, etc.). It is only when the data needed does not exist that, in some instances, specific surveys may be envisaged to collect primary quantitative data.

Perceptual diagnosis is an overview of collective health problems said to be ‘felt’ (or observed) and expressed. The information gathered using qualitative methods (interview, observation, focus groups) or quantitative methods (questionnaire) reveals the importance, distribution and consequences of health problems via ‘the experience and the knowledge of a situation and what people feel: populations and professionals’. These collective health problems arise from the opinions of the public or health professionals. These opinions are forged by the knowledge, beliefs, attitudes and values of a group at a given moment of its history.

Initial reflex must be to find out whether secondary exist before setting out to collect primary data.

Analysing the problem must include a description of the problem and details of its consequences and causes (determinants). Prioritising collective health problems is done on the basis of predefined criteria (frequency, severity and consequences) and on the basis of negotiation between the different stakeholders about what is felt to be important.

Following prioritisation, a maximum of three collective health problems are selected; the determinants of these are then subjected to an in-depth problem tree analysis.

3. IDENTIFYING PUBLIC HEALTH PROBLEMS AND POTENTIAL INTERVENTIONS

According to the definition adopted by MdM, a public health problem is either a collective health problem (responding to the criteria of frequency, severity and socioeconomic consequences); or a determinant of this collective health problem. It is therefore a matter of identifying the public health problem which is the focus of the intended intervention and then of seeing which interventions may be instigated.

The choice of intervention must take account of what is already being done in a given area (i.e. existing projects) as it is a question of adopting a complementary approach and not of duplicating efforts. The choice of intervention must also take account of what we know how to do and what we want to do.

Possible interventions must be reviewed based on operational criteria relating to prioritising, potential added value and critical opportunities, constraints and conditions. The choice of intervention must be communicated to the parties involved in the analysis process and must be understood by the partners.

Following this stage, the intervention strategy is drawn up and detailed in the exploratory mission report.
II. SPECIFIC ASPECTS OF CONTEXT ANALYSIS
WHERE THE FIELD OF INTERVENTION INCLUDES SRH

With specific regards to SRHR, this is about questioning the setting up of the overall continuum of care and identify potential gaps. MdM’s strategy identifies 3 main priorities that reflect breaking-points in the continuum, and with components that are often neglected. Specific attention must be given to the analysis of these components. However, this must not be to the expense of a global view of the continuum of care which requires a comprehensive analysis in order to suggest integrated and holistic approaches. Similarly, whilst analysing the needs in SRH of a population as a whole, specific attention will be given to vulnerable people, for whom services are, in many cases, inadequate (for example adolescents and youngsters).

The diagnosis methods may encompass the following:
- A literature review/documentary analysis
- Stakeholder mapping
- Individual interviews with key stakeholders
- Group interviews
- Observation sessions
- Rapid assessment approach depending on context

Participative approaches will be used whenever possible, so as to involve all actors from the onset of the diagnosis: health authorities, civil society organisations and representatives of the community.

The diagnosis methodology should of course be carried out in accordance with the principles of confidentiality, safety, ethics and respect. For further information on this topic, please refer to the document ‘For ethics in the field’, by MdM.

1. HEALTHCARE POLICY

Particular attention must be paid to knowledge and understanding of public SRH policies. Encouraged by the Millennium Development Goals followed by the Sustainable Development Goals, numerous sexual and reproductive health policies and strategies have been implemented at national, regional and international level. The FP2020 also encouraged the development of national strategies regarding access to contraception. Each country develops one or several health policies or action plans for women’s health, family planning, sexual health, tackling STIs, etc. Often these policies and strategies are not centralised in one single document but are contained in several, difficult to obtain texts. In addition, these texts which impact on women’s health may emanate from a country’s Ministry of Health but may equally come from other ministries or government bodies (e.g. Ministry for Social Affairs, Ministry of Education, Ministry for the Status of Women, etc.).

Furthermore, numerous texts promoting sexual and reproductive health now exist (see chapter 1. I. ‘Commitment of Médecins du Monde’). It is important to thoroughly understand the way States commit to implementing international texts, regional commitments and national policies, and the scope of their application in the field of SRH. These different elements influence the quality and nature of the care provided, the way in which women’s rights are respected at every level of public institutions and, consequently SRH projects in a given context. This analysis will also be the basis to influence advocacy at national and potentially regional and sub-regional level.

2. STAKEHOLDER AND SERVICES MAPPING

In order to best identify the gaps in the continuum of care, or the gaps in terms of geographical coverage, it is essential to carry out a comprehensive mapping of available stakeholders and services. The aim will be to analyse the main actors in SRH, what their scope of intervention is, what activities/services they provide, where, when (opening hours), with which partners, etc. The actors can be government-based, international organisations, United-Nations agencies, community organisations, etc.

It is not always possible in our projects to address all SRH needs (specifically secondary health care/CEmONC, response to abortion request, and holistic care of GBV), therefore strong knowledge of the actors will facilitate efficient referral systems to be organised. For that purpose, a quality evaluation of service provision (including private facilities) is crucial (through regular contacts and visits to these facilities). This information will also be important when it comes to building partnerships and collaboration, as well as in developing advocacy strategies.

3. LEGAL FRAMEWORK

Knowledge of the legislative context is often crucial for sexual and reproductive health. Questions relating to abortion, gender-based violence, family planning and adolescent health can sometimes be controversial in some countries. Therefore, it is imperative to know the laws governing a country to understand the conditions of access to some rights, and the obstacles that will be faced by MdM in the realisation of the intervention.

For example, on the issue of abortion, the relevant provisions in the legislation must be known so as to establish the possible scope of
In the Philippines, SRH of youngsters and adolescents is an important public health issue. It is the only country in South-East Asia where early pregnancies and their associated mortality are increasing. Due to an extremely conservative religious context, it is a real challenge for youngsters and adolescents to access comprehensive sexuality education, STIs prevention and treatment services, contraceptive methods or care for GBV. There is a multiplicity of sociocultural or legal barriers. Face with this situation, MdM decided to carry out an exploratory mission on SRH for adolescents and youngsters in the Philippines. To achieve this, we conducted a documentary analysis, a comprehensive stakeholder mapping, as well as an analysis of the country’s legal framework around GBV. The analyses undertaken helped understand how international norms such as the Maputo Protocol were integrated in national legislation and how they were interpreted in national jurisdiction. Recommendations emerged from this analysis that were used to enrich MdM’s advocacy and support strengthening national policies. For this, MdM developed a legal framework analysis tool (See Fact Sheets: Management of unwanted pregnancies and Comprehensive Abortion Care: 3. Methodology for analysing the legal framework). All projects can use this tool provided they get in touch with the legal department of MdM’s headquarters.

With regards to questions on the care of GBV, one can also refer to the guidance note on SRH/GBV in crisis settings (See Guidance note on SRH and GBV in a crisis settings: 2.8 Legal support).

Therefore, it is crucial to obtain the most comprehensive understanding possible of the legal framework which includes legislation but also the interpretation of that legislation by law and health professionals and the subsequent judicial practices, so as to set up effective and quality SRH projects.

4. GENDER

The gender approach is an important element to include in a context analysis to respond to specific needs of men, women and transgender people in terms of health and to develop actions that contribute to reducing gender inequalities in SRH. A gender analysis helps to identify specific health needs of people by conducting health profiles that integrate needs due to biological differences between sexes as well as differences due to the social differentiation between genders. This analysis also points out the inequalities and power dynamics between genders and their impact on individuals’ experience and access to healthcare facilities. This analysis comprises a macro-analysis of factors of influence that have an impact on relationships and gender roles, as well as a micro-analysis of the roles occupied by men and women and transgenders in the community, including access and control over different types of resources. This will permit to gain a better understanding of the main gender inequalities that exist in a given context of intervention, and to question them with regards to their impact on access to health services. As previously mentioned, gender encompasses other elements constitutive of people’s identity that will also determine their role in society. These elements can be race, social class, gender identity, sexual orientation, age, ethnicity, etc. The combination of these elements is called intersectionality. It is important to consider intersectionality when conducting the analysis.

Gender analysis is an essential pre-requisite to developing actions that...
target specific needs of individuals and contribute to balancing existing gender inequalities, or at least to avoid increasing them.

The introduction of the gender approach in our interventions must be incremental and adapted to context. It must be co-constructed with the communities benefitting from the interventions. It is about setting up actions that address gender specific needs, which we call gender-sensitive actions. Gradually, projects can be integrated in gender-transformative actions. Towards that venture, an empowerment approach and work around new and positive masculinities helps to restore balance in relationships by working for and with the people. One of the aspects is to accompany women and transgender people, so that they can exercise more autonomy. Another aspect is to encourage a true co-responsibility in terms of health and SRH, through involving men in preventative actions regarding GBV, STI, contraception, parenting, etc. Gender and gender continuum evaluation charts regarding factors of influence, roles and control over resources are provided in Appendix 6 along with a planning/evaluation tool for assessing the impact of our actions on gender inequality.

5. Evaluating Healthcare Facilities

In order to get to know the health context it is important to study the health system. Knowing the healthcare pyramid (and different levels of care) is necessary to position the continuum of care in space. It also implies to analyse the overall services in the continuum of care overtime (see chapter 1. III. 2. Provision of care: health promotion, prevention and curative care, Figure 2: The continuum of care in SRH).

The theoretical level of care of health facilities must be coherent with the reality of these facilities (type of facility, state, activities undertaken, existing medical equipment, number and type of health professionals, communication and referral between facilities, etc.). The theoretical level of health is collected through the information on existing health policies: which SRH services depending on the level of the health facility in the health pyramid. The effective level can be identified through on-field observations by the teams that are conducting the exploratory mission.

The level of care must be analysed with regards to quality criteria among which:

- **Availability of care**: there is a need for at least 5 facilities providing emergency obstetric and neonatal care (BEmONC), including one that provides comprehensive emergency obstetric and neonatal care (CEmONC) for 500,000 people. Those services must be accessible 24/7.
- **Accessibility**: services must be geographically accessible and affordable means of transportation must be reduced, if not free.
- **Cultural adequacy**: services must consider local culture.
- **Security**: services must respect a set of norms to ensure the safety of their users at all times.
- **Respect**: services must respect standards of humanity and respect the users’ choice and preferences.

**FIGURE 5: THE WHO QUALITY OF CARE FRAMEWORK (SOURCE: IAFM)*

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8. Work to be undertaken with men to reshape concepts linked to dominant masculinity in favour of positive/egalitarian masculinities

9. IAWG, Inter-agency Field Manual on Reproductive Health in Humanitarian settings, 2018

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An SRH evaluation chart is suggested by MdM and available in Appendix 5. The gap between theoretical and effective levels will point out the needs in terms of support of the health system.

6. EVALUATING HEALTHCARE WORKERS

Around the world, the lack of skilled practitioners in SRH such as midwives and skilled birth attendants increases the challenge in accessing comprehensive SRH services, especially when seeking care in the case of obstetrical complications or comprehensive abortion care. In some countries, the number of midwives should be increased tenfold to address the needs. Moreover, a number of healthcare professionals in SRH do not have the required skills to provide a comprehensive quality care package.

Healthcare practitioners have a strong impact on reducing neonatal and maternal morbidity and mortality as well as in setting up SRH services according to needs. Their assessment is therefore an important stage of the context analysis.

In order to achieve this, it is important to get to know the curriculum of professionals working in SRH, so as to find out the content and the duration of their training. Then, a comparison should be made between the required skills and the effective skills of practitioners who work in health facilities. For this analysis, observation can be conducted during visits in health facilities by the team of the exploratory mission. Tests to evaluate knowledge can also be proposed. The maternal and neonatal health programme JHPIEGO provides some assessment tools to evaluate practitioners (see Appendix 5).

The time devoted for context analysis is usually short, therefore the question must be studied in depth at the onset of the project.

7. SOCIAL AND ANTHROPOLOGICAL STUDY

It is essential in a given context to be able to understand perceptions and representations around SRH, sexuality, contraception, abortion, existing services, etc., so as to best adapt the activities that will be developed. For this reason, it will be important to consider conducting social anthropological studies aiming at improving the understanding of sociocultural and community determinants.

Research in socio-anthropology of health aim at contributing to an interdisciplinary approach on public health issues and help decision-making on the orientation of health programmes. This will in turn improve their quality, their adequacy and their effectiveness.

‘Several months ago, the MdM delegation in Toulouse initiated a reflection around integrating the gender approach in its projects and around access to SRH services for homeless women in the city of Toulouse. The teams had identified a rise in the past years of the number of isolated women with or without children, and of families among the homeless people. However, the teams had the feeling that they were failing to reach out to them through our interventions, which is why the delegation questioned the therapeutic pathway and access to healthcare in SRH for homeless women. For that reason, an overview of access to SRH services for homeless and precarious women and an analysis of the extent to which gender is considered in the existing projects. This worked helped rise several topics for reflexion and action, in particular the possibility of developing ‘reaching out’ interventions in some emergency shelters or community insertion centres that welcome women and to suggest collective or individual actions around SRH. The possibility of opening a specific premise and schedule allocated to women within the community insertion centre to discuss questions of SRH was raised and must be further discussed’

Céline Vicrey, Regional Coordinator - Midi-Pyrénées, France

‘In Ivory Coast and Madagascar, I conducted social anthropological studies for MdM on sociocultural and community determinants of unwanted pregnancies and abortion for adolescents and youngsters. The aim of the research and the data collection sites were defined in collaboration with on-field teams and populations. Individual and collective interviews as well as observations were then carried out with adolescents and youngsters, their families, community and religious leaders, social and education stakeholders, healthcare practitioners from both traditional and biomedicine, policy makers, etc. In both contexts, the studies pointed out many obstacles to accessing contraception, the norms and behaviours of adolescents with regards to sexuality and management of unwanted pregnancy, as well as the conflict values experienced within society when it comes to considering the active sexuality of adolescents. The results of the study provided operational recommendations which underpin the new project for one mission, and the reorientation of an ongoing project for the other. The teams used the results and recommendations to define activities as well as to identify levers for advocacy to decision makers. From that perspective, social anthropological research within MdM have been identified by the teams as an important and efficient part in improving access to care and exercise of sexual and reproductive rights’

Marie-Laure Denefle Dobrzynski, Researcher in public health and social anthropology

CHAPTER 4

ASPECTS OF THE CONTINUUM OF CARE
I. COMPREHENSIVE SEXUALITY EDUCATION

1. DEFINITION

‘Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.’

CSE presents scientifically sound contents that are adapted to the age and development stage of the child and adolescent/youngster. It is a continuous educational process that starts from the youngest age, and where new information are underpinned by already acquired knowledge. CSE takes into account the sociocultural context. It is founded on scientifically precise and realistic information. It offers a positive vision of sexuality and is not only centred on the risks that come with sexuality. It refrains from judgement and encourages the empowerment of learners by improving their skills in analysis, communication, and preparation to everyday life. It is underpinned by a human rights and gender equality approach and contributes to several Sustainable Development Goals (SDG 3, 4 and 5).

In the absence of CSE, silence, embarrassment and disapproval of adults (parents, teachers, health practitioners, etc.) faced with the adolescents and youngsters’ concerns about sexuality do not help prepare them to take ownership of their sexual life.

1. UNESCO. International technical guidance on sexuality education: an evidence-informed approach overview. Revised edition, 2018
2. MINIMUM PACKAGE OF ACTIVITIES

a) Objectives

- To increase adolescents’ and young people’s knowledge and improve their attitudes in terms of sexual and reproductive health behaviours
- To promote a positive vision of sexuality that is not only based on information about risks and diseases
- To promote affective-sexual relationships based on consent and free will
- To enable adolescents and young people to exercise their sexual and reproductive rights;
- To reduce the number of unwanted pregnancies and early pregnancies for adolescents and young people;
- To reduce the mortality and morbidity caused by pregnancy, childbirth and abortion for adolescents and young people;
- To prevent STI for adolescents and young people.
- To prevent gender-based violence

2. Support to the development of school curricula taking into account the issues of CSE, training for teachers and educators.

3. Training for health professionals providing SRH services about main concepts of CSE and inclusion of awareness-raising messages adapted to targeted populations as a part of the SRH consultation.

4. Strengthening and/or setting up and awareness about peer networks on the topic of CSE.

5. Developing IEC (Information-Education-Communication) tools on issues around sexuality with and for adolescents and young people.

b) Contents

Key concepts

UNESCO has established Technical Guidance for sexuality education which were reviewed in 2018. This technical guidance suggests a comprehensive set of concepts, themes and, for information purposes, key learning objectives that help guide the development of school curricula that are adapted to local contexts. CSE is structured around 8 equally important concepts that strengthen each other and are to be taught simultaneously. These concepts can also be used to raise awareness on health and well-being for young people. The different concepts present a positive vision of sexuality, since sexuality education is not reduced to information on reproduction and risks and diseases.

Adaptability to each age group

Each theme has its own learning objectives and contents that can be adapted to each age group and according to the child or adolescent/young person’s stage of development. CSE programmes usually identify 4 age groups:

Level 1: 5-8 years old
Level 2: 9-12 years old
Level 3: 12-15 years old
Level 4: 15-18 years old

### Table 1: CSE Key Concepts and Associated Themes (Source UNESCO)

<table>
<thead>
<tr>
<th>KEY CONCEPT</th>
<th>ASSOCIATED THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERPERSONAL RELATIONSHIPS</strong></td>
<td>• Family relationships&lt;br&gt; • Friendships, romantic and love relationships&lt;br&gt; • Tolerance, inclusion and respect&lt;br&gt; • Long-term commitment and parenting</td>
</tr>
<tr>
<td><strong>VALUES, RIGHTS, CULTURE AND SEXUALITY</strong></td>
<td>• Values and sexuality&lt;br&gt; • Human rights and sexuality&lt;br&gt; • Culture, society and sexuality</td>
</tr>
<tr>
<td><strong>UNDERSTANDING THE CONCEPT OF GENDER</strong></td>
<td>• Social construction of gender and gender-based norms&lt;br&gt; • Gender equality, stereotypes and prejudices&lt;br&gt; • GBV</td>
</tr>
<tr>
<td><strong>VIOLENCE AND SAFETY</strong></td>
<td>• Violence&lt;br&gt; • Consent, privacy, physical integrity&lt;br&gt; • Safe use of information and communication technology</td>
</tr>
<tr>
<td><strong>CAPACITIES FOR HEALTH AND WELL-BEING</strong></td>
<td>• Norms and peer influence on sexual behaviour&lt;br&gt; • Decision making&lt;br&gt; • Skills for negotiation and communication of refusal&lt;br&gt; • Managing media and sexuality&lt;br&gt; • Finding help and support</td>
</tr>
<tr>
<td><strong>BODY AND HUMAN DEVELOPMENT</strong></td>
<td>• Sexual and reproductive anatomy and physiology&lt;br&gt; • Reproduction&lt;br&gt; • Puberty&lt;br&gt; • Body image</td>
</tr>
<tr>
<td><strong>SEXUALITY AND SEXUAL BEHAVIOUR</strong></td>
<td>• Sex, sexuality, sexual life cycle&lt;br&gt; • Sexual behaviour and sexual response</td>
</tr>
<tr>
<td><strong>SRH</strong></td>
<td>• Pregnancy and preventing pregnancy&lt;br&gt; • Stigma associated with HIV and AIDS, treatments, care and support&lt;br&gt; • Understanding, considering and reducing the risk of STI, including HPV and infection with HIV.</td>
</tr>
</tbody>
</table>

### Table 2: Example of the Theme ‘NORMS AND PEER INFLUENCE ON SEXUAL BEHAVIOUR’ Broken Down by Level (Source UNESCO)

#### Learning Objectives for Level 1:
- **Define peer pressure**
  - Peer-influence can take multiple and diverse forms
  - The influence of a peer can be positive or negative

#### Learning Objectives for Level 2:
- **Describe social norms and their influence on behaviours**
  - Social norms influence values and behaviours including those regarding sexuality
  - Assertiveness and other techniques can help face social norms and peer pressure

#### Learning Objectives for Level 3:
- **Explain how peer pressure and social norms influence decisions and behaviours**
  - Social norms and peer influence, such as bullying and negative group pressure may have an influence on decision making and behaviour
  - Being assertive means to know when and in what conditions to say ‘yes’ or ‘no’ to sexual relationships, and stick to that decision

#### Learning Objectives for Level 4:
- **Describe competencies required to resist peer pressure**
  - It is possible to make rational decisions regarding sexual behaviour
  - It is possible to resist negative peer influence on decision making around sexuality
c) Implementation

Sociocultural adaptability
To be efficient, CSE must adapt to the context and specific needs of adolescents and young people. That is why it is important to understand cultural messages around gender, sex, and sexuality (importance of the sociocultural diagnosis linked with a gender approach). Understanding context might lead to targeting specific themes such as discrimination, gender inequalities linked to sexuality, GBV, HIV and AIDS, early marriages and harmful traditional practices, unwanted pregnancies, unsafe abortions etc. The content should be adapted to national laws and policies. It is important that the content of the CSE reflects the local context, however some central themes are essential in maintaining quality and satisfying to international standards.

It is crucial to anticipate underlying value conflicts while developing comprehensive sexuality education and to raise awareness of the society to the benefits of CSE.

For better sociocultural acceptability of CSE, it is important to involve adolescents and young people as well as their parents, community and religious leaders, health carers whether in traditional medicine or biomedicine, teachers and other socio educative referents in the reflection and decision making throughout the different stages of the project. In most contexts, it is useful to collaborate closely with adolescent peers, parents and teachers. Raising their awareness and training them in intergenerational dialogue and training on setting up CSE improves CSE at school, with families and peers. Sociocultural determinants are to be considered for different types of groups. This will help adapt to the needs of each type of group the chosen tools and means of communications by co-constructing them with the group members (adapt content, language, images, building on legitimate people in the group to raise a topic, etc.). The creation of messages and tools is also an appropriate moment to give some thought to beliefs and stereotypes that exist around sexuality in the community and among young people, to make them emerge, and find messages that illustrate positive and non-discriminating sexuality.

Encouraging adolescents’ and young people’s involvement
It is crucial that adolescents find an opportunity to speak up in the individual and collective research of solutions to set up CSE. This is to promote the capacity and legitimacy of adolescents and young people to determine and promote the contents of CSE that address their needs. The approaches and tools used for CSE are to be co-created with adolescents and young people themselves. Interactive and playful methods, role plays, and the use of new technologies for information and communication are particularly adequate when talking to adolescents and young people. When conceiving these tools, special attention should be given to using appropriate language (‘youth speak’ that enables the comprehension of definitions and technical terms, etc.). There should be encouragement to avoid the repetition of messages and visuals that reproduce and reinforce gender stereotypes and discourses that carry discrimination that can lead to normalising inequalities and aggressive and/or violent behaviours. The approaches and tools are to be tested on a sample of the target population before being scaled up to the project. A self-evaluation tool on communication is available on the intranet.

4. IMPLEMENTATION

The intervention strategies presented here follow the different action areas of the Ottawa Charter for health promotion. MdM builds on this charter to underpin project planning.

Whilst it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

Whatever the chosen intervention strategies, it is essential that the services providing comprehensive sexuality education be carried out with respect for the patient’s privacy. Medical data must be protected. For further information it is advised to consult the document ‘For ethics in the Field’ by MdM.

By further investing in CSE, governments can enable adolescents and young people to exercise their fundamental rights in terms of SRH, and to develop knowledge and attitudes that will help them prepare to a safe and thriving sexuality as well as better management of risks situation. Thus, CSE develops adolescents’ and young people’s capacities to make informed decisions and stick to them. It encourages communication with parents and other trusted adults. It is therefore essential to encourage governments and policies towards the development of CSE programmes. When it is lacking, we can provide technical support to decision makers such as the ministry of Health or the ministry of Education and/or conduct advocacy actions.

The following outcomes can therefore be pursued:

- **The political environment is supportive** to the exercise of sexual and reproductive rights;
- **Advocacy actions for better consideration of questions on CSE** are developed and implemented in collaboration with key actors of the civil society when possible;
- **Quality CSE programmes within schools** based on UNESCO’s Technical Guidance are developed and implemented;
- **a) Supporting formulation or strengthening national policies regarding CSE** (element relating to ‘Building healthy public policy’ in the Ottawa Charter)

In Burkina Faso, MdM is a part of the ‘Stop unwanted pregnancies’ advocacy group. That group is involved in the advocacy process in favour of integrating Comprehensive sexuality education in the training curriculum in school and non-school settings, to reduce unwanted pregnancies. Various activities are conducted towards that venture. Organisations of the civil society came together as an alliance to work closely with focal points and key resources in the Ministry of Education. A major interactive television show on the topic during which a representative of the Ministry of Education made commitments in favour of CSE. We also actively participate to concertation meetings with scientific committee for updating training curricula and the development of a frame of reference ‘zero unwanted pregnancy in school settings’. As a first result of our advocacy, we were there to witness the adoption of this frame of reference along with measures of prevention of unwanted pregnancies in school setting.

Cécile Thiombiano-Yougbare, Advocacy Coordinator, Burkina Faso

In the French-speaking African countries concerned by the programme: ‘Promoting the right to decide to reduce mortality and morbidity caused by unwanted pregnancies’ of MdM, it has been difficult to find adequate tools to train our teams and partners on the topic of sexual and reproductive health of teens and young people (modules often focused on abstinence and out of phase with reality). To address this, we reviewed our existing training module to strengthen the context of SRH for adolescents and young people, specifically on CSE taking into account the most recent recommendations. Our teams in charge of implementing the programme were trained alongside our partners for each mission; those training sessions were extremely useful as they provided us with an opportunity to work on personal barriers and obstacles with regards to access to services by adolescents and young people. We were able to identify through these workshops the champions to facilitate access to services for young people and for advocacy on CSE.”

Sodeha Hien, Regional Coordinator for SRH / Unwanted pregnancies

CHAPTER 4: ASPECTS OF THE CONTINUUM OF CARE

In the French-speaking African countries concerned by the programme: ‘Promoting the right to decide to reduce mortality and morbidity caused by unwanted pregnancies’ of MdM, it has been difficult to find adequate tools to train our teams and partners on the topic of sexual and reproductive health of teens and young people (modules often focused on abstinence and out of phase with reality). To address this, we reviewed our existing training module to strengthen the context of SRH for adolescents and young people, specifically on CSE taking into account the most recent recommendations. Our teams in charge of implementing the programme were trained alongside our partners for each mission; those training sessions were extremely useful as they provided us with an opportunity to work on personal barriers and obstacles with regards to access to services by adolescents and young people. We were able to identify through these workshops the champions to facilitate access to services for young people and for advocacy on CSE.”

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In Burkina Faso, MdM is a part of the ‘Stop unwanted pregnancies’ advocacy group. That group is involved in the advocacy process in favour of integrating Comprehensive sexuality education in the training curriculum in school and non-school settings, to reduce unwanted pregnancies. Various activities are conducted towards that venture. Organisations of the civil society came together as an alliance to work closely with focal points and key resources in the Ministry of Education. A major interactive television show on the topic during which a representative of the Ministry of Education made commitments in favour of CSE. We also actively participate to concertation meetings with scientific committee for updating training curricula and the development of a frame of reference ‘zero unwanted pregnancy in school settings’. As a first result of our advocacy, we were there to witness the adoption of this frame of reference along with measures of prevention of unwanted pregnancies in school setting.

Cécile Thiombiano-Yougbare, Advocacy Coordinator, Burkina Faso

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Chapter 4: Aspects of the Continuum of Care

In the French-speaking African countries concerned by the programme: ‘Promoting the right to decide to reduce mortality and morbidity caused by unwanted pregnancies’ of MdM, it has been difficult to find adequate tools to train our teams and partners on the topic of sexual and reproductive health of teens and young people (modules often focused on abstinence and out of phase with reality). To address this, we reviewed our existing training module to strengthen the context of SRH for adolescents and young people, specifically on CSE taking into account the most recent recommendations. Our teams in charge of implementing the programme were trained alongside our partners for each mission; those training sessions were extremely useful as they provided us with an opportunity to work on personal barriers and obstacles with regards to access to services by adolescents and young people. We were able to identify through these workshops the champions to facilitate access to services for young people and for advocacy on CSE.”

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1. DEFINITION

Given the disparity of terminologies on the topic of contraception and family planning, and the difficulty to differentiate concepts, we suggest the following definitions:

➡ The term **contraception** refers to a method that enables to prevent a pregnancy by acting on ovulation, implantation and/or fertilisation. A method is considered efficient when it has been scientifically tested and validated.

➡ **Family planning** refers to the overall services and methods that enable individuals and couples, depending on their desire or not to have children and the number of children that they want, to choose the moment of birth. This is made possible by the use of contraceptive methods and fertility treatments.

➡ The term **birth spacing** refers to the possibility of maintaining a time space between births. To limit the negative impact of closely-spaced pregnancies on the mother’s health and that of the existing children, the WHO recommends a 24 months birth spacing (between the delivery and the beginning of the next pregnancy).

In this section, the term **Counselling and services providing efficient methods of contraception** is voluntarily used based on the premise that contraception can also be used outside a family planning perspective. It must also be understood that only the scientifically validated methods of contraception are promoted in this guide. Other methods sometimes referred to as ‘traditional methods’ that have not been evaluated through evidence-based research are not presented here.

**Services providing efficient contraceptive methods must be integrated in preventative and curative care in sexual and reproductive health.** They include health education and counselling that enable people to make informed decisions on their contraception and are also able to provide contraceptive methods. They may also answer to the needs in care or referral in the case of infertility, as well as offer prevention and care services for STI.
Access to contraception is essential element of the continuum of care towards promoting women’s and individuals’ well-being and autonomy. Services providing contraceptive methods have an impact on social change, gender equality, education, and women’s financial security. They also have an important public health impact on reducing maternal and child mortality and morbidity.

This section is based on the various WHO recommendations reviewed in 2017 and 2018 regarding services providing contraceptive methods; new scientific recommendations were published that widen the scope of available methods. For example, emergency contraception with ulipristal acetate, progesterone vaginal rings, and subcutaneous injections of DMPA were included in the main guides for professionals and were therefore added to the list of medications when revising this guide.

2. MINIMUM PACKAGE OF SERVICES

a) Objectives
– To enable people to exercise their sexual and reproductive rights and to choose if and when they want to have children;
– To provide enlightened information regarding all efficient contraceptive methods (including emergency contraception) and how to use them;
– To reduce the number of unwanted pregnancies;
– To reduce unsafe abortions and their associated mortality and morbidity;
– To reduce closely-spaced pregnancies and their associated morbidity and mortality;
– To prevent and treat STI;
– To prevent and screen for cervical cancer.

b) Key interventions

1. Health education adapted to the specific needs of each type of user (adolescents, LGBTQ+ populations, sex workers, migrants, etc.) and communities: based on scientifically sound information on contraception and family planning, alongside actions towards clarification, deconstruction of myths and false beliefs in terms of contraception.

2. Contraception:
   ➡ Delivering information on advantages, side-effects, medical contraindications for each contraceptive method;
   ➡ Providing a large choice of efficient contraceptive methods (at least three methods and emergency contraception) and adapted to each individual;
   ➡ Promoting free access to efficient contraceptive methods, regardless of age or marital status;
   ➡ Requesting informed consent from the person before prescribing contraceptives;
   ➡ Referral and/or care in a CEmONC for feminine or masculine sterilisation according to national protocols;
   ➡ Provision of emergency contraception and information on its use.

3. STI including HIV:
   ➡ Preventing, screening and managing STI, with a treatment adapted for the woman and her partner;
   ➡ Promotion of double protection (pregnancy and STI) and distribution of condoms (masculine and feminine);
   ➡ Counselling and screening for HIV on a voluntary basis, and referral for treatment if necessary.

4. Breast cancer and cervical cancer (depending on national protocols and availability of necessary resources for screening and early treatment (see chapter 5. I. Prevention of cervical cancer):
   ➡ Information and advice for prevention and treatment;
   ➡ Breast cancer screening (including explaining self-examination) and referral to adapted services if necessary;
   ➡ Screening of precancerous lesions for cervical cancer (depending on availability and current national recommendations);
   ➡ Treatment of precancerous lesions in cervical cancer (in line with current national recommendations), and referral to adapted services in the case of cancerous or advanced lesions.
   ➡ Referral to existing specialised services if screening is not available in family planning services.

5. Identification, care, or referral, and support of survivors of gender-based violence (see chapter 5. II. GBV):
   ➡ Identification of survivors of GBV;
   ➡ Primary prevention of violence;
   ➡ Referral or medical care and initial psychosocial support;
   ➡ Referral to other services according to needs (legal assistance, psychosocial support, emergency shelter, etc.).

6. Initial identification of infertile couples, care and treatment (treatment of STI) or referral in an adapted service (if available) for specialised care.

3. UNDERSTANDING THE ISSUE

a) Background information

Despite an increasing use of efficient contraceptives in many regions of the world, in particular in Asia and Latin America, they are still underused in Sub-Saharan Africa. Nowadays, 214 million women who wish to postpone or avoid pregnancy still have no access to contraception. Most of these women are in developing countries.

On a global scale, the use of contraceptives has increased, between 1990 and 2014 from 54% to 57.4%.

On a regional level, the proportion of married women between the age of 15 to 49 who declare using a modern contraceptive method has increased slightly between 2008 and 2014. In Africa, it has increased from 23.6% to 27.6%; in Asia it has only slightly progressed from 60.9% to 61%; this is similar to the situation in...
CHAPTER 4: ASPECTS OF THE CONTINUUM OF CARE

Latin America and the Caribbean raising from 66.7% to 67%. It is important to note that men’s use of contraception represents a relatively small proportion of the prevalence rates mentioned above. Contraceptive methods available for men remain limited.

Overall, programme efforts regarding family planning have been enhanced over the past few years, however the unmet needs remain high in many countries. This reveals important barriers to access and services with limited quality mostly cause by political weaknesses.

The Family Planning 2020 initiative (FP2020) - of which MdM has been part since 2017 - rose from a global partnership between governments, funders, private organisations, civil society organisations and research organisations to support the ‘rights of women and girls to decide freely and for themselves, whether, when, and how many children they want to have’. The FP2020 focuses on 69 priority countries and contributed to raise the health of the couple, and women (men often feel less concerned with contraception and expressing their needs, views, and feelings). Unmet needs must be fulfilled building on communication for behaviour change, value change and acquisition of new skills and knowledge, in particular for people in vulnerable situations (in a crisis context, adolescents, poorest people, ethnic minorities). For those reasons, it is imperative to operate a real change through the commitment of policy makers and leaders in the healthcare sector to promote access to quality services offering effective and varied contraceptive methods.

b) The right to access contraception

‘Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples to decide freely and responsibility the number, spacing and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health’.

This right to access efficient contraception is reported in many international benchmark documents (see Appendix 3).

Each person who wishes to should have access to an efficient contraception of his/her choice, including adolescents and unmarried people. By no means should anyone be coerced into using contraception, for it would constitute a violation of human rights. Individuals have the right to be informed and to access safe, efficient, affordable and acceptable methods. They must have the possibility to make an informed choice. Access to all existing methods, including emergency contraception, should be possible for each user.

c) Quality services

Family planning services must be integrated in the continuum of care and must include counselling and prevention, treatment of STI, as well as care adapted to the specific needs of certain users (adolescents, people living with HIV, LGBTQ+ people, people with a handicap, sex workers, migrants, etc.). Services offering efficient contraceptive methods should be routinely offered during the postpartum and the post-abortion period.

Factors influencing the quality of services providing contraceptive methods are the following:
- A large panel of contraceptive methods to answer the needs and choices of individuals including long-term methods (tubal sterilisation or vasectomy, implant, intrauterine device);
- Qualified and trained practitioners who can accompany people without judgment or discrimination;
- Sufficient number of health facilities to ensure a good coverage of the population;
- Good management of equipment and contraceptive stock so as to guarantee continuous availability of various methods;
- Availability of tests and drugs for screening and treatment of STI;

10. UNFPA, Making reproductive rights and sexual and reproductive health a reality for all, 2008.
12. Inter-agency working group (IAWG), Inter-Agency Field Manual on Reproductive Health in Humanitarian settings, Revised 2010 version.
CHAPTER 4: ASPECTS OF THE CONTINUUM OF CARE

Information of the population regarding the existence of these services and what they provide.

Particular attention should be drawn to drug interaction, specifically with the treatments of tuberculosis, some anticonvulsants and antiretroviral. The eligibility criteria for each contraceptive method can be found in ‘WHO’s Medical Eligibility Criteria for Contraceptive Use Guide of 2015’ which comes with the Medical eligibility criteria wheel for contraceptive use14.

Counselling is also a crucial element of the quality of care and is developed in the next section.

d) Counselling in efficient contraceptive methods

Each year, 25 million unsafe abortions occur as a consequence of as many unwanted pregnancies. The consequences of these abortions represent the 3rd cause of maternal mortality. An important proportion of these unwanted pregnancies is a result of the unavailability of contraception methods but also of failure of contraception through misuse. Moreover, some inconveniences linked to a contraceptive method can lead to a woman stopping to use it, which is usually a decision that is made through lack of choice, stockout, incorrect use or fear of side-effects. Those are the signs of the failure of counselling and services in family planning.

The reason for the absence of use of contraceptive methods are diverse5:

- Limited choice of methods or stockout in healthcare facilities;
- Limited access to services offering efficient contraceptive methods. This is particularly true for young people, adolescents and stigmatised and/or vulnerable groups;
- Poor quality of existing services;
- Fear of side-effects;
- Cost;
- Cultural or religious opposition;
- False beliefs, myths, a priori of users and health professionals on certain methods;
- Gender inequalities and gender-differentiated socialisation.

On the missions in France, in 2018, 89% of women of childbearing age did not have any contraception versus 3% in the general population16.

Even when individuals had knowledge on contraception, false beliefs or fear of side-effects of contraceptive methods, as well as questions around religion were some of the barriers to using services.

Quality counselling can help users choose the contraception that is adapted to them and use it in an appropriate manner. This also enables to avoid discontinuity in the use of contraceptive methods.

It is important to understand the representation that is made of contraception by individuals and communities to offer them quality counselling. The information must encompass benefits and risks for each method, correct use of the chosen method, side-effects, warning signs and prevention of STI. This information must be presented in a language and in a form that facilitates understanding and access.

Each person has different needs, it is therefore essential to let individuals express their needs. We must ensure that each person uses methods efficiently and is satisfied. For this, it is also important to take into account how, in a given context, gender relationships can influence contraceptive practices and adapt counselling accordingly. For example, it is crucial to be able to talk about negotiation techniques on condom use when this is the chosen method by the user (attitudes to adopt to convince her partner to use a condom, key messages about condoms, attitudes in the case of refusal, etc.).

A successful counselling session includes all of these factors and requires time and qualified personnel. It is a key element of quality services in contraceptive methods, whether at the adoption stage or during the follow up visits. Individuals must also be encouraged to consult again if they wish to, and to plan the next consultation.

On the topic of access to contraception, MdM has chosen to adopt the following definitions in relation to the concept of new user suggested by the FP2020 initiative17.

Let’s remember that the use of a contraceptive is not static but dynamic. In the course of their lives, women and men begin, continue and stop using contraceptives for various reasons:

- The ADOPTION of a contraceptive method comprises the people who use a given method for the first time in their life, or those who had temporarily stopped contraceptives and resume using them = new user
- The CONTINUATION of a contraceptive method refers to the people who have already been using contraceptives for some time and continue to use them. This includes people who use short-term and long-term methods.
- The INTERRUPTION of a contraceptive method occurs when people stop using contraceptives. The reasons for interruption are varied and include a wish for pregnancy, menopause, side-effects, to name a few.

e) Emergency contraception

Emergency contraception (EC) refers to a ‘back-up’ contraception that women can use in the days following an unprotected intercourse to avoid an unwanted pregnancy. Emergency contraception is a response to women’s rights to access family planning, to have a choice when confronted with a potential pregnancy, and help reduce the number of unwanted pregnancies and, as a consequence, the number of unsafe abortions. It should be noted that recent studies have proven the harmlessness of the emergency contraceptive pill even in the case

15. WHO, Family Planning: Fact Sheet, 2018
of repeated use on a single cycle. However, the use of EC as a regular method of contraception should not be advised, which is why a long-term contraceptive method should be proposed at the time of EC delivery.

Emergency contraception can be used in the case where there is an absence of contraception and unprotected intercourse, failure of the contraception used (e.g. missed/inappropriate intake, vomiting and diarrhoea between 2 to 4 hours following oral intake of contraception, condom breakage, etc.) or in the case of rape.

Hormonal methods (emergency contraceptive pill, Yuzpe method) or mechanical method (through insertion of a copper IUD) are possible.

It is paramount that healthcare practitioners are trained to those methods, to their use and modes of action so that women can have access to them. Those methods must be readily available for victims of sexual abuse as well as any person who requires them after unprotected intercourse or failure of contraceptive use.

The emergency contraceptive pill or ‘morning-after pill’

Even if the emergency contraceptive pill is available in many countries, it is still scarcely used and often misunderstood. False perception around this method are frequent in developing countries as well as in high-income countries. Countless studies and several decades of hindsight have shown the safety of emergency pills. Moreover, their mode of action is not abortive but will prevent ovulation and/or reduce sperm mobility, therefore they will have no impact on an already existing pregnancy.

To date, two types of emergency pills exist:

- Ulipristal Acetate Pill (UAP) in a single-dose pill of 30 mg
- Levonorgestrel (LNG) in a single-dose pill of 1.5 mg or in two doses of 0.75 mg to be taken 12 hours apart

Those two pills must be taken within five days (120 hours) of the unprotected intercourse to be efficient. The earlier the intake, the higher the success rate. Ulipristal Acetate Pills have shown a higher efficiency between 72 and 120 hours compared to those with LNG. They are often more expensive.

The side-effects resulting from the use of emergency pills are comparable to those of oral contraceptives (nausea, vomiting, irregular vaginal bleeding, headaches, mammary tension, etc.). Those side effects are rare and harmless.

It is important to note that there are no medical restrictions (except the case of known allergy to any of the excipients) for the use of emergency contraceptive pills. Women can be provided in advance with emergency contraceptive pills to ensure they have immediate access to them when they need to and will be able to take early action after unprotected sex.

The intrauterine device

The copper intrauterine device or copper IUD may also be used as emergency contraception when it is inserted within five days (120 hours) after an unprotected intercourse. It prevents pregnancy in 99% of cases. There will be no abortive action, but the IUD will postpone or prevent ovulation and reduce sperm mobility. The woman is equipped with long-term efficient contraception.

The Yuzpe method

This method is used when the emergency contraceptive pill is not available and emergency contraception is required. It is based on the multiple intake of combined oral contraceptives, i.e. contraceptive pills that contain both an oestrogen and a progestogen.

The doses depending on the drug formulation are also available in the WHO 2018 handbook for family planning.

f) Community-based provision

Many programmes have shown that community-based provision of contraceptives was effective in improving access to family planning. In Pakistan, six studies have shown an increase in contraceptive prevalence rates from 12% to 33% after a year. This is also the case in Africa, where community-based provision of injectable contraceptives has helped debottleneck health centres by decentralising family planning services, specifically thanks to community health workers.

A technical consultation conducted in 2009 infers that community workers are competent to safely and efficiently administer injectable contraceptives. A review of initiatives underpinned by that premise in four Sub-Saharan countries was carried out by the Guttmacher Institute in 2014. This review concluded that community-based provision of injectable contraceptives was an innovation that was worth upscaling. Nonetheless, it set certain prerequisites suggesting that this type of initiative should be an addition to existing programmes of community provision of other contraceptive methods and that focus should be put on training programmes.
community agents towards that venture. Indeed, as opposed to contraceptive pills and condoms that are easily accessible in chemist shops, injectable contraceptives require a skilled person for the injection. It is therefore essential to train community health workers and monitor their activity. This type of activity widens the choice of contraceptive methods that are provided to populations who are usually underserved and to reduce unmet needs in family planning.

**g) Postpartum and post-abortion contraception**

Many studies have shown the benefits of routinely offering efficient contraceptive methods in postpartum and post-abortion. This practice is recognised to be an activity of high impact on access to contraception25. Immediate postpartum represents a major opportunity for women to access a method of contraception even before being discharged from maternity services. Several methods can be prescribed immediately after birth (implants, progesterone pills, IUD). It is essential to inform women that pregnancy can occur in the 4 weeks following childbirth. For that pregnancy can occur in the 4

26. WHO, Family planning: a global handbook for providers, 2018
27. WHO, Family planning: a global handbook for providers, 2018
28. UNAIDS, Data 2017

contraception must be routinely offered after an abortion. In the case of legal abortions, the question of contraception must be raised during the pre-abortion consultation. In the contexts of illegal abortion, it is crucial that this be integrated in post-abortion care.

27. WHO, Family planning: a global handbook for providers, 2018

**h) Infertility**

Infertility is the incapacity to conceive children. Infertility can be primary for couples who have never conceived, or secondary for a couple who has already known one or several pregnancies. A couple will be referred to as infertile after 12 months of unprotected intercourse resulting in no pregnancy. This infertility can be difficult to deal with for couple. The possibility of having a child is part of reproductive rights as previously stated, and therefore is a part of family planning services.

Infertility affects 1 couple out of 10 worldwide. In Sub-Saharan Africa, over 30% of women aged 25 to 49 suffered from secondary infertility in 200429. In over 1/3 of cases, the couple’s infertility resulted from masculine infertility.

Infertility can be caused by different factors or conditions in the woman, the man, or the couple. Infectious diseases, including sexually transmitted infections, are one of the main causes of infertility. Indeed, without an appropriate treatment, some STIs such as chlamydia and gonorrhoea can affect the genital tract and lead to infertility. Postpartum or post-abortion infections can also lead to temporary or permanent infertility.

Basic care can be provided in family planning services such as:

- **Counselling the couple** to help achieve pregnancy (information on fertility, ovulation periods);
- **Screen and treat STI** and other infections;
- **Refer the couple** to services that can provide an evaluation after a year of sexual intercourse not leading to pregnancy.

28. UNAIDS, Data 2017

**j) STI/HIV (double protection)**

In 2016, there were 357 million new cases of curable sexually transmitted infections (syphilis, chlamydia, gonorrhoea, trichomonas)27 and 1.8 million new HIV infections in 201728. It is mandatory to tightly knit prevention and treatment of STIs within SRH services that offer contraception methods. Moreover, STIs are a major cause of infertility. It is therefore important to detect them and treat them to help couples with difficulties to conceive a child.

The feminine or masculine condom is the only contraceptive that prevents the risks of sexual transmission of HIV or STI. Family planning services must promote double protection which consists in preventing unwanted pregnancies and STI, either using the condom alone, or a condom associated with another contraceptive method.

The added benefit of condoms - efficient protection against infection - must be brought to light to those who use contraception so that they can make a free and informed choice regarding the contraceptive method. This double protection should also be promoted for men, young people and population at high risk of STI, by explaining the importance and benefit of its use. Similarly, it is essential to discuss and counsel women about negotiating the use of a condom by the male partner.

Finally, the services providing contraception play an essential role in tackling HIV/AIDS by offering users the possibility of voluntary screening and counselling. Appropriate counselling in family planning will also be delivered to seropositive couples.

**j) Cervical cancer**

Services offering contraception methods are a good entry point to discuss and offer CC screening if this one is available in that given context. It can lead to treatment of precancerous lesions and referral for management in the case of cancer. Right now, MdM has integrated this offer to services offering contraception in its projects in Ivory Coast and Burkina Faso (see Chapter 5. l. Prevention of CC) but could extend this in the future to offer it in services providing antenatal / postnatal care or screening for STI/HIV.

4. Intervention Strategies

The intervention strategies presented here follow the different action areas of the Ottawa Charter for health promotion. MdM builds on this charter to underpin project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

Whatever the chosen intervention strategies, it is essential that the services providing contraception be carried out with respect for the patient’s privacy. Medical data must be protected. For further information it is advised to consult the document ‘For ethics in the Field’.

a) Supporting formulation or strengthening national policies regarding access to contraception

(element relating to ‘Building Healthy Public Policy’ of the Ottawa Charter)

By further investing in services providing contraception, governments help individuals access their fundamental right to decide on their reproduction as stated in international texts. Thus, this improves the health of women and children and promotes major social and economic changes. Therefore, it is crucial to encourage governments and policy makers towards developing and integrating these services. Where this is not the case, we can consider providing technical support to decision-making bodies such as the Ministry of Health or to conduct advocacy actions.

The following outcomes can therefore be pursued:

- Access to services providing quality contraceptive methods throughout the territory, specifically to people in vulnerable situations;
- National protocols for services providing contraceptive methods including access to emergency contraception are developed and made aware of;
- The political environment supports the exercise of sexual and reproductive rights.

b) Reducing barriers to access to services providing methods of contraception

(element relating to ‘Creating supportive environments’ of the Ottawa Charter)

As part of the efforts regarding access to family planning, it is important to identify and eliminate financial, legal, sociocultural, and geographical barriers that are an impediment to access.

The following outcomes can therefore be pursued:

- A sociocultural diagnosis with a gender approach is carried out to identify sociocultural barriers to accessing family planning services and to using contraception, as well as inequalities and discrimination linked to sexuality that potentially impact the sexual experience of people and their full exercise of their sexual and reproductive rights;
- Women’s status in communities shifts towards better equality regarding accessing and exercising SRHR;
- Women have acquired competencies in recognising, expressing, and addressing their needs in SRH for them and in their couples. Men have acquired competencies in taking responsibility for their health and taking co-responsibility, in an equal and respectful manner, for the health of the couple;
- Couples have access to modern contraceptive methods that are free or affordable;
- Health mediators are trained and work in services providing contraception methods, with the aim of facilitating the link between carers and communities (in contexts where healthcare professionals and users do not share the same language or the same sociocultural reality).

c) Improving service provision

(element relating to ‘Reorienting health services’ of the Ottawa Charter)

The services providing contraception methods must be an integral part of primary health facilities to facilitate access. Service provision must offer quality care and be adapted to the needs of women, men and/or couples as well as the needs of adolescents and young people.

The following outcomes can therefore be pursued:

- A wide choice of efficient contraceptive methods (including emergency contraception) is offered to women, men and couples;
- Services are culturally adapted to women, their families and their communities to facilitate their use;
- Supply management of contraceptive methods is reinforced through information and support of the practitioners in healthcare facilities;
- Double protection is promoted, and masculine and feminine condoms are provided;
- Health practitioners in charge of services providing contraception methods have enhanced their skills through basic and continuous training;
- The management teams conduct regular and adapted supervisory sessions for health practitioners in the wards;
- Services are adapted to potential specific needs of their users (adolescents, people with HIV, LGBTQI+ people, people with a handicap, migrants, etc.).

d) Strengthening or setting up health education for women, men, couples and communities

(element relating to ‘Developing personal skills’)

Strengthening knowledge on health can improve access to service offering contraceptive methods and contribute to reducing maternal and child mortality and morbidity. Indeed, strengthening women’s knowledge will help them have more autonomy, and be in capacity to

decide the number of children they want and to plan their pregnancies. It is necessary that women stop being the only recipients of these awareness-raising actions, so that their partners, families and communities also get involved. Family and community involvement are a core element for adoption of healthy behaviours towards women’s access to care.

The following outcomes can therefore be pursued:

❖ Leaders and other influential people in the community (religious leaders, traditional birth attendants, traditional healers, etc.) are aware of the importance of accessing contraception and family planning and encourage the use of services;

❖ Community players and women’s groups act to spread messages on sexual and reproductive rights in the community and to promote sexual and reproductive rights to local authorities;

❖ Community health workers are trained and supervised to deliver contraceptives on a community level (after an initial medical prescription).

e) Promoting community involvement around access to contraception
(element relating to ‘Strengthening community action’)

It can be interesting to elaborate projects with the civil society to have a greater impact and adapt interventions to communities’ reality, whilst supporting them in building their own individual and collective change. Projects are more effective when they are the result of the combined efforts of both community and government.

The following outcomes can therefore be pursued:

❖ Women/adolescents as well as men/adolescents improve their knowledge about contraception and family planning, different contraceptive methods, double protection, prevention of STI;

❖ Women are aware of their rights in sexual and reproductive health, including the right to access family planning and to decide the number of children they want.

Within the hospital supported by the project, midwives implement a large scope of awareness-raising activities on family planning in the different wards. A varied choice of contraceptive methods (implants, IUD, pill, injectable contraceptive, condoms, tubal ligations through referral to a partner) are available in the hospital. Information on contraception is delivered as early as during antenatal care, immediate postpartum, and throughout post-abortion care and during care for survivors of GBV. We have had interesting results and contraception prevalence is satisfactory. The next step for our teams is to raise further awareness of men on that topic, since in the context of our project, the partner is often an obstacle to accessing contraception.'

Blandine Brits Betbeder, Medical Coordinator, Uganda

‘Pakistan is the 6th most populated country in the world, yet its contraceptive prevalence rate is only 35% and there is an estimated 20% of unmet needs regarding family planning. Despite existing services providing contraceptive methods, demand is low. In Punjab, MdM works with a team of community mobilisers to strengthen the population’s knowledge of family planning. We have created a network of volunteers, men and women, who have the trust of communities and contributed to spreading information based on scientific recommendations thus countering false information that persists around contraception. This task of generating demand goes together with strengthening health professionals’ skills in counselling on family planning. We also support these professionals in organising mobile clinics to limit geographical barriers to access. In only a year, the number of users, male and female, of contraceptives has significantly increased and we have observed a remarkable involvement of men on these questions.’

Dr. Rubina Moin, Medical Coordinator, Pakistan

‘Niger – Imam’s involvement in promotion of family planning

‘In the implementation of activities for promotion of family planning in the district of Illéla, MdM involved religious leaders who were supportive of the issue in community awareness-raising activities. Conclusive results were achieved in family planning on a district level. Progress was monitored by comparing the 18% contraceptive prevalence rate in the first trimester of 2011 before the intervention to the first trimester of 2012 of 32%.’

Adamou Samou, IEC Officer
1. DEFINITION

Antenatal care is care provided during pregnancy by a skilled healthcare professional with the aim of ensuring the birth of a child in a good health while minimising the risks for the mother and preserving her sociocultural and physical integrity. Antenatal care should also enable the mother to have a positive experience of pregnancy and birth and strengthen her autonomy. Antenatal care must offer a package of essential interventions.

The minimum number of antenatal consultations stated in international recommendations has changed several times over the past few years. In 2016, the WHO defined a set of Recommendations on Antenatal Care for a Positive Pregnancy Experience32. In those guidelines, the WHO recommends that antenatal care models plan at least eight contacts to reduce perinatal mortality and improve women’s experience of care. The previous model of targeted care with four visits does not enable appropriate contact between women and carers and is no longer recommended.

<table>
<thead>
<tr>
<th>TABLE 3: RECOMMENDED SCHEDULE OF CONTACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIRST TRIMESTER</strong></td>
</tr>
<tr>
<td>Contact 1: before the 12th week of pregnancy</td>
</tr>
<tr>
<td><strong>2ND TRIMESTER</strong></td>
</tr>
<tr>
<td>Contact 2: 20 weeks</td>
</tr>
<tr>
<td>Contact 3: 26 weeks</td>
</tr>
<tr>
<td><strong>3RD TRIMESTER</strong></td>
</tr>
<tr>
<td>Contact 4: 30 weeks</td>
</tr>
<tr>
<td>Contact 5: 34 weeks</td>
</tr>
<tr>
<td>Contact 6: 36 weeks</td>
</tr>
<tr>
<td>Contact 7: 38 weeks</td>
</tr>
<tr>
<td>Contact 8: 40 weeks</td>
</tr>
<tr>
<td>Contact at 41 weeks if delivery has not yet occurred</td>
</tr>
</tbody>
</table>

The term contact is favoured over the term consultation/visit, it implies an active relationship between a pregnant woman and health professional. Depending intervention contexts, the contact can be implemented as a part of community actions and may involve non-professional health workers.

32. WHO, Recommendations on Antenatal Care for a Positive Pregnancy experience, 2017

2. MINIMUM PACKAGE OF SERVICES

a) Objectives

- To prevent maternal complications and to promote maternal and neonatal health;
- To prevent, detect and treat maternal complications;
- To foster a positive experience of pregnancy and maternity (strengthen self-confidence, skills and autonomy for mothers).

b) Key interventions

1. Assessment of maternal and foetal well-being

1.1 Medical history and clinical examination

- Identifying previous health issues (family, surgical, gynaecological, and obstetrical history);
- Confirming pregnancy and calculating the estimated due date;
- Identifying unwanted pregnancies;
- Monitoring the progress of pregnancy and the state and well-being of mother and foetus.

1.2 Assessment of maternal health

- Complete blood count or measurement using a hemoglobinometer according to availability
- Urinary bacterial culture or Gram staining for diagnosis of asymptomatic bacteriuria depending on availability
- Identification of the victims of GBV
- Clinical investigation when evaluating disorders that may be caused or aggravated by violence

- Care or referral of survivors (medical, psychosocial, etc.) (see chapter 5. II. GBV)
- Prevention and care of female genital mutilation (see chapter 5. III. Management and prevention of harmful traditional practices)
- Discussion regarding smoking, alcohol use and psychoactive substances consumption
- Counselling and screening of HIV infection on a voluntary basis for pregnant women and their partners. Referral for treatment with an appropriate antiretroviral treatment during pregnancy and birth in the case of seropositivity for the woman and/or her partner. Support and care for mothers infected with HIV (which includes psychosocial care, treatment of opportunistic infections, support for treatment compliance and nutritional advice for mother and child) (see chapter 5. IV. Preventing mother-to-child transmission of HIV)
- Screening active tuberculosis (routinely practiced in the contexts where tuberculosis prevalence exceeds 100/100 000 inhabitants)
- Screening and treatment of pregnancy complications (anaemia, hypertensive disorders, pre-eclampsia, eclampsia, breakthrough bleeding, gestational diabetes, etc.) and early referral where additional care is required to an appropriate healthcare facility.

NB: routine screening of hyperglycaemia during pregnancy is not recommended. However, a hyperglycaemia that was identified for the first time during pregnancy should be considered gestational diabetes or
diabetes during pregnancy, as per the criteria set by the WHO.

1.3 Assessment of foetal health

- Abdominal palpation and measurement of fundal height
- Perceived foetal movements (around 18-20 weeks) and foetal heartbeat
- Ultrasound scan before 24 weeks of pregnancy is recommended if available.

NB: the routine use of antenatal cardiotocograph is not recommended for pregnant women for the purpose of improving maternal and perinatal pregnancy outcomes.

2. Nutritional interventions

2.1 Advice in enhancing health nutrition and continued physical activity during pregnancy

2.2 Nutrition education regarding the increase of the daily energy intake and protein supply (undernourished populations)

2.3 Balanced energy and protein supplementation (undernourished populations)

2.4 Daily oral supplementation in iron and folic acid (30 to 60 mg of elemental iron and 0.4 mg of folic acid)35

2.5 Daily supplementation in calcium (1.5 - 2 g of elementary calcium) (populations in which calcium intake is weak)

2.6 Vitamin supplementation (women living in areas where deficiencies in Vitamin A are a major public health issue)

2.7 Reduction of the daily caffeine intake (women whose daily consumption is important > 300 mg per day)

3. Preventative measures

3.1 Information and advice on the benefits of antenatal care, hygiene, resting during pregnancy, dangers signs during pregnancy, preventing STI and HIV, addictions (tobacco, alcohol and drugs), breastfeeding, family planning and healthy lifestyle. This information is directed at pregnant women but also, to the extent possible, at their partners, families and communities. The messages are to be adapted along the way as consultations take place and the due date approaches.

3.2 In the case of asymptomatic bacteriuria (over 10% of cases in pregnant women), an antibiotic treatment should be taken for seven days to prevent persistent bacteriuria. 3.3 Anthelmintic (antiparasitic) preventative treatment after the third trimester (only in endemic areas)

3.4 Tetanus toxoid vaccination depending on the immunisation status

3.5 Preventative and intermittent treatment of malaria using sulfadoxine-pyrimethamine (only in endemic areas). The administration should be initiated in the second trimester with doses spaced of at least a month.

3.6 Encouraging the use of treated mosquito nets (endemic malaria areas)

3.7 Oral Pre-Exposure Prophylaxis to HIV (TP) offered preventatively to pregnant women exposed to a substantial risk of HIV infection

3.8 Screening and treatment of syphilis, interventions to prevent and treat STI destined to pregnant women and their partners.

3.9 Information, screening (only until 20 weeks of amenorrhoea) and treatment of precancerous cervical lesions (see chapter 5.1 Prevention of cervical cancer).

4. Interventions when confronted to commonly encountered clinical symptoms

4.1 Treatment of nausea and vomiting at the beginning of pregnancy, depending on the woman’s preference and available options

4.2 Advice about food diet and lifestyle to prevent and soothe heartburn.

4.3 Magnesium, calcium or non-pharmaceutical options in the treatment of cramps in the lower limbs

4.4 Regular exercise to prevent lower back pain and pelvic pain

4.5 Fiber supplementation and dietetic advice to ease constipation

4.6 Compression socks or stockings maintaining feet high and immersion in water to care for varicose veins and oedema, depending on the woman’s preference and available options.

5. Intervention aiming at improving the use and quality of antenatal care

5.1 Consultation records (antenatal booklet) that women retain to improve the continuum of healthcare

5.2 Developing a birth and emergency preparedness plan and advice to recognise danger signs during pregnancy

5.3 A birth and emergency preparedness plan is drawn up, if possible, with the family and the medical staff and must include:

- The choice of skilled medical personnel or healthcare facility with skilled medical personnel;
- The choice of place of birth and practical details of how to get there, including how to obtain emergency transport if necessary;
- Setting aside money required to pay the skilled care provider and for all drugs and equipment required if the services are not free. This money should also include transport and other indirect costs associated with using healthcare facilities;
- The choice of person to support and accompany the mother at birth or in an emergency;
- The choice of possible blood donors in the case of bleeding (family members are recommended);
- Preparing materials required for the birth (health card and clean linen for mother and newborn);
- Discussion on the desired contraception in postpartum.

5.4 Model of continuity of care where one or a few familiar midwives follow the woman throughout the continuum of health care (in contexts where SRH services function well)

5.5 Activities towards community mobilisation through the impulse of community intermediaries (health education sessions, participatory women’s groups, etc.) specifically in rural areas

5.6 Antenatal home visits in rural areas with limited access to healthcare facilities
of pregnant women worldwide have had at least one antenatal consultation. However only 3 out of 5 had received four. In regions of the world where the maternal mortality rates are highest such as Sub-Saharan Africa and South Asia, the estimated rates of women who had had at least four antenatal consultations were much lower (respectively 52% and 46%)\(^{35}\). Therefore, a lot remains to be done to ensure women receive necessary care throughout their pregnancy. Moreover, consultation rates do not provide an evaluation of the quality of care received.

In France, in 2018, of the overall population of pregnant women welcomed in healthcare, advice and referral centres (CASO, MdM free healthcare centres), 42% were behind their schedule of antenatal appointments\(^{37}\). Several studies\(^{38}\) have shown the existence of social inequalities in SRH between immigrant women and women born in France. The rates of inadequate antenatal care are more important in immigrants than in women born in France. This is particularly the case for women from Sub-Saharan Africa. Moreover, studies show an increased risk of maternal death in immigrant women. Besides, maternal mortality is considered the key indicator of the quality of the healthcare system in a country. In France, it shows social inequalities with a mortality rate 2.5 times higher for migrants and 3.5 times higher for women born in Sub-Saharan Africa compared to women born in France. Difficulties in accessing care are multifactorial and are determined, among other factors, by language barriers, working conditions for women in precarious situations, lack of financial resources and cultural symbolic barriers\(^{39}\).

### FIGURE 1: PERCENTAGE OF WOMEN WHO HAVE HAD AT LEAST ONE CONSULTATION AND 4 ANTENATAL CONSULTATIONS WITH A DOCTOR, NURSE, MIDWIFE, AUXILIARY MIDWIFE, 2010-2016 (Source UNICEF*).

\* Unicef Global database, from Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS) and other nationally representative sources, 2017.

5.7 Delegation of activities related to health promotion and promotion of health behaviours for mother and newborns, including delegation to the health agents with no medical training.

5.8 Delegation of activities related to the delivery of nutritional supplements and intermittent preventative treatments to health professionals.

5.9 Support interventions directed at the staff to facilitate recruitment and maintenance of qualified health professionals in remote rural areas.

### 3. UNDERSTANDING THE ISSUE

#### a) Background information

Antenatal care is important in the continuum of care and can constitute an entry point to the health system. It is considered cost-effective as it participates in reducing maternal mortality, and neonatal mortality as a consequence. Moreover, it incorporates and provides special access to cross-cutting programmes from the healthcare system (HIV, STI, malaria and malnutrition). It is also an opportunity to build a link with the other services in the SRH continuum of care. For example, it could be about detecting situations of GBV or to introduce the issue of screening for cervical cancer.

The data collected by UNICEF over the 2010-2016 period states that 86% of pregnant women have had at least one antenatal consultation. However only 3 out of 5 had received four. In regions of the world where the maternal mortality rates are highest such as Sub-Saharan Africa and South Asia, the estimated rates of women who had had at least four antenatal consultations were much lower (respectively 52% and 46%)\(^{35}\). Therefore, a lot remains to be done to ensure women receive necessary care throughout their pregnancy. Moreover, consultation rates do not provide an evaluation of the quality of care received.

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#### b) Duration of visits

The duration of focused antenatal visits has been estimated\(^{40}\) to be of 40 minutes for the first and last one, and 36 minutes for the others (40 minutes and 20 minutes according to the WHO\(^{40}\)), of which 15 minutes are for health education and counselling. The consultation has to be as comprehensive as possible to meet the needs of pregnant women in terms of their needs of pregnant women in terms of their need for health education and counselling.

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35. Educational, legal, financial interventions etc.
36. UNICEF Global Database, Monitoring the Situation of women and children
37. Médecins du Monde, Observatoire de l’accès aux Soins [Observatory on Access to Healthcare], 2018
39. Haut Conseil à l’Égalité [High Council for Equality], 2017
of health promotion, prevention and detection of complications. These visit durations do not include PMTCT for which 20 minutes must be added to the antenatal consultation. It must also be noted that psychosocial needs of women can vary and be increased in the case of vulnerable groups (adolescents, migrants, women with handicaps, etc.). Therefore, the organisation of antenatal care must be adapted to each woman.

c) Health education

The antenatal consultation is often one of the first forms of contact women have with healthcare services, it is therefore important to make the most of this opportunity during consultations, awareness-raising sessions in the waiting areas of health facilities and even as part of a community outreach strategy. Advantage must be taken of every opportunity to inform women and their families on when and where to seek care if necessary, as well as to promote a healthy lifestyle. Family and community involvement are vital for healthy behaviours to be followed at home during pregnancy. This is a major determinant in the use of antenatal consultation services. Support from family and community helps women follow recommendations, encourages shared decision-making and thus improves the health of mothers and newborns.

Antenatal care offers a special opportunity to tackle numerous health education topics such as nutrition, hygiene, the importance of antenatal and postnatal care, having a skilled birth attendant at delivery and a birth and emergency preparedness plan, danger signs during pregnancy, HIV/AIDS and other STI, prevention of cervical cancer, postpartum contraception, breastfeeding, etc.

d) Medical complications and referrals

A significant proportion of obstetric, foetal and neonatal complications and their consequences can be avoided by providing a continuum of care throughout pregnancy, during labour and in the postpartum period. Thus, antenatal care is particularly effective when the woman is seen as early as possible in her pregnancy and even for pre-conception consultations[43]. In many cases, individuals who develop complications during pregnancy and who require increased care can be identified, treated and monitored during pregnancy. For example, monitoring cases of pre-eclampsia can reduce maternal deaths resulting from hypertensive disorders by 48% and neonatal deaths linked to premature birth by 15%[44]. However, as 15% of pregnant women develop complications during pregnancy, labour and postpartum and as the majority of these complications are not predictable, it is essential that the continuum of care is strengthened and that emergency obstetric and neonatal care (EmONC) is available and accessible to all women to reduce maternal mortality and morbidity.

Abandoning the risk-based approach in favour of an approach based on complications

In 1992, a summary report on the WHO maternal health and safe motherhood research programme revealed that a risk-based approach did not allow maternal health services to be used sensibly and nor did it avoid maternal deaths[44]. Indeed, women with different risk factors (women under 18 years of age, women less than 140 cm tall, great multiparas, etc.) do not necessarily develop complications, while women with no risk factors can present complications. The approach, based on the identification of risk factors and the referral of women presenting any risk for an assisted birth and even to a more specialised facility, has therefore been abandoned in favour of an approach linked to complications. The latter takes into account the need for all women to be monitored during pregnancy and to give birth with skilled health personnel, since every woman is potentially at risk of complications during pregnancy and childbirth.

e) Birth and emergency preparedness plan

The aim of a birth and emergency preparedness plan is to enable women to receive timely, quality care, whether during pregnancy or in the course of labour and whether the birth is normal or complicated. The birth and emergency preparedness plan can therefore help avoid two out of the three delays responsible for maternal mortality: the delay in seeking care and the delay in actually receiving care[45] (see chapter 4. IV. Obstetric care and immediate neonatal care).

Around 15% of women develop a complication during pregnancy or childbirth. Evidence suggests that it is almost impossible to predict which woman will present a complication. It is thus extremely important to work in collaboration with women to ensure that they are able to give birth with skilled personnel, to recognise complications and to draw up a plan of action in case such a complication should arise.

To do this, healthcare personnel must be able to explain the importance of giving birth in a facility with skilled personnel available, about the value of being organised in case of an emergency and for the delivery itself (transport, care costs, an accompanying person and someone chosen to take care of other children, etc.), about the danger signs during pregnancy and signs of the onset of labour and about the things to bring to the facility (medical record, clean linen, etc.). When the nearest facility is some distance away, women should ideally make arrangements to stay close to where they will give birth during the last month of pregnancy.


Women who have attended antenatal consultations are more likely to give birth with skilled personnel\textsuperscript{46}. This is why it is important during antenatal care to get up on the issue of preparing for birth and emergencies.

f) Preventing maternal anaemia

Anaemia affects almost half of pregnant women worldwide: 52\% in developing countries and 23\% in developed countries. Anaemia increases the risk of maternal mortality and premature birth. Anaemia is associated with 40\% of perinatal and maternal deaths\textsuperscript{47}. The most frequent causes of anaemia are under-nutrition, deficiencies in iron and other micronutrients, malaria and the parasitic infestations Ancylostomiasis (hookworm) and Schistosomiasis (bilharzia); infection by HIV and haemoglobinopathies such as Sickle Cell Diseases and Thalassaemia are additional factors.

Pregnant women must routinely receive iron and folic acid supplements. In confirmed cases of anaemia, causal treatment must be associated to nutritional advice.

g) Preventing maternal and neonatal tetanus

In 2015, around 34,000 newborns died from neonatal tetanus\textsuperscript{48}. Even though the incidence of this disease has declined by 96\% between 1988 and 2015, it is important to continue prevention efforts so that it can be successfully eradicated (<1 case per/1000 live births in a district over the period of one year). Tetanus is also the cause of an unknown number of maternal deaths each year. Prevention involves taking hygiene precautions during birth (using sterile equipment) and vaccinating pregnant women, measures which limit infection in the mother and newborn. Once a pregnant mother has been vaccinated, she transfers the antitoxin to the foetus. In 2011, 70\% of pregnant women in the world received at least two doses of tetanus vaccine (TT2+)\textsuperscript{49}. The goal is to achieve at least 80\% immunisation levels for pregnant women\textsuperscript{50}. In 2017, tetanus is eradicated in South-East Asia and the Americas. Nonetheless, the disease remains a major public health issue in many regions of the world, especially in districts with low income, where immunisation coverage rates are low and where deliveries usually take place in poor hygiene conditions.

h) Prevention of STI including syphilis

Sexually transmitted infections (STI) such as syphilis, gonorrhoea and chlamydia may be screened for and treated as part of antenatal consultations. If they remain untreated, sexually transmitted infections cause congenital and perinatal infections in the newborn. They may also have serious consequences for the health of the mother and child. STI are notably the main cause of sterility, particularly among women. They indirectly increase HIV transmission and are the cause of cell modifications that may generate certain types of cancers. An estimated 357 million people aged 15 to 49 are infected each year with four types of incurable STI: syphilis, chlamydia infection, gonorrhoea, trichomonas\textsuperscript{51}. Today, the WHO reckons that the efforts in place to slow the spread of contamination of STI remain insufficient. Resistance to drugs, specifically antibiotics enabling the treatment of gonorrhoea\textsuperscript{52} also represents a major threat to the reduction of STI impact worldwide.

As for syphilis, it is a STI that can be transmitted by the mother to the unborn child. The majority of people affected by syphilis are unaware that they have contracted the disease and may therefore pass it on to their sexual partners and, in the case of pregnant women, to the foetus. In the absence of treatment, 25\% of pregnancies in women suffering from early syphilis result in stillbirth, making it the second cause of avoidable stillbirth after malaria\textsuperscript{53}.

Efforts to combat syphilis among pregnant women and congenital syphilis are crucial and rely on universal antenatal screening and testing, and treatment of positive cases. However, a large number of women currently attending antenatal consultations do not benefit from specific testing or treatment for syphilis where required. The majority of countries do have an antenatal screening policy, but effective screening is still insufficient. A lack of consumables for screening is often the reason for this, even though sensitive and easy-to-use syphilis screening tests currently exist and can even be used in primary healthcare facilities. The WHO reckons that making these rapid combined HIV-syphilis tests available can be an interesting initiative to explore to improve syphilis screening rates\textsuperscript{54}.

Treatment for syphilis in adults involves administering a single dose of benzathine benzylpenicillin (2.4 MIU)\textsuperscript{55} via intramuscular injection; in the event of penicillin allergy, erythromycin can be administered orally (2 g per day in two to four separate doses for 14 days). It is to be noted that benzathine benzylpenicillin is a generic injectable drug that very few suppliers produce in the world and that the dangers of stock-outs and shortages on site remains an issue.

i) The personal medical record

Various studies have shown that when women retain their personal medical record, it improves the continuity and quality of care and leads to a better experience of pregnancy. Pregnant women are responsible for bringing their medical record to each antenatal consultation. This also improves the

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\textsuperscript{48} WHO. Tetanus: Key facts, 2018

\textsuperscript{49} WHO. Immunization surveillance, assessment and monitoring. Neonatal tetanus, 2011 Data. www.who.int

\textsuperscript{50} WHO. Tetanus vaccine. WHO position paper, Weekly Epidemiological Record, N° 20, 2006, 81, 198-205.

\textsuperscript{51} WHO, Global health sector strategy on Sexually Transmitted Infections 2016-2021, 2016

\textsuperscript{52} WHO, News release: Antibiotic-resistant gonorrhoea on the rise, new drugs needed, 2017

\textsuperscript{53} WHO, Syphilis screening and treatment integration with HIV services, 2017

\textsuperscript{54} WHO, Syphilis screening and treatment integration with HIV services, 2017

availability of antenatal records during visits to healthcare facilities. Women are also more likely to bring the medical record along during a future pregnancy.\(^\text{56}\)

When a woman retains her own medical record, it reinforces her right to make decisions about her own health (particularly regarding at which healthcare facility to give birth) and her right to have permanent access to it, including in emergencies. Health services managers must give some thought to the form that these records should take and determine whether the whole or a part of the notes are to be retained by the woman.

MdM therefore recommends that every woman should be responsible for her own medical record which she keeps at home between visits and which allows her to be more in control of her own health.

\(\text{j) Preventing and treating maternal malaria}\)

Malaria during pregnancy is a major public health issue and causes important risks for women and newborns. Each year, malaria is responsible for 20% of stillbirths in Sub-Saharan Africa, of 11% of all neonatal deaths in Sub-Saharan Africa and of 10,000 maternal deaths worldwide\(^\text{57}\). Asia, Latin America and to a certain extent, the Middle-East, as well as some parts of Europe are also concerned by the issue. In 2017, malaria was present in 87 countries and territories.

Pregnant women are particularly vulnerable as pregnancy lowers their immunity, which makes them more susceptible to malaria infection and increases the risk of serious malaria, severe anaemia and death. Maternal malaria also increases the risk of miscarriage, foetal death, hypotrophy and premature birth. In addition, malaria increases the risk of mother-to-child transmission of HIV in mothers affected, as it reduces the effectiveness of the placental barrier. Antenatal consultations are an essential means of preventing malaria in pregnant women\(^\text{58}\). However, the rates of intermittent preventative treatment during pregnancy and the distribution of insecticide-treated mosquito nets remain insufficient.

This observation highlights the importance of strengthening malaria prevention at antenatal consultation level.

4. INTERVENTION STRATEGIES

The intervention strategies presented here follow the different action areas of the Ottawa Charter for health promotion. MdM builds on this charter to underpin project planning.

**TABLE 4: PRINCIPAL EFFECTS OF MALARIA IN PREGNANT WOMEN AND NEWBORNS**

<table>
<thead>
<tr>
<th>IN ZONES WHERE TRANSMISSION LEVELS ARE STABLE (ENDEMIC)</th>
<th>IN ZONES WHERE TRANSMISSION LEVELS FLUCTUATE (SEASONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low birth rate: 8% to 14% of births</td>
<td>• Severe malaria with central nervous system complications</td>
</tr>
<tr>
<td>• Intra-uterine growth restriction: 15% to 70%</td>
<td>• Anaemia</td>
</tr>
<tr>
<td>• Premature birth: 8% to 36%</td>
<td>• Miscarriage (first trimester)</td>
</tr>
<tr>
<td>• Neonatal death: 3% to 8% or 75,000 to 200,000 deaths per year</td>
<td>• Low birth weight</td>
</tr>
<tr>
<td>• Maternal anaemia: 2% to 15% of severe maternal anaemia which increases the risk of death for the mother</td>
<td>• Premature birth (infection in third trimester)</td>
</tr>
<tr>
<td></td>
<td>• Stillbirth</td>
</tr>
<tr>
<td></td>
<td>• Death of the mother</td>
</tr>
</tbody>
</table>


While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

\(\text{△ Whatever the chosen intervention strategy, it is essential that antenatal care be carried out with respect for the patient's privacy. Medical data must be protected. For further information it is advised to consult the document ‘For ethics in the field’\(^\text{59}\), by MdM.}\)

\(\text{a) Supporting formulation or strengthening national policies in terms of antenatal care (element relating to ‘Building healthy public policy’ in the Ottawa Charter)}\)

Guidelines taking into account epidemiological contexts and international recommendations are in order and should go into detail with the essential basic components of antenatal care. When this is not the case, we can consider providing technical support to decision-making bodies such as the Ministry of Health or to engage in advocacy action.

The following outcomes can therefore be pursued:

- Antenatal care must be integrated or strengthened in the curricula of midwives, nurses, physicians, and the number of competent medical personnel is increased;
- Antenatal care protocols are harmonised, implemented and disseminated, specifically those concerning referral systems;
- Links with other existing programmes

\(\text{56. WHO, WHO recommendations on antenatal care for a positive pregnancy experience, 2017}\)
\(\text{57. WHO, UNICEF, USAID, Implementing malaria in pregnancy programs in the context of WHO recommendations on antenatal care for a positive pregnancy experience, 2018}\)
\(\text{59. Dromer C. et al., For ethics in the field - Sensitive personal data management, MdM, 2010.}\)
(national strategies to tackle HIV, malaria, syphilis and STI but also malnutrition) and sexual and reproductive health services are strengthened;

- Advocacy is developed for protection and access to healthcare for all pregnant women, regardless of their age, marital status, or administrative status in a country;
- The political environment is supportive of the exercise of sexual and reproductive rights.

b) Reducing the barriers to accessing healthcare for all women
(element relating to ‘Creating supportive environments’)

Antenatal care should be accessible to all women regardless of their socioeconomic situation or place of residence. Uptake of antenatal care services will be encouraged if the barriers to them are reduced. National policy, along with locally adapted guidelines, should enable access for all to quality healthcare.

The following outcomes may therefore be pursued:

- A sociocultural analysis is carried out with a gender approach to identify the sociocultural barriers to accessing antenatal care services, and to identify inequalities and discriminations potentially impacting the full exercise of sexual and reproductive rights;
- Women’s status in communities shifts towards better equality in accessing SRH services and exercising their SRHR;
- Women have acquired skills to recognise, express and address their needs in SRH for themselves and in their couple. Men have acquired skills to take co-responsibility for health in the couple in a respectful and equal manner;
- Financial and administrative barriers for access to care for pregnant women are lifted;
- The link between carers and communities is strengthened via community-based health education activities and an outreach strategy for healthcare provision;
- Healthcare practitioners are trained on the specific needs of women, men, adolescents, sex workers, LGBTQ+ people and migrants. Antenatal care is delivered in accordance with those specific needs.

The following outcomes can therefore be pursued:

- A minimum package of antenatal care is implemented, based on national protocols and international standards;
- Healthcare facilities are supplied with the drugs and equipment required to provide quality antenatal care;
- Existing antenatal services are strengthened by implementing certain cross-cutting programmes: Preventing and treating malaria, PMTCT, screening for and treating syphilis and testing for cervical cancer in line with national health policies;
- Initial training and continuing medical education for antenatal care providers are strengthened;
- The National Health Information System is consolidated, and health data is used to monitor and improve the coverage and quality of antenatal care;
- The referral system between the different levels of healthcare facility is implemented and effective;
- Capacities in management teams are increased for supervising healthcare providers;
- Pregnant women are integrated in perinatal networks helped by the work of health mediators (e.g. in France where our facilities welcome many migrant women).

d) Consolidating or implementing health education for women, their partners, families and communities
(element relating to ‘Developing personal skills’)

Consolidating health related knowledge increases women’s access to antenatal care and helps reduce maternal and infant mortality. Indeed, consolidating women’s skills enables them to become more autonomous and better able to change their practices. Women must not be the only ones to benefit from these awareness-raising activities; their partners, families and communities must also be involved. Commitment on the part of families and communities is essential for health behaviour to be adopted and to ensure access to care.

The following outcomes can therefore be pursued:

In the setting of our health mediation activities, we are often confronted to difficulties in accessing SRH services for women in precarious situations. A few months ago, I accompanied a woman of Romanian nationality living in a slum. Pregnant with her 6th child, we met her when she was 6 months pregnant. At the time, she had had no medical examination for her pregnancy. We informed her of the appropriate steps to undertake with the closest maternity and that she needed to make contact with a midwife. We came with her for this. At the maternity service, the patient was first confronted to an administrative barrier, as many elements were required for her to sign up (proof of residence, proof of social security, ultrasound). At first and without our intervention, the front desk of the maternity did not offer that her tests be free of charge thanks to the district mother and child services and nobody facilitated her referral to a social worker in the maternity. We explained that she was entitled to State Medical Aid and that she already had a medical file after consulting the emergency ward. At last, this patient was able to have her ultrasound in a clinic that worked in partnership with district authorities and the hospital was able to provide antenatal care. In this kind of situation, it is essential to support women in sometimes complex procedures that they are not familiar with, whilst facing professionals who are not always aware of the issues of precarity.

Elsa Andrieux, Health Mediator, France
Women improve their knowledge and understanding of the value of antenatal care and of the signs of pregnancy complications;

- Women and their families prepare a birth and emergency preparedness plan with the help of healthcare personnel;
- Men are involved in health education sessions and are aware of the benefits of antenatal care and birth assisted by skilled practitioners.

4) Promoting community involvement in health prevention activities and care for women who are pregnant or who present obstetric complications (element relating to ‘Strengthening community action’)

To be effective, safe motherhood interventions must be implemented at all levels of the country’s healthcare system. Projects are more effective when they are carried out as part of a concerted effort and with the combined commitment of community and government. It is therefore essential to involve the community to reduce maternal mortality and morbidity.

The following outcomes can then be pursued:

- Leaders and other influential people in communities (traditional birth attendants, religious leaders, traditional healers, etc.) support health education messages regarding the importance of antenatal care;
- Community health workers are trained and carry out health education sessions within communities to promote referrals of pregnant women to healthcare facilities;
- A community referral system is implemented for transporting pregnant women showing signs of complications or on the point of giving birth;
- The link between carers and communities is strengthened via health education activities with communities.

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"We work on teenage pregnancy by setting up support by community health agents. Pregnant young girls who wish to carry their pregnancy to full term benefit from a close up monitoring. Community health agents make sure they do attend their antenatal consultation and act as a link with healthcare facilities. We can offer financial support to purchase drugs and laboratory tests. Community health agents also act as link with school educators and teachers. We inform young girls of the importance of getting a pregnancy certificate from the school doctor. This certificate will enable them to postpone their education. The antenatal period can be difficult for youngsters and adolescents, this is why it seemed important to us to set up specific activities to facilitate medical care but also limit stigma and isolation."

Florence Koni Kouadio, Field Coordinator, Republic of Ivory Coast

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**IV. OBSTETRIC CARE AND IMMEDIATE NEONATAL CARE**

1. **DEFINITION**

Obstetric care and immediate neonatal care are preventative and curative care provided during labour, birth and immediate postpartum (2 hours following childbirth) to the mother and newborn. They are aimed at reducing maternal and neonatal mortality and morbidity by early and timely screening and treatment of obstetric and neonatal complications. In particular, neonatal care are essential care delivered to children after birth to ensure a smooth transition to extra-uterine life. They consist in preventative interventions and detection and early treatment of neonatal complications.

Emergency obstetric and neonatal Care (EmONC) are the ‘basic’ and ‘comprehensive’ care that a health facility can provide a woman with obstetric needs or complications. EmONC includes immediate neonatal care (2 hours following birth).

All the recommendations on intrapartum care is available in the WHO 2018 Guide ‘WHO recommendations: Intrapartum care for a positive childbirth experience’.60

2. **MINIMUM PACKAGE OF SERVICES**

a) **Objectives**

- To care for and prevent secondary pathologies during birth and postpartum for women and newborns through essential care during labour, birth and immediate postpartum;
- To prevent neonatal complications and childhood diseases;
- To provide early screening and treatment of potential complications for the mother or the child;
- To promote practices enhancing health for the mother and the child;
- When necessary, to accompany the initiation of the mother-to-child bond (strengthening skills and autonomy of the mothers).

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60. WHO, WHO recommendations: intrapartum care for a positive childbirth experience, 2018
b) Key interventions

1. Early referral in the case of complications and/or situations which demand specialised care (e.g. multiple pregnancy or dystocic presentations) and access in a timely manner to an Emergency Obstetric and Neonatal Care facility (EmONC).

2. Care during labour and birth with a skilled health professional

   At Basic EmONC centre (BEmONC):
   2.1 Diagnosing labour
   2.2 Authorising/suggesting the presence of a birth partner chosen by the patient to provide her with support, and choice of birthing position
   2.3 Efficient communication from the personnel and enlightened information of the patient
   2.4 Observing and monitoring labour and well-being of the mother and foetus using a partograph
   2.5 Strategies for pain relief (epidural analgesia if not contra-indicated and depending on availability, parental opioids if not contra-indicated, relaxation and pain management techniques, manual techniques such as massages)
   2.6 Oral fluid and food intake during the first stage of labour (women with a low risk of complications)
   2.7 Auscultation using a doppler ultrasound or Pinard foetal stethoscope to examine the foetus at admission, followed by intermittent auscultation of the foetal heartbeat
   2.8 Encouraging mobility during the first and second stage of labour
   2.9 Performing a vaginal examination every 4 hours to systematically assess the progression of labour
   2.10 Detecting and treating complications (including dystocic presentation, dystocic labour, hypertensive disorders, bleeding and infection) and referring early to a centre offering Comprehensive EmONC in cases where a Caesarean-section or blood transfusion proves necessary
   2.11 Encouraging the adoption of birth positions that have been individually chosen by the woman
   2.12 Active management of the third stage of labour (delivery)
   2.13 Dealing with episiotomies or tears (routine performance or wide use of episiotomy are not recommended in the case of spontaneous labour)
   2.14 Using uterotonic drugs (according to availability: oxytocin, misoprostol, ergometrine/methylergometrine) for preventing postpartum haemorrhage during the third stage of labour
   2.15 Providing post-abortion care, notably after an MVA procedure
   2.16 Observing universal hygiene rules and precautions to avoid any possible infection-related complications.

   In a CEmONC centre:
   2.17 Providing the same services as in a BEmONC centre
   2.18 Receiving and treating women presenting with complications and referred by a BEmONC centre for treatment
   2.19 Birth by Caesarean
   2.20 Management of postpartum haemorrhage with access to blood transfusion.

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**TABLE 5: AVAILABLE SERVICES IN BEMONC AND CEMONC**

<table>
<thead>
<tr>
<th>BASIC EMERGENCY OBSTETRIC CARE</th>
<th>BASIC EMERGENCY NEONATAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parenteral administration of antibiotics</td>
<td>1. Keeping the baby warm and dry, stimulation, positioning and clearing airways</td>
</tr>
<tr>
<td>2. Administration of uterotonics (e.g. misoprostol, oxytocin by parenteral route)</td>
<td>2. Essential neonatal care: vitamin K supplementation, skin-to-skin contact, initiation of immediate breastfeeding</td>
</tr>
<tr>
<td>3. Parenteral administration of anticonvulsants to treat pre-eclampsia and eclampsia (e.g. magnesium sulphate)</td>
<td>3. Treatment of severe bacterial infection symptoms by administration of an initial dose of antibiotic</td>
</tr>
<tr>
<td>4. Manual extraction of placenta (artificial delivery)</td>
<td>4. Referral of complications to a hospital service</td>
</tr>
<tr>
<td>5. Evacuation of intra-uterine residual products of conception, notably in the cases of miscarriage or induced abortion (namely, manual or vacuum intra-uterine aspiration (MVA) or dilation and evacuation</td>
<td></td>
</tr>
<tr>
<td>6. Assisted vaginal delivery with use of vacuum extractor (Ventouse)</td>
<td></td>
</tr>
<tr>
<td>7. Basic neonatal resuscitation (including manual ventilation with the help of a mask and Ambu bag or ball)</td>
<td></td>
</tr>
<tr>
<td>8. Referral system to a facility with the capacity to conduct surgery and transfusion 24/7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPREHENSIVE EMERGENCY OBSTETRIC CARE</th>
<th>COMPREHENSIVE EMERGENCY NEONATAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrying out vital actions 1 to 7, plus:</td>
<td>Carrying out vital actions 1 to 3, plus:</td>
</tr>
<tr>
<td>9. Performing surgery including Caesarean section</td>
<td>5. Ventilation with Ambu bag and mask in the case of severe respiratory distress</td>
</tr>
<tr>
<td>10. Carrying out a blood transfusion</td>
<td>6. Kangaroo care units for newborns and mothers who are clinically stable</td>
</tr>
<tr>
<td></td>
<td>7. Implementation of WHO recommendations regarding premature newborns and care of severe bacterial infections</td>
</tr>
</tbody>
</table>

61 IAWG, Inter-agency Field Manual on Reproductive Health in Humanitarian settings, 2018
3. Neonatal care

3.1 Delayed cord clamping (>1 minute) except when the mother is HIV+ (in that case clamping should be immediate, see chapter 5. IV. PMTCT)

3.2 Monitoring newborn’s temperature, avoiding hypothermia, establishing skin-to-skin contact with the mother during the first hour of life provided there are no complications, and early breastfeeding (if the mother has chosen to breastfeed)

3.3 Screening for warning signs of complications, Apgar score assessment62

3.4 Newborn resuscitation if necessary, specifically through manual ventilation with an Ambu bag and adapted mask in the case of respiratory distress

3.5 Monitoring and control of well-being: general examination, biometry measurements, assessment and establishment of the mother-child

3.6 Screening and management of complications (respiratory, infections, prematurity, low weight), identification of any major anomalies (cleft palate, spinal deformity-spina bifida-oesophageal atresia and anal imperforation), and transfer to a suitable hospital if necessary

3.7 Dispensing immediate care to the newborn: eye and umbilical cord care, avoiding hypothermia through skin-to-skin between mother and child

3.8 Administering vitamin K1 to the newborn

3.9 Promoting exclusive breastfeeding and early initiation of breastfeeding during the first hour of the baby’s life

3.10 Preventing or treating syphilis depending on the maternal blood test results

3.11 Immunisation in accordance with national guidelines (BCG, anti-hepatitis B, poliomyelitis)

3.12 Postponing the first bath to at least 24 hours post-birth

3.13 Setting up and monitoring of the ‘Kangaroo Mother Care’ (which can take place with either parent) for premature babies or babies weighing less than 2500g.

4. Immediate postpartum

4.1 Observing the mother and newborn: preventing, detecting and treating complication

4.2 Offering information and advice on hygiene, how to take care of her health at home, nutrition, exclusive breastfeeding, family planning, postpartum care and caring for baby, as well as the danger signs and preparing for any potential emergency.

5. Identifying and caring for victims of gender-based violence

5.1 Detecting FGM, taking account of risk factors relating to complications during birth and providing care for cases of FGM. Suturing is not recommended for Type III FGM following birth (see chapter 5. III. Management and prevention of harmful traditional practices)

5.2 Identifying, treating and/or referring cases of gender-based violence.

6. Preventing and detecting fistulas: Referring or treating is carried out after the birth and the postpartum period. (see chapter 5. V. Obstetric fistulas)

7. Recording births and/or deaths at the registry office and medical information in health records and files

8. Monitoring and responding to maternal deaths and ‘near misses’ at institutional and community level

8.1 Carrying out audits on maternal deaths and ‘near misses’

8.2 Reporting all maternal deaths and assisting with their recording in registry office records

8.3 Applying recommendations in response to results obtained during audits.

9. Preventing malaria: to be considered in endemic areas

9.1 Placing the mother and newborn under an insecticide-treated mosquito net during their stay in hospital

9.2 Informing mothers and their families of ways of preventing malaria and of the importance of sleeping under an insecticide-treated mosquito net.

10. Prevention of mother-to-child transmission of HIV (see chapter 5. IV. PMTCT)

10.1 Providing counselling and voluntary screening during labour or postpartum if not done during pregnancy

10.2 Counselling and screening for other family members if a diagnosis is made of seropositivity for the pregnant woman

10.3 Dispensing antiretroviral (ARV) treatment for the mother, the newborn and other members of the family if they are diagnosed positive, in accordance with national or international protocols for mother and child

10.4 Taking precautions to avoid artificially rupturing membranes and invasive procedures during labour and delivery (episiotomy, vacuum extraction)

10.5 Placenta delivery using controlled cord traction (third stage of labour)

10.6 Immediate cord clamping

10.7 Observing universal precautions; 10.8 Counselling and supporting the mother in her choice of method for feeding her baby

10.9 Adapted counselling on postpartum contraception (contraception combined with condom use depending on the partners serological status).

3. UNDERSTANDING THE ISSUE

a) Background information

In 2015, despite the fact that the number of maternal deaths had dropped by 44% between 1990 and 2015, it still remained high with 303 000 deaths in 2015. In addition, 99% of maternal deaths occur in developing countries. While the risk of maternal death in a developed country in the course of woman’s life was of 239/100 000 births in 2015 in developing countries, it drops to 12/100 000 births in developed countries. One of the targets of the
**CHAPTER 4: ASPECTS OF THE CONTINUUM OF CARE**

Sustainable Development Goal 3 is to decrease that risk and bring it to a world average of under 70/100 000 live births.

For every woman who dies, 12 others suffer lesions, infections and impairments caused by pregnancy or birth - i.e. at least 3.5 million per year\(^6^3\). Health problems associated with pregnancy and childbirth include serious anaemia, infertility, lesions of the uterus and the birth canal caused by birth, including obstetric fistulas.

Maternal mortality and morbidity have an important impact on the family unit as well as on the community. The health of the mother also has a major impact on the health and survival of the child (particularly with regards to nutrition). Studies have shown that a newborn whose mother dies has a lower chance of survival.

Insufficient maternal care during pregnancy and birth is in large part responsible for the almost 5 million stillbirths and neonatal deaths that occur every year in the world. Neonatal deaths represent 47% of the deaths of children under the age of 5. Even if the programmes set up towards the Millennium Development Goals have helped reduce neonatal deaths, from 4.4 million 1990 to 3.1 million in 2010, important progress can still be made and the decrease of neonatal mortality between 1990 and 2017 was slower than that of children under the age of 5.

Between 25 and 45% of deaths occur within the 24 first hours of life, i.e. immediate postpartum, and 75% occur during the first week\(^6^4\). In developing countries, very few newborns receive care during that period of time.

The three main causes of neonatal death are\(^6^5\):
- low weight or premature newborns;
- infections;
- asphyxia and trauma linked to birth.

Any delay in identifying complications and managing them can be fatal.

Most risk factors for the three main causes of neonatal death are preventable or treatable. Moreover, neonatal morbidity is important when newborns are not cared for in an appropriate or timely manner. A majority of newborn deaths occur in low-income countries. We are forced to recognise that, up until recently, too little effort has been dedicated to neonatal care.

Maternal and neonatal deaths are closely linked. Thus, the main causes of neonatal deaths are evitable through adapted care during pregnancy, birth and postpartum:
- low birth weight and prematurity can be avoided by appropriate monitoring of pregnancy, adequate nutrition, supplementation in micronutrients during pregnancy, treatment of HIV for seropositive mothers, prevention of malaria through intermittent preventative treatment, reducing tobacco use;
- infections can be avoided by screening and treating STI during pregnancy, vaccinating mothers against tetanus, carrying out deliveries in adequate hygiene conditions;
- asphyxia and trauma at birth can be avoided by providing adapted care by skilled personnel at birth.

Spacing pregnancies through information and family planning services also has an impact, since we know that closely-spaced pregnancies are not in favour of the survival of the next child. Indeed, children who are born within two years of a previous birth are at 60% increased risk of child mortality compared to those who were born after at least three years\(^6^6\).

It is estimated that around three quarters of neonatal deaths could be prevented if women had adapted nutrition, and received necessary care during pregnancy, birth and postpartum\(^6^7\).

**b) The value of BEmONC and CEmONC**

The majority of maternal deaths take place after giving birth, most often within 24 hours. Around 25% occur during pregnancy and 15% during delivery\(^6^8\).

Even if women receive appropriate antenatal care, it is impossible to predict most maternal complications; women’s timely access to emergency obstetric care alone is enough for the vast majority of maternal deaths to be avoided.

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63. WHO, Maternal mortality : Fact Sheet, 2018
64. WHO, Newborns : reducing mortality : Fact Sheet, 2018
65. Health problems associated or birth - i.e. at least 3.5 million per year\(^6^3\). Health problems associated with pregnancy and childbirth include serious anaemia, infertility, lesions of the uterus and the birth canal caused by birth, including obstetric fistulas.
67. WHO, Global Health Report, 2018

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**FIGURE 2: CAUSES OF NEONATAL DEATHS IN 2016**

Source: UN Inter-agency group on estimating child mortality

- Tetanus 1%
- Diarrhoea 1%
- Pneumonia 6%
- Congenital abnormalities 11%
- Septicaemia or meningitis 15%
- Other 7%
- Complications due to prematurity 35%
- Events linked to birth 24%
- Convolutions 6%
- Asphyxia 15%
According to international estimates, the proportion of pregnancies requiring an intervention is 15%. Between 5 and 15% require a Caesarean section.

The following table highlights the estimated period of time between the appearance of symptoms of a major obstetric complication and maternal death in the absence of medical care.

<table>
<thead>
<tr>
<th>OBSTETRIC COMPLICATIONS</th>
<th>HOURS</th>
<th>DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antepartum haemorrhage</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Postpartum haemorrhage</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Eclampsia</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Labour dystocia</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

The elements of BEmONC enable the principal obstetric complications to be treated: infections (antibiotics), postpartum haemorrhage (uterotonics and assisted delivery), pre-eclampsia and eclampsia (anticonvulsants, antihypertensive treatments), incomplete abortion (manual vacuum, aspiration), and labour dystocia (vacuum extraction); and the referral to another centre with possibility of surgery if necessary (CEmONC).

The elements of CEmONC in addition enable women presenting with severe complications or labour dystocia to have access to a Caesarean section. Moreover, transfusion is available for cases of massive haemorrhaging or severe anaemia.

For this reason, projects aimed at reducing maternal mortality must strive to ensure that every woman has access to emergency obstetric care within an appropriate period of time where there is a potential or confirmed complications. For this to be achieved, it is essential that pregnant women give birth with a skilled health professional, ideally within or close to a facility providing EmONC. A referral system must also exist to ensure women have access to such services within a short period of time.

Numerous studies have shown that putting emergency obstetric care in place is an essential factor in reducing maternal mortality.

International recommendations state that there should be at least five facilities providing BEmONC and one CEmONC for 500 000 inhabitants. It is however important to adapt these figures to the context of the intervention (population density, means of communication and transport, etc.).

c) The skilled birth attendant

A skilled birth attendant is a recognised health professional, namely a midwife, doctor or nurse, who has been trained and has acquired the necessary skills to provide care during normal pregnancy, birth and immediate postpartum period (i.e. without complications). This professional knows how to identify, manage and, if necessary, take the decision to transfer women and newborns presenting complications.

The presence of skilled birth attendants in health facilities can reduce maternal and neonatal mortality, since they can manage complications which are for a large part unpredictable and can detect them early to refer women and newborns to an adapted facility.

The proportion of births assisted by skilled birth attendant is under 50% in developing countries.

d) Access to healthcare

The ‘three delays model’ shows that three types of delays can contribute to maternal mortality and morbidity:

- At patient level: delay in deciding to seek care and identifying available care;
- From community to health facilities: delay in attending a healthcare facility (inability to find transport, cost of transport, distance, state of the roads, insecurity, checkpoints, etc.);
- At healthcare facility level: delay in receiving appropriate treatment at the facility (lack of personnel, equipment or drugs, payment prior to treatment, late or complicated referral to a higher level of care, etc.)

It is essential that women have access to appropriate care at a facility offering EmONC and potentially CEmONC. Efforts must therefore be made to eliminate the three delays: pregnant women as well as their partners, families and communities must know when to seek care (awareness of signs of danger) and how to do so (access, available transport to the health centre). It is important to facilitate the transport of women from communities to healthcare facilities by preparing a birth and emergency preparedness plan.

In addition, healthcare personnel must be capable of screening for and dealing with complications and then referring cases as early as possible to a higher level of care if necessary (i.e. a CEmONC). This would help reduce the third delay and permit women’s access to adequate treatment within an appropriate time frame. It is essential to consider how to implement suitable referral services between the different levels providing care to women. This should be carried out as early as possible in the project, in the diagnosis stage.

In addition, certain sociocultural determinants often hamper access to care and so it is essential to know what these are in each of MdM’s

69. Inter-agency working group (IAWG), Inter-agency Field Manual on Reproductive Health in Humanitarian settings, Revised 2010 version.
72. WHO, ICM and FIGO joint declaration, Making pregnancy safer: the critical role of the skilled attendant, 2005; Definition approved by the WHO, UNFPA and World Bank.
74. Thaddeus S., Maine D., Too far to walk: maternal mortality in context, Social Science Medicine, 38: 1091-1100, 1994.
project intervention areas. A qualitative survey is an important tool to ensure healthcare provision is best adapted to the practices and care pathways of those benefiting.

For example, WHO recommends that a woman should choose her birth partner and that this should form part of her birth and emergency plan. The impossibility of travelling, the lack of a choice of birth position and the non-acceptance of certain traditional practices surrounding birth can also hamper a woman’s ability and wish to give birth at a healthcare facility. Attention must be paid to the availability, accessibility and also the acceptability of the healthcare provision.

**e) The partograph**

The partograph is designed to monitor not only the progress of labour but also the mother and the foetus’s state of health during labour. The partograph comprises different variables (foetal heartbeat, cervix dilation, contractions and mother’s pulse) represented on a pre-printed document. The layout of the data enables health professionals involved to identify any anomaly early and to come to a decision regarding direct intervention or transfer. The slowing down and prolonging of labour as well as the delay in taking decisions are the principal causes of mortality in mothers and newborns in developing countries. If labour is not progressing normally, there may be serious complications, such as mechanical dystocia, dehydration, exhaustion, maternal infection, haemorrhage, or uterine rupture. The slowing down of labour may also be the cause of neonatal infections, asphyxia, or contribute to death of the child.

In developing countries, the partograph represents a simple tool for monitoring labour and is cost effective. A case-control study carried out in Pakistan revealed that the partograph can reduce the frequency of prolonged labour, accelerated labour, postpartum haemorrhage, uterine rupture, and puerperal infection, as well as maternal and perinatal morbidity and mortality.

The partograph is considered one of the greatest advances in modern obstetrics. WHO views it as an essential tool for providing care and advises its universal use during labour. It is important to use the partograph of the country concerned and, where such does not exist, to use the WHO partograph (available here).

It is to be noted that recent studies have pointed out a misuse of the partograph in numerous contexts. To address this, the WHO partograph was amended and simplified in 2017 (suppression of the latency phase). It is therefore essential to implement training projects and regular training updates as well as formative supervision of its use.

### f) Immediate newborn care

Neonatal deaths (i.e. in the first 28 days of life) account for 47% of deaths in children under the age of 5 (to be compared with 40% in 1990). In almost 75% of cases, these deaths can be attributed to three major causes: infection, asphyxia and premature birth. Most neonatal deaths occur in the course of the first week, and around a million newborns die in the 24 hours following birth.

Moreover, a majority of children born outside a hospital environment receive no postnatal care and even in the case of births at a health facility, mothers and newborns are often obliged to leave the centre in the hours following birth.

Lastly, 99% of neonatal deaths occur in developing countries.

It is increasingly acknowledged that it is essential and logical that there be a synergy between maternal and newborn care. As a large population of neonatal deaths take place in the period immediately after birth, improving the availability and quality of obstetric care represents an effective means of reducing neonatal mortality. Hence, women who benefit from care delivered by midwives aiming at preserving the continuum of care present a 16% lower risk of losing their child, and a 24% lower risk of giving birth prematurely. However, it is also necessary to implement neonatal healthcare services and to have the skilled personnel to provide this specific care as part of CEmONC centres.

The following are included in essential neonatal care:

- **Cord care:** This must be administered using antiseptic to reduce the risk of infection (compress preferably soaked with chlorhexidine 71%, or a maximum of 3 applications if povidone 10%) to reduce the risk of infection;

- **Skin-to-skin:** it is recommended that an ocular prophylaxis treatment be applied (silver nitrate 1%, povidone-iodine 2.5 % solution, or tetracycline 1% ointment), in accordance with national protocols. However, if the STI responsible for conjunctivitis (gonorrhoea and chlamydia infection) are automatically tested for and treated in the mother and her partner during pregnancy, it is not strictly necessary to administer prophylactic treatment to the newborn;

- **Eye care:** it is recommended that newborns who present no complications be kept in skin-to-skin contact with their mother during the first hour of life. This contact has beneficial clinical effects in combating hypothermia and improving maternal breastfeeding and mother-child bonding. In order to facilitate this action, which could be viewed as ‘natural’, it is therefore recommended to put policies in place in hospitals and maternity units which encourage ‘skin-to-skin’ contact;
In developing countries, mortality rates estimates are higher for different reasons. The survival of a premature newborn, specifically in the case of very preterm births, is lower due to the absence of specialised care services that are required for their treatment. There is also a need for specialised costly equipment and skilled human resources.

As for the premature babies who survive, they present an increased risk of morbidity (breathing, sensory, cognitive and/or psychomotor disorders).

**Care of these children**

There are 50% of neonatal deaths that are linked to prematurity or low birth weight. The first days and first weeks are at high risk for newborns with an insufficient weight. Therefore, these children require additional care to enhance their chances of survival.

For these children it will be important to:

- **Promote exclusive maternal breastfeeding** and for those who cannot succeed to encourage cup-feeding with maternal milk;
- **To ensure that the newborn is kept warm** (Kangaroo care);
- **To pay particular attention to signs of complications to enable early treatment and referral of the child to a neonatal unit if necessary** (specifically in the case of respiratory disorders).

### Kangaroo Mother Care

Kangaroo Mother Care consists in carrying a newborn skin-to-skin against the belly of the mother, the father, or any other familiar person when the mother is not available. It is an efficient and easy way to address the need for warmth, breastfeeding, protection against infections, stimulations, and security of the newborn, regardless of the environment, weight, gestational age and clinical state. This method is not costly and must be initiated in healthcare facilities under the supervision of skilled medical personnel and can then be continued at home by the mother.

A review of studies conducted on the Kangaroo Care method has shown that it enables to reduce mortality and morbidity of premature newborns or newborns of low birth weight. Indeed, when comparing with traditional neonatal care (requiring important expenses in terms of equipment, maintenance, and trained neonatal practitioners), the Kangaroo method also reduces the number of infections, nosocomial infections, hypothermia, respiratory infections and length of hospital stay. Over 75% of deaths of premature newborns could be avoided without requiring intensive care. The Kangaroo Care method is therefore particularly appropriate and could save 450 000 newborns per year. The method goes with an important support to breastfeeding that may encompass the use of breast pump, cup-feeding or feeding with other utensils and complementary techniques. A close follow-up must also be organised at home after the newborn is discharged from a hospital setting.

### h) Exclusive breastfeeding

Exclusive breastfeeding is initiated shortly after birth and continues for the child’s first six months without the introduction of other solid food or liquids.

In 2017, only 40% of newborns in the world were exclusively breastfed during the first six months following birth.

So-called early introduction to breastfeeding must take place in the first hour following birth. This ensures the breastfeeding gets off to a better start and stimulates the mother’s uterus, which in turn diminishes the risk of postpartum haemorrhage. It is particularly adapted to the needs of the newborn. Raising awareness of exclusive breastfeeding - and of ‘skin-to-skin’ during the antenatal period and supporting the mother have an important impact on this practice. It helps reinforce the mother-child bond.

For those from disadvantaged backgrounds marked by poor hygiene and lack of drinking water, breastfeeding is a way to reduce infant mortality. It actually protects the newborn against infectious diseases, particularly gastrointestinal infections.

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84. Squassero Y. Optimal duration of exclusive breastfeeding. RHL Commentary, WHO reproductive health library (Last revised March 28th, 2008).
which contribute considerably to infant morbidity and mortality in developing countries. Breastfeeding strengthens the immune system’s defences and helps reduce the risk of allergies. It is also worth pointing out that, every year, malnutrition is a factor in nearly 45% of the 11 million deaths among children under 5 in developing countries. An increase in immediate and exclusive breastfeeding rates in the neonatal period could contribute to reducing these deaths. It is also a free feeding method that avoids buying milk and equipment for artificial feeding.

i) Immediate postpartum

Immediate postpartum is defined to be the first 2 hours after birth of the child and the delivery of the placenta; and a period of increased risk for mother and child that extends to the first 24 hours. Healthcare personnel must pay particular attention to monitoring and caring for women during this time. In fact, 50% of maternal and 40% of neonatal deaths occur during the 24 hours following birth.

The biggest cause of maternal mortality remains postpartum haemorrhage and it occurs mainly in the first 24 hours. According to international data, 10% of births give rise to a primary postpartum haemorrhage, less than 24 hours after birth. Postpartum haemorrhage can rapidly lead to maternal death (i.e. within two hours). These maternal deaths are, however, avoidable where the presence of personnel with birthing skills is assured and preventative measures, greater monitoring during the hours following birth and appropriate treatment in the event of a haemorrhage are implemented.

Yet in a large number of countries, women are rapidly discharged from the healthcare facility where they have given birth. Those who have a home delivery rarely have access to postpartum monitoring in the initial hours. Despite the scale of morbidity during postpartum, there is little care administered during this time in developing countries and generally it represents less than half the coverage of antenatal or obstetric care.

It is essential that women have access to skilled personnel capable of managing obstetric and immediate postpartum complications. Women must also be encouraged to rest under medical observation for the first 24 hours after delivery when they have given birth in a healthcare facility. Where women give birth at home, they must quickly consult a skilled medical practitioner and come forward with her child to a BEmONC centre where they will receive essential care for both. In the case of complications, transfer to a centre offering BEmONC may prove necessary.

During immediate postpartum, an intrauterine device can be inserted within 10 minute post placenta delivery or within the first 48 hours following childbirth.

j) Baby-friendly services

For a number of years, the WHO and UNICEF have implemented the ‘Baby Friendly Initiative’ to encourage facilities throughout the world to adopt appropriate practices with parents and newborns and to foster an environment that supports the success of maternal breastfeeding:
- To have written policy charter of maternal breastfeeding and set up trainings on this policy
- To provide pregnant women with comprehensive information on the benefits of maternal breastfeeding and rules on safe maternal milk storage
- To support early initiation of maternal breastfeeding
- To avoid giving newborns other sources of nutrition than maternal milk except for medical reasons or if the women does not wish to breastfeed
- To avoid separating mother and child, especially in the first 24 hours
- To facilitate the creation of support groups around maternal breastfeeding, etc.

In 2017, we were forced to notice that the coverage of that initiative was still limited: 35% in Europe, under 5% in Africa and South-East Asia.

Nonetheless, on top of this initiative it is important to think about simple measures to implement to support breastfeeding and to facilitate and accompany the mother-child bond. The organisation Action Contre la Faim (Action Against Hunger) has developed a set of recommendations to implement baby friendly spaces, which are very useful in a crisis context. It involves reducing malnutrition and supporting breastfeeding, as well as improving mothers and newborns’ well-being, strengthening the parent-child bond, helping families facilitate their child’s development and finding appropriate and sustainable solutions for children for whom breastfeeding is not an option. On top of these health education activities, this means to be able to set up spaces for psychosocial support activities (discussion groups, relaxation workshops, etc.) to reinforce parents’ autonomy and self-confidence. These activities can be particularly interesting when destined to isolated and vulnerable populations, for example young people and adolescents or migrants.

k) Monitoring maternal deaths and providing a response

The rate and ratio of maternal mortality are difficult to obtain, and the figures are often inaccurate. They are often underestimated, particularly because deaths in communities are not reported.

Monitoring maternal deaths and responding appropriately involve several stages: identifying maternal deaths, reporting on and examining the cases and, lastly, formulating a response that includes action to prevent future maternal deaths.

86. WHO, National implementation of the Baby-Friendly Hospital Initiative, 2017
87. ACF, Baby Friendly Spaces: holistic approach for pregnant, lactating women and their very young children in emergency, 2014
The methods for analysing maternal deaths are of value in different ways, such as improving the health information system by taking account of all maternal deaths - developing registers of births and deaths - and by taking account of the lessons that both professionals and communities can learn from a maternal death.

Examing and auditing maternal deaths should be viewed as a dynamic process leading to ongoing improvements in quality. But this type of initiative must, without fail, lead to recommendations being extracted and thus changes being effected both at the level of healthcare services and at community level. It must therefore be carried out with the participation of personnel in healthcare facilities, management teams and members of the community in such a way as to make each individual take responsibility for the recommendations arising from the audits.

Various methods currently exist, namely:
- **Verbal autopsy** or studies of maternal deaths in the community; these reveal the individual, family and community factors likely to have contributed to a maternal death outside a medical facility;
- **Study of maternal deaths in healthcare facilities**: This consists in qualitative research methods to investigate the causes and circumstances surrounding maternal deaths occurring in a healthcare facility. In so far as it is possible, an attempt is made to identify the factors in the community and during referral to the healthcare facility that also contributed to the death;
- **Confidential survey of maternal deaths**: This involves a systematic multidisciplinary and anonymous research method comprising a full representative sample of maternal deaths arising at local, regional or national level in order to record the number, causes and factors which can be avoided to remedy the problem. It is important to encourage those who can influence changes in the healthcare system to take part in the survey, as this will subsequently facilitate the use of its conclusions when national or regional maternal health programmes are being devised;
- **Survey of serious morbidity and ‘near misses’**: This comprises identifying and investigating cases of pregnant women who have survived obstetric complications which were seen as life-threatening. Cases of serious maternal morbidity or ‘near misses’ are more numerous than maternal deaths and a study of these should enable more reliable conclusions to be drawn concerning the risk factors and those which can be remedied or avoided, particularly as women have the opportunity to tell their story and describe the care and treatment received. Moreover, a study of women who have had life-threatening complications but whose lives has been saved may be less compromising for healthcare providers than a study of deaths;
- **Clinical audit**: This process aims to improve the quality of care and its outcomes by systematically reviewing the care given in relation to precise criteria and by proceeding to make changes.

4. **INTERVENTION STRATEGIES**

The intervention strategies suggested here are set out in relation to the different areas of the Ottawa Charter for health promotion. MdM builds on this Charter for project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

Whatever the chosen intervention strategy, it is essential that antenatal care is carried out in complete confidentiality and with respect for the patient’s privacy. Medical data must be protected. It is recommended to refer to the document “For Ethics in the Field” by MdM on this issue.
guidelines should enable everyone to access quality healthcare.

The following outcomes can then be pursued:
- A sociocultural analysis is carried out to identify the sociocultural barriers to accessing EmONC services and to identify inequalities and discriminations likely to impact the full exercise of sexual and reproductive rights;
- The status of women within communities is improved towards better equality in accessing services and exercising rights in SRH;
- Women have acquired skills to recognise, express and address their needs in SRH for themselves and for their couples. They are able to prepare and implement a birth and emergency plan. Men have acquired skills to take co-responsibility in an egalitarian and respectful manner in the health of the couple. They are specifically involved in preparing and implementing the birth and emergency preparedness plan;
- Financial barriers to accessing obstetric and neonatal services are removed;
- Geographical barriers to accessing care are reduced by implementing an efficient referral system;
- The link between carers and communities is strengthened via community health education activities and an outreach strategy of healthcare provision (e.g. postpartum care).

c) Improving the quality of obstetric care (element relating to ‘Reorienting healthcare services’)

The criteria for quality obstetric and neonatal care are clearly defined. The quality level within the services should be examined and the elements requiring improvement should be highlighted.

The following outcomes may therefore be pursued:
- Healthcare facilities are equipped with the drugs and medical equipment required to provide emergency obstetric and neonatal care;
- Healthcare facilities offer emergency obstetric and neonatal care that are cultural appropriate to women, their families and their community;
- Protocols for managing obstetric and neonatal emergencies that follow international standards (including the partograph) are in place and shared between healthcare facilities;
- An efficient referral system between different levels of healthcare facilities;
- Healthcare personnel is trained in emergency obstetric and neonatal care through appropriate basic training and continuing medical education;
- The Kangaroo Mother Care method is used and promoted in healthcare facilities;
- Management teams’ capacity to supervise health workers is improved;
- Monitoring of maternal deaths and ‘near misses’ is implemented using audits and surveys accompanied by appropriate responses;
- Provision of essential care for newborns and managing neonatal complications are incorporated into all services offering emergency obstetric care;
- Baby-friendly spaces are in place in the existing services.

d) Consolidating or implementing health education for women, their partners, families and communities (element relating to ‘Developing personal skills’) Consolidating health-related knowledge increases women’s access to obstetric care and helps reduce maternal and infant mortality. Indeed, consolidating women’s skills enables them to become more autonomous and better able to change their practices. Women must not be the only ones to benefit from these awareness raisons activities: their partners, families and communities must also be involved. Commitment on the part of families and communities is essential for health behaviour and to ensure women’s access to obstetric care.

The following outcomes may therefore be pursued:
- Individuals improve their knowledge and understanding of the value of giving birth with skilled personnel, the warning signs during pregnancy or childbirth and existing resources;
- Every pregnant woman and her partner (if she wishes) draws up a birth and emergency preparedness plan with the help of healthcare personnel and community health workers;
- Exclusive breastfeeding is promoted within the community;
- Men and all the members of the community are aware of the value of giving birth in a health facility with skilled personnel.

e) Promoting community involvement in health prevention activities and care for women who are pregnant, about to give birth or presenting obstetric complications (element relating to ‘Strengthening community action’) To be effective, safe motherhood interventions must be implemented at all levels of the country’s healthcare system. Projects are more effective when they are carried out as part of a concerted effort and with the combined commitment of community and government. It is thus essential to involve the community to reduce maternal mortality and morbidity.

The following outcomes may therefore be pursued:
- Leaders and other influential people in communities (traditional birth attendants, religious leaders, traditional healers, etc.) support health-education messages regarding the importance of obstetric care and giving birth with skilled personnel;
- Community healthcare workers (or peer educators) are trained and run health-education sessions within communities to encourage the referral to healthcare facilities of women who are about to give or have just given birth;
- A community referral system is implemented for transporting women on the point of giving birth or presenting obstetric complications; traditional birth attendants are included in the referral system from the community to the healthcare system
(reminder of danger signs, distribution of hygienic birthing kits).

- Women’s groups are supported in their community activities to promote exclusive breastfeeding.

‘Pakistan has one of the highest maternal and neonatal death rates in the world. MdM intervenes in the districts of Hangu and Tank in the province of KPK. In these areas, a high number of deaths are caused by extremely high rates of home births taking place without a skilled birth attendant. In the past, there were no round-the-clock services providing basic emergency and neonatal obstetric care, and the closest hospital providing CEmONC was 100 km away. To promote giving birth within these facilities, MdM followed the upgrading of four rural health centres so that they were able to offer 24/7 BEmONC. MdM also supported the setting up of a referral system using an ambulance for obstetric emergencies. Finally, health education activities were conducted at community level to raise awareness of the importance of giving birth in a health facility, of danger signs, of the topic of family planning, etc. Between November 2017 and June 2019, over 9000 antenatal consultations and 2000 births occurred in the facilities supported by MdM. An excellent community acceptation enables those results to be achieved.’

Asma Hasnat, Supervisor in Reproductive Health, Pakistan

1. DEFINITION

Postpartum care is care dispensed to a mother following delivery of her baby and up to 42 days (six weeks) after birth. Although a return to a pre-pregnancy physiological state (including the return of menstruation) can take longer, there is a consensus that the end of this period should be fixed as 42 days. However, it is interesting to note that in certain health systems and contexts, the postpartum visit takes place at 6 months postpartum.

The postpartum period is divided into three sections:
- Immediate postpartum during the first 24 hours of the baby’s life;
- Early postpartum from the second to the seventh day after birth;
- Late postpartum covering the period from the eighth to the forty-second day after birth (i.e. six weeks).

The WHO recommends that all women and all newborns benefit from four postnatal visits during the first six weeks following childbirth. The previous 2013 recommendations only advised two postnatal examinations with the first three days following childbirth. The new recommendations advise the following:
- Comprehensive examination of both mother and newborn within the first 24 hours postpartum;
- Follow-up contact at day 3 postpartum;
- Follow-up contact between day 7 and day 14;
- Last contact six weeks after birth.

Postnatal care refers to care given to both mother and newborn; it is essential that care for the mother and the newborn are conducted simultaneously.

Postnatal care to mother and child

90. WHO, Postnatal care of mother and newborn, 2013

reduces the risk of complications and helps mothers and fathers to give their children a best start in life.

The mother’s state of health must be regularly checked during the 24 hours following birth as well as during the first week, the period of greatest risk to the mother. It should then be checked again six weeks after birth, with a specific focus on access to family planning. Immediate postpartum care is mostly dealt with in section chapter 4. IV. Obstetric care and immediate neonatal care.
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Depending on context, these contacts can take place at home with midwives, other qualified health professionals or community health workers who are trained and supervised according to national recommendations.

As for newborns, the essential interventions in the neonatal period can potentially prevent over 50% of neonatal deaths. Moreover, they are likely to make a notable improvement of the quality of life after the neonatal period.

Newborn care should be undertaken as follows:91 92 93;
- Within the first 24 hours after birth: one neonatal examination within six hours after birth followed by 24 hours of monitoring in a healthcare facility by skilled personnel (a comprehensive examination will take place before the child and his mother are discharged) or home visit or visit in a health facility by a skilled personnel;
- This should be followed by three visits that take place at the same time as the mother’s postnatal check-ups (at day 3, between day 7 and day 14, and at six weeks);
- For the mother, postpartum traditionally ends six weeks after birth. Care for the newborn and the mother must take place simultaneously. In some cases (PMTCT for example), visits must continue throughout breastfeeding and can be adjusted to the immunisation schedule so that both can be combined.

2. MINIMUM PACKAGE OF SERVICES

a) Objectives
- To prevent maternal complications;
- To prevent neonatal complications and child pathologies;
- To detect and treat postpartum complications;
- To provide access to contraception to women who want it, using adequate information and making methods of contraception available;
- To promote practices that are in the interest of the health of mother and child;
- To foster a positive maternity experience and accompany the mother-child bond if necessary (strengthening self-confidence, skills and autonomy of mothers).

b) Key interventions

1. For the mother

1.1 Organising an examination of both mother and newborn in the first 24 hours of life and organising three follow-up visits at home or in a health facility
1.2 Monitoring the mother’s state of health and well-being
1.3 Screening for and treating postpartum complications (anaemia, infections, eclampsia, haemorrhages, thromboembolic disorders, postpartum depression, etc.) and early referral to an appropriate healthcare facility when further treatment is required

1.4 Informing and advising about the value of postnatal care, nutrition, newborn feeding, hygiene, rest during the postnatal period, danger signs for mother and baby during the postnatal period, contraception, preventing STI and HIV, addictions (tobacco, alcohol and drugs) and promoting a healthy lifestyle. This information is directed at mothers but also, as far as is possible, at their partners, families and communities.

1.5 Promoting, protecting and supporting exclusive breastfeeding preferably and accompanying artificial feeding

1.6 Information regarding umbilical cord hygiene and cord care by natural drying, in accordance with context and national recommendations, promotion of the use of Chlorhexidine for newborn umbilical cord care at home (in replacement of the use of harmful traditional substances)

1.7 Preventing and treating anaemia by administering iron and folic acid for three months

1.8 Preventing perineal infections and complications by administering antibiotics to any women presenting type 3 and 4 perineal tears

1.9 Providing vaccination against tetanus (follow-up to ensure immunisation programme is completed)

1.10 Testing and treating mothers and partners for STI

1.11 Screening for and treating cervical cancer and treatment of precancerous lesions in accordance with availability of services and national protocols (from six weeks postpartum on)

1.12 Paying attention to victims of gender-based violence (see chapter 5. II. GBV):
- Preventing and identifying gender-based violence;
- Providing medical and psychological care and legal support to victims, or referring them;
- Preventing and treating FGM (chapter 5. III. Management and prevention of harmful traditional practices).

1.13 Counselling on contraception and providing appropriate methods of contraception

1.14 Early detection of fistula for referral or treatment (see chapter 5. V. Obstetric fistulas)

1.15 Recording births, deaths and medical information in medical records and health cards:
- Monitoring and responding to maternal deaths and ‘near misses’ (see chapter 4. IV. Obstetric care and immediate neonatal care); carrying out audits of maternal deaths and ‘near misses’;
- Reporting all maternal deaths and helping register them in registry office records;
- Applying recommendations in response to audit results.

1.16 Prevention of mother-to-child

91. WHO, Postnatal care of mother and newborn, 2013
92. WHO, UNICEF, Save the Children, Newborn health in humanitarian settings, 2018
transmission of HIV (see chapter 5. IV. PMTCT):
- Counselling and testing women of unknown serology and their partners for HIV infection on a voluntary basis;
- Delivering prophylactic treatment, introducing or continuing antiretroviral treatment for mothers and newborns during the postnatal period, or referring them towards that venture;
- Referring or caring for mothers with HIV infection (this includes psychosocial care, treating opportunistic infections, helping with treatment compliance and advising on mother and child nutrition).

1.17 To promote rich in vitamin A diet for breastfeeding women

1.18 Preventing and treating cases of malaria:
- Encouraging the use of insecticide-treated mosquito nets (ITNs) for mothers and babies;
- Early diagnosis and treatment of malaria cases.

1.19 Specific psychosocial support for women at high risk of developing postpartum depression (history of depression, situation of GBV, unwanted pregnancy, isolation, etc.)

2. For the child

2.1 Anti-hepatitis B, BCG and anti-polioymelitis (PV-0) vaccinations for newborns of at least a week, information on national immunisation programme

2.2 Prevention and treatment in the case of congenital syphilis:
- neonatal prophylaxis when maternal syphilis is diagnosed, whether it is treated or not;
- Treatment or referral of symptomatic newborns;
- Treatment of the mother and her partner if infected and untreated.

2.3 Information regarding cleaning and care of the umbilical cord by natural drying and, in accordance with contexts and national recommendation, promoting the use of Chlorhexidine for cord care at home (in replacement of harmful traditional substances)

2.4 Organising 3 follow-up visits (at day 3, between day 7 and day 14, and at six weeks postpartum)

2.5 Information and advice regarding exclusive maternal breastfeeding, nutrition, thermal protection, newborn care, hygiene, benefits of postnatal care and follow-up of the child, immunisation, signs of danger in the newborn that should lead to seeking care, healthy lifestyle, recording births. This information is directed at mothers, and as far as is possible, at their partners, families and communities. It must be delivered in a culturally adequate manner and in a language that can be understood by the beneficiaries.

2.6 Recording births, deaths and medical information in medical records and health cards

2.7 Preventing malaria in endemic areas: advice on prevention and provision of ITNs

2.8 Providing psychosocial support by a professional in the case of difficulties establishing the mother-child bond (isolation, depression, etc.).

3. UNDERSTANDING THE ISSUE

a) Background information

Underuse of services
When birth takes place with a professional carer, whether at home or in a health facility, a woman is monitored for the first 24 hours and is checked again on the seventh day, and then accesses a healthcare facility for the six-week check-up. This care is not systematically dispensed.

In places where a majority of births take place at home, care may not be provided at all in the period following birth or women may be unaware that such services exist. Poverty and cultural constraints sometimes combine to create a ‘social barrier’ to accessing postpartum care.

While the need for immediate postpartum care is broadly recognised, subsequent care during this period is often completely overlooked or neglected.

At an international level, there is little data on postnatal consultations. According to the 2013 dataset, at global level, less than half the women and their newborns receive a postnatal visit in the first 3 days94.

According to observations, women are more likely to come back for a postnatal visit if they have given birth with skilled practitioners, which means that increasing the number of births with skilled personnel should have an impact on postpartum care. Moreover, this data does not give any indication of the quality of postpartum care.

The value of postpartum care
The postpartum period is responsible for around 2/3 of maternal mortality which takes place in majority during immediate postpartum (the first 24 hours after birth)95.

Postpartum haemorrhage is the primary cause of maternal mortality, accounting for 24% of complications; it occurs principally in the immediate postpartum period but can also occur in subsequent days, when it is referred to as secondary haemorrhage. Infection and septicaemia, representing 15% of complications, are the second most common cause of maternal death during the postpartum period; these are avoidable causes of death if prevented during delivery and/or treated in a timely and appropriate way during the postnatal period.

As for neonatal deaths, 25 to 45% of them occur during the first 24 hours, and 75% deaths occur during the first week96. This shows how crucial it is to organise care and follow-up neonatal visits during this period.

b) Medical complications and referrals

The major postpartum complications - postpartum haemorrhage, infection, septicaemia and eclampsia - must be prevented and/or managed by skilled personnel. Transfer to a centre offering Basic or Comprehensive EmONC may be necessary with minimal delay. It is therefore essential that women have an attended birth and good postnatal care to allow early detection of any possible complications.

The three delays in women receiving treatment also exist during the postnatal period:

- Delay in seeking and identifying possible care: representations and beliefs sometimes conflict with medical and health imperatives. Similarly, a lack of risk awareness and the fact that the care pathway primarily goes through traditional healers can delay the decision to seek care.

- Delay in accessing a healthcare facility: geographical barriers, cost and finding a means of transportation can lead to delays in getting to a healthcare facility.

- Delay in receiving appropriate treatment at the healthcare facility: the lack of skilled personnel, of awareness of postpartum-related risks and of essential equipment or drugs at healthcare facilities can lead to a delay in women receiving treatment.

It is therefore essential that women, their families, the community and healthcare personnel are aware of the risks posed during this period so that emergencies are responded to appropriately, both at community and hospital level. Work needs to be done in relation to sociocultural determinants to reduce the barriers to accessing healthcare. A system for referring from the community to healthcare facilities and between different levels of facility must provide a means for managing all obstetric complications including postpartum complications. Particular attention must also be paid to the financial and geographical barriers to accessing healthcare.

c) Health education

Postnatal care provides continuity between maternal and infant healthcare services and reinforces healthy behaviours introduced during antenatal consultations, labour and delivery. Information must be given and repeated to mothers and their immediate circle at different stages of the continuum of care so that they can make informed decisions both about themselves and their babies and so that they can find support within the family and community.

The aim of the health-education element of postpartum care is to encourage mothers and their families to adopt recommended health practices: exclusive breastfeeding, nutrition, spacing birth, etc.

An important and often overlooked part of postpartum health education is raising awareness of potential emergency situations indicated by danger signs.

A study in different developing countries has shown that the risks during postpartum are much less well-known than those during pregnancy and birth. When a danger sign is identified relating to postpartum, it is bleeding in 70% of cases.\(^7\)

Attitudes and practices in the event of postpartum complications must be discussed and included in the birth and emergency preparedness plan drawn up by the woman and her immediate circle during pregnancy. This ensures that the idea of postpartum risks is not only taken onboard, but those risks are also dealt with by reducing delays in seeking care.

Regarding the health of newborns, research has shown the difficulty for families to identify symptoms of complications in the newborn, particularly in the first week.\(^8\). This lack of knowledge has an impact on practices and causes delays in seeking and, therefore, receiving adequate care. Some traditional practices, such as giving a cold bath, cleaning the cord with earth and other substances, throwingcolostrum away and feeding the baby other things than maternal milk after birth, can be harmful to the health of the newborn and compromise his/her survival. The ‘Saving Newborn Lives’\(^9\) initiative has shown that communicating on a behaviour change through community involvement on health practices such as exclusive breastfeeding, adequate cord care, ‘skin-to-skin’ for thermal regulation of the newborn could reduce neonatal mortality by around 50%.

There is therefore a need to reinforce mothers and families in their capacity to identify symptoms that could reveal health issues and seek medical help without delay. Good practices such as exclusive breastfeeding, newborn thermal protection, hygiene rules for cord and skin care will be essential topics to cover with communities to help behaviours evolve. Finally, it is important to insist on the importance of postnatal care for the newborn to reduce neonatal morbidity and mortality.

d) Promotion of exclusive breastfeeding

Exclusive breastfeeding must be introduced from birth with the patient’s consent. Healthcare personnel have a crucial role to play in counselling, promoting, initiating and supporting exclusive maternal breastfeeding. Postnatal consultations represent a key moment for supporting and encouraging women in this practice, particularly where it is not widespread. (see chapter 4. IV. Obstetric care and immediate neonatal care).

e) Cervical cancer screening

When this service is available, for women who has not received early antenatal screening, or for those whose screening test revealed abnormalities,
the postnatal consultation is a precious opportunity to screen for cervical cancer (or to control the test) and to organise the treatment of potential precancerous lesions. This can be carried out by the health professional who delivers the postnatal consultation provided that professional has been trained (see chapter 5. I. Prevention of cervical cancer).

f) Access to effective contraception methods

The health of a woman and her children is threatened if the pregnancies are too closely spaced (less than 2 years), or if there are too many. Promoting birth spacing enables the body to recover fully after a pregnancy and birth. Pregnancy complications are more frequent in great multiparas. In developing countries, the risk of premature birth doubles when the conception occurs in the six months following the previous birth. The risk of infant death rises by 60% when children are born less than two years after the previous birth.100

Postpartum consultations are a key moment for promotion of contraception and its initiation. It is therefore essential that contraception— if it has not been discussed antenatally or if the patient has not made her choice— be discussed during these consultations.

Some efficient contraceptive methods can be offered just after birth (intrauterine device within 10 minutes after placenta delivery or in the 48 hours following birth, contraceptive implant before discharge from the maternity). Some can also be anticipated, such as tubal ligation in the case of a planned caesarean or IUD abdominal insertion at the end of a caesarean. The postnatal consultation six weeks postnatally is also important to initiate contraception for those who wish to.

Numerous contraceptive methods exist, and they must be offered and adapted to each woman and take account of her health, whether she breastfeeds or not, her wish to space or stop pregnancies and her sexuality.

Double protection against STI/ HIV and pregnancy using masculine and feminine condoms must always be explained and made available to women. Moreover, information on the emergency contraception will be given so that women are aware of its existence and may use it if they need it.

g) Skilled practitioners in newborn care

Care for the health of newborns is sometimes fragmented. It can be carried out by the staff in charge of obstetric care and postpartum care, but also by the personnel in charge of children under 5 years, specifically for vaccination. Nonetheless, neonatal care is underdeveloped, and follow-up is often neglected.

First, it seems necessary to have qualified practitioners for birth who are capable of caring for the immediate needs of the newborn and referring in the case of complications. This is the first link in the chain. In addition, there has been discussion for a number of years about including a newborn module in the training for Integrated Management of Childhood Illness (IMCI), given that, to date, the training only focuses on infants. Certain countries like India, Tanzania and Malawi have already adopted the neonatal module101. It is also essential to link the care of the mother with that of the child.

For home care, if community health workers can support the action of skilled practitioners, specifically in promoting healthy behaviours, they are not to act as substitutes.

The priority will therefore be to reinforce the number of health practitioners with the ability to care for newborns and strengthen their skills through continuous training.

h) Home care for newborns102

A majority of babies born at home receive no postnatal care. The lack of access by newborns to postnatal care, especially when the woman gave birth at home, raises the question of home care. It is a fact that care in the 24 hours after birth significantly reduces neonatal mortality. This has led the WHO and UNICEF to encourage home care to ensure a larger coverage of postnatal care. The WHO and UNICEF encourage supporting the continuum of care in space: in the community/at home, in primary healthcare centres and in referral hospitals.

According to the WHO and UNICEF, the newborn’s follow-up for mothers who gave birth at home and care not able to go to a health facility should include three home visits:

- In the first 24 hours following birth: home visit by the skilled birth attendant who performed the delivery or by qualified personnel;
- Between day 7 and day 14;
- In the sixth week following birth.

Depending on the context, these visits can be carried out at home by midwives, other qualified health professionals or community health workers who are trained and supervised in accordance with national recommendations.

A review of different studies has shown that community-based activities, conducted by influential members of the community, has an impact on reducing neonatal mortality and morbidity103. Actions taken by community health workers, community groups in health promotion, complementary with skilled health practitioners are recommended. The highest impact is achieved on the themes of raising awareness about dangers signs and referral and early initiation of maternal breastfeeding. It is important to raise awareness for mothers and their partners on these themes.

100 Cleland J. et al., Contraception and health, The Lancet, Family Planning, July 2012
103 Laos S.S. et al., Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes, Cochrane Database of Systematic Reviews, 2010.
CHAPTER 4: ASPECTS OF THE CONTINUUM OF CARE

i) Immunisation

Immunisation helps combat and eradicate infectious diseases that are potentially fatal. It is considered the most cost-effective investment in the field of health. Birth and postnatal follow-up are essential moments to initiate and promote vaccination. The WHO recommendations\(^{104}\) are presented here. It is however advised to consult the national immunisation programme schedules when they exist. Vaccines can generally be co-administered (several vaccines administered in different injection sites during the same consultation, in the absence of any contrary recommendations).

At birth (< 24 hours):

- **BCG**: vaccination is recommended at birth for children living in countries where morbidity due to tuberculosis is high. The immunisation schedule is of one single dose.

Concerning children exposed to HIV, it is recommended to postpone vaccination until the results of the CRP test (when available) and at least to avoid vaccination in the case of signs and symptoms of HIV infection; this is due to the increased risk of disseminated BCGitis in the case of contamination. It is important to refer to national protocols based on national and regional factors (prevalence of tuberculosis, of HIV, possibility of testing newborns, etc.;

- **hepatitis B**: perinatal transmission or early postnatal hepatitis B is an important cause of chronic infection in the world. Recommendations are in favour of vaccination at birth, even in low-endemic situations. The immunisation schedule can vary depending on national schedules from 3 to 4 doses spaced by at least four weeks. Vaccination is all the more important for newborns with a mother who presents with positive HBs antibody;

- **OPV** (oral polio vaccine): in countries where poliomyelitis is endemic, the administration of OPV is recommended at birth. For other countries, this will be carried out at six weeks postpartum. Primo vaccination is composed of three doses spaced by at least four weeks.

At six weeks:

The last postnatal consultation is an opportunity to complete immunisation schemes initiated at birth and administering other vaccines. The WHO recommends initiation primo-vaccination at six weeks of the following: DTC vaccine (diphtheria, tetanus, pertussis, three-dose immunisation scheme), Haemophilus influenzae B (three-dose immunisation scheme), pneumococcal vaccine (two or three dose immunisation scheme), and rotavirus vaccine (two or three dose immunisation scheme).

4. INTERVENTION STRATEGIES \(^{105,106}\)

The intervention strategies proposed here are set out in relation to different areas of the Ottawa Charter for health promotion. MdM uses the Charter as a basis for project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of care so that none is omitted.

The postpartum period is an essential and often neglected part of the care continuum.

MdM is keen to pay particularly close attention to this element, as it has significant impact on reducing not only maternal but also infant mortality and morbidity, being closely linked to newborn care. In addition, it offers excellent means of introducing women and their partners to family planning.

Whatever the chosen intervention strategy, it is essential that postpartum care is carried out in complete confidentiality and with respect for the patient’s privacy. Medical data must be protected. It is recommended to refer to ‘For Ethics in the Field’\(^{107}\), by MdM on this issue.

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a) Formulating or strengthening national policies relating to postpartum care

(element relating to ‘Building healthy public policy’ in the Ottawa Charter):

Guidelines are needed which take account of epidemiological contexts and international recommendations and they should detail the minimum essential components of postpartum healthcare. Where this is not the case, providing technical support to decision-making bodies such as the Ministry of Health or taking advocacy action may be envisaged in pursuit of the following outcomes:

- **Women have access to postpartum care** (an often neglected element of the continuum of care) and to maternity leave (advocacy action);
- **Women who have just given birth have free access to healthcare for themselves and their children**;
- **National protocols for postpartum care and services are harmonised and share**;
- **Collection of data on the postnatal period is improved** via registry office records and by incorporating postpartum care indicators into the national health information system;

b) Reducing the barriers to accessing healthcare

(element relating to ‘Creating supportive environments’):

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b) Reducing the barriers to accessing healthcare

(element relating to ‘Creating supportive environments’):
Barriers to accessing healthcare need to be reduced, especially for postnatal services, which are often underused. Demand for this care among women is low and there are delays in making use of postnatal services.

The following outcomes may therefore be pursued:

- A sociocultural analysis with a gender approach is carried out to identify the sociocultural barriers to accessing postnatal care for the mother and child, as well as inequalities and discriminations that may impact the full exercise of sexual and reproductive rights.
- Women’s status in the communities is improved towards better equality of access and exercise of SRH rights.
- Women have acquired skills to recognise, express and address their needs in SRH and for their newborns’ needs, for themselves and in their couples. Men have acquired skills to take co-responsibility in an equal and respectful manner regarding the child’s health, in the couple, specifically postpartum contraception.
- Financial barriers to accessing postnatal services for mothers and children are lifted.
- The link between carers and communities is strengthened via community health-education activities and an outreach strategy of healthcare provision.

**c) Improving the quality of postpartum care**

(Element relating to ‘Reorienting healthcare services’):

These services are often underused, so it is essential to improve the care provided at facilities and within the community. Care provided must be of good quality and adapted to women’s needs.

The following outcomes may therefore be pursued:

- Access to efficient methods of contraception is integrated into postpartum care.
- Screening of cervical cancer is offered at the postnatal visits (at six weeks postpartum), when appropriate screening and treatment methods for precancerous lesions of the uterine cervix are available.
- Health facilities are equipped with the adequate drugs and equipment to provide quality postpartum care.
- Health facilities provide postpartum care that is culturally adapted to women, their families, and their communities.
- Pregnant women and those who have just given birth are integrated into perinatal networks (e.g. in France).
- The referral system between different levels of care is effective and efficient.
- Healthcare personnel have the skills needed to manage postpartum care and these are developed through initial training and continuing medical education.
- Capacities of management teams to supervise those working in healthcare are strengthened.
- Newborn care is carried out at home during the first week in order to reduce neonatal mortality.
- Monitoring maternal deaths and ‘near misses’ is implemented using audits and surveys accompanied by appropriate responses.

**d) Consolidating or implementing health education for women, their partners, families and communities**

(Element relating to ‘Developing personal skills’):

Consolidating health-related knowledge increases women’s access to postnatal care and helps reduce maternal and infant mortality. Indeed, consolidating women’s skills enables them to become more autonomous and better able to change their practices. Women must not be the only ones to benefit from these awareness-raising activities: their partners, families and communities must also be involved. Commitment on the part of families and communities is essential for health behaviour to be adopted and to ensure women’s access to care.

The following outcomes may therefore be pursued:

- Women improve their knowledge and understanding of the value of postpartum care, the warning signs during postpartum and existing resources.
- Exclusive breastfeeding is promoted within communities via peer educators.
- Men are involved in health-education sessions and are aware of the importance of postnatal care for mothers and children.

**e) Promoting community involvement in health prevention activities and care for women who are pregnant, about to give birth or presenting obstetric complications**

(Element relating to ‘Strengthening community action’):

To be effective, safe motherhood interventions must be implemented at all levels of the country’s healthcare system. Projects are more effective when they are carried as part of concerted effort and with the combined commitment of community and government. It is therefore essential to involve the community to reduce maternal mortality and morbidity.

The following outcomes may therefore be pursued:

- Leaders and other influential people in communities (traditional birth attendants, religious leaders, traditional healers, etc.) support health-education messages regarding the importance of postnatal care.
- Community healthcare workers are trained and run health-education sessions within communities to encourage the referral to healthcare facilities of women who have given birth.
- Women’s groups are supported in their community actions promoting exclusive breastfeeding.
- A community referral system is implemented for transporting women on the point of giving birth or presenting obstetric complications in postpartum. This system involves traditional birth attendants whose knowledge on detecting complications in postpartum for mother and child is strengthened.
VI. PROVISION OF CARE FOR UNWANTED PREGNANCIES AND COMPREHENSIVE ABORTION CARE

1) DEFINITION

As mentioned in chapter I (see chapter 1, II, 5. Abortion) there is a variety of terminology to describe abortion. The definitions that are presented here can also be found in MdM’s practical sheets: Management of Unwanted Pregnancies and Comprehensive Abortion Care108.

The term abortion applies to any form of pregnancy termination before the foetus is capable of extra-uterine life (before 22 WA or under 500g in weight). The abortion may be spontaneous (also called miscarriage) and occur without any intervention, or it can be an induced abortion when there has been an intervention to terminate pregnancy.

The different existing types of induced abortion are the following:

- **Safe abortion**: is a procedure aiming at terminating pregnancy, performed by skilled practitioners in good safety conditions. It can be a therapeutic abortion that is carried out in accordance with the legal framework when pursuing pregnancy puts the woman's physical or mental health at risk. It can also be a voluntary abortion when, in accordance with the legal context, a woman does not wish to carry the pregnancy to term, whatever the reasons. This type of abortion can be carried out at various times of pregnancy. When States accept the existence of therapeutic abortions, there is usually a set time-limit in pregnancy.

- **Unsafe abortion**: which is carried out in risky conditions or in bad security conditions, i.e. by unqualified people and/or in an environment that doesn’t reach the minimal medical standards of care. In 2017, the journal The Lancet published estimations on unsafe abortion and safe abortions at a global level109 and for the first time, this included sub-categories within the unsafe abortions category, i.e. 'less safe' or 'least safe'. This distinction enables a more subtle understanding of the various conditions of abortion for women who cannot access safe abortion by a skilled practitioner. The difference between the two is particularly important when looking at harm reduction strategies in relation to unsafe abortions. In particular, this is to be accounted for in strategies that favour the use of self-administering of misoprostol view as ‘less safe’ than safe abortion with medical practitioners but much safer than many harmful practices. Thus, the following concepts can be defined:

- **Less safe abortions**: abortions that are carried out either by a health practitioner using a risky or outdated method, or by an unskilled practitioner even if he/she uses a safe method such as misoprostol treatment (a drug that can be used for various medical purposes, including to induce an abortion).

- **Least safe abortions**: abortions carried out by unqualified people with harmful methods such as the insertion of objects, and herbal medicines.

**Comprehensive abortion care (CAC)** is a set of services provided by a skilled health professional: pre-abortion consultation, safe abortion (using medical or surgical treatment), post-abortion care and post-abortion contraception. It is to be noted that an abortion carried out in good hygiene conditions by a trained practitioner is at low risk of complications.

The concept of care for unwanted pregnancies refers to the care delivered to a woman or an adolescent in the case of an unwanted pregnancy. Depending on the woman/adolescent’s choice, it can be care in the case where pregnancy is continued and therefore involves providing antenatal care and psychosocial support, or care in the case where the patient’s choice

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108. MdM. Practical sheets : Management of unwanted pregnancies and comprehensive abortion care, 2019

109. The Lancet, Global, regional and sub regional classification of abortion by safety, 2010-2014: estimates from a Bayesian hierarchical model, 2017
is abortion. In certain contexts, this will be a safe abortion with a health professional, while in others where the legal dispositions are restrictive, it could be the self-administration of misoprostol in the framework of a harm reduction strategy or setting up a referral system.

MdM acknowledges how essential it is to be able to provide women with adequate care in the case of a spontaneous abortion, but also to offer access to safe abortion in accordance with the legal framework, to provide care for complications of abortions and adequate counselling before and after an abortion. In a context where induced abortion is regulated by restrictive laws, the project team may discuss with MdM’s decision-making bodies as to the importance, the responsibilities engaged and riskinvolved for the organisation, its members and the service users, in offering access to safe abortion whether through the services we support or though our partners in the field. 10

It is to be noted that safe abortion care may also provide opportunities to identify other needs in sexual and reproductive health and to offer counselling to women in family planning.

2. MINIMUM PACKAGE OF SERVICES

a) Objectives

— To enable women to exercise their sexual and reproductive rights;
— To reduce maternal mortality

b) Key interventions

Following analysis of the local or national context, interventions are adapted accordingly.

1. Setting up activities towards value clarification and attitude transformation with all the people involved in the project (regardless of the legal framework)

2. Health education for individuals (including adolescents) and communities on contraception and available services, unwanted pregnancies, the consequences of unprotected sex, coerced sexual intercourse, the consequences of unsafe abortions, the availability of services offering pregnancy testing and care of complicated pregnancies, including provision of safe abortion.

3. Pre-abortion care: provision of a pre-consultation:

3.1 Discussion and counselling: information on possible options for the outcome of pregnancy (abortion, carrying on with the pregnancy and adoption), assessing personal support available to the woman, ensuring she has not been coerced, discussing, if so wished, the reasons for her choice and informing her of the procedures, risks and side-effects of the various procedures;

3.2 Medical history and clinical examination with aim of clinically assessing the patient;

3.3 Confirming pregnancy diagnosis and dates (date of last period, clinical examination and, if necessary, blood sample and/or ultrasound scan);

3.4 Testing for and treating STI;

3.5 Other complementary examinations if needed: pregnancy test, ultrasound scan if suspected atopic pregnancy, haemoglobin rate, blood group. Performing these routine tests is not a compulsory pre-requisite and should by no means impede rapid access to comprehensive abortion care;

3.6 Prophylactic antibiotic treatment (recommended by WHO and IPPF to reduce the risk of infection) in cases of planned surgical pregnancy termination;

3.7 Counselling in contraception;

3.8 Detecting and caring for women who have suffered gender-based violence, or referring them;

3.9 Prescribing pain-relief treatment (anti-inflammatory) particularly in cases where medical abortion is carried out at home;

3.10 Collecting informed consent for the chosen procedure;

3.11 Identifying potential necessary measures for psychosocial support of the patient depending on her needs and available services.

4. Safe abortion care:

4.1 Management or referral, depending on the situation and existing options, to a healthcare facility dealing with abortions following the woman’s free and informed decision. Whatever the legal context, she must be fully informed;

4.2 Choice of procedure (medical/surgical) depending on the patient’s medical situation, availability of services, and wish/preference of the patient after she has received enlightened information on the different methods;

4.3 National and/or international protocols are followed when carrying out a medical (ideally mifepristone + misoprostol or misoprostol alone if mifepristone is unavailable) or surgical (manual or electric aspiration, or cervical dilation and evacuation) abortion, depending on gestational age;

4.4 Basic psychosocial support, benevolent attitude, use of clear, empathic and non-judgemental communication;

4.5 Pain management for women (anti-inflammatory drugs, local anaesthesia for surgical methods using a paracervical block);

4.6 Respect for universal precautions and availability of adequate equipment in the case of a surgical abortion (size of cannula adjusted to gestational age and size of the womb);

4.7 Verbal comforting throughout the procedure of surgical abortion

4.8 Rapid identification and management, or referral of women with immediate complications;

4.9 Counselling and provision of modern contraceptive methods and referral with appropriate facilities to deal with permanent or long-term birth control methods that are not available at primary care level;

4.4 Informing the woman about the danger signs, the importance of not being alone in the hours following the

10 MdM positioning on SRH, validated in board meeting in 2012

111 International Planned Parenthood Federation.
procedures and the available services in the case of complications.

5. Activities in relation to harm reduction strategies linked to the risks of unsafe abortions practiced in bad conditions in contexts where this is the case (restrictive legal framework), notably information strategy on self-administration of misoprostol.

6. Post-abortion care (this must be available regardless of the legislative context):
6.1 Management or referral of incomplete abortions for misoprostol administration or manual or electric aspiration (depending on clinical state, availability and wish of the patient);
6.2 Detecting signs of infection;
6.3 Management of complications linked to an unsafe abortion (or referral to an EmONC centre in the cases where a transfusion or a surgical procedure is required);
6.4 Appropriate pain management;
6.5 Counselling and delivering modern contraceptives or referral to facilities where permanent or long-term contraception is available as opposed to primary care level;
6.6 Informing women of the recovery process and warning signs (no follow-up visits recommended);
6.7 Vaccination against tetanus for women who have undergone unsafe abortion (vaccine and testing depending on the vaccinal status);
6.8 Evaluation of the emotional state and referral to psychological support services where needed;
6.9 Assessment of possible other needs in SRH and referral to appropriate services (e.g. screening for cervical cancer).

7. In the context where the legal framework is restrictive, advocacy actions at national and/or regional level are developed in favour of safe and legal abortion.

8. Medical and psychosocial support throughout pregnancy for adolescents and women faced with an unwanted pregnancy and who cannot or will not terminate their pregnancy.

9. Identifying, caring for and supporting survivors of gender-based violence:
   ➡ Identifying survivors of gender-based violence;
   ➡ Primary prevention of GBV;
   ➡ Referral or management of complications resulting from GBV (physical, psychological, etc.).

10. Counselling and screening of HIV on a voluntary basis and referral for medical care if necessary.

3. UNDERSTANDING THE ISSUE

a) Background information

In the world, 214 million women and girls who would rather postpone or avoid a pregnancy still live in countries where they have no access to efficient and safe contraception. According to estimates, around 89% of unwanted pregnancies occur in these countries and over a quarter lead to unsafe abortion.

Each year, unsafe abortion causes the death of 22,800 to 31,000 women, i.e. 8 to 11% of maternal mortality, while 8 million others suffer from temporary or permanent impairments112. Those unsafe abortions are the third cause of maternal mortality, yet they are easily preventable deaths.

Today, the issue of unwanted pregnancies is faced with strong oppositions at an international level, making progress in that matter weak and limited. Yet, unwanted pregnancies represent a core public health issue and are one of the main factors of maternal mortality and morbidity. This translates in reality by the multiplication of high-risk pregnancies, an important number of unsafe abortions or ruptures in the life of young girls or women who had not planned their pregnancy or who were not willing to welcome a child at that point in time.

The obstacles to comprehensive abortion care are numerous: legal and administrative barriers but also geographical and financial barriers, sociocultural and religious factors, lack of skilled human resources, lack of equipment and adequate treatment, etc. It is essential that these barriers are considered and that the question of caring for unwanted pregnancies and access to comprehensive abortion care can be integrated as part of the global response to SRH needs that MdM strives to bring forward by implementing its projects.

b) Barriers to accessing abortion

The barriers to accessing safe abortion care can be multiple:
   ➡ Legal and administrative barriers (law on abortion, complex procedures, short timescales)
   ➡ Lack of trained professionals
   ➡ Value conflicts for health professionals
   ➡ Sociocultural and religious determinants
   ➡ Lack of equipment and adequate drugs
   ➡ Financial barriers
   ➡ Lack of information on availability of services, on the legal framework (from users and health professionals)
   ➡ Fear of being stigmatised, judged in the community

c) Activities towards value clarification and attitude transformation

Several researchers suggest that stigmatising behaviours at individual or community level, or on the part of health professionals or transmitted by national policies, represent an important barrier to the management of unwanted pregnancies and to comprehensive abortion care. Those attitudes can potentially also be reflected within MdM teams.

In that context, MdM recommends developing strategies to positively influence knowledge, attitudes and behaviours towards abortion. This should be implemented systematically before beginning activities in relation to unwanted pregnancies regardless of the legal context. This is enabled by methodologies for value clarification.
CHAPTER 4: ASPECTS OF THE CONTINUUM OF CARE

and attitude transformation (VCAT)\(^\text{113}\). Those methodologies recognise that the values influencing attitudes and beliefs about abortion and its associated issues are likely to change through time in response to new experiences and an in-depth understanding of issues and context. They can also be used to recruit and select health professionals, community workers, pharmacists to be associated with the implementation of the projects. VCAT activities aim at encouraging participants to examine common hypotheses and myths about abortion and its associated issues, and to help them express their intention to act in accordance with the asserted values. Those activities should be organised in an environment supportive of discussions and by setting up a trusted space. They should also be facilitated by trained professionals. (See ‘Practical sheets: Management of Unwanted Pregnancies and Comprehensive Abortion Care for more detailed information.)

\section*{d) Abortion methods\(^\text{114}\)}

Several methods exist for abortion: medical and surgical. Using one or the other will depend on the availability of services and their quality, the training of the personnel, the patient’s clinical state, the gestational age, the presence of potential contra-indications to either of the methods, but also of the patient’s preference or her situation (difficulty to access a health facility several times, isolation, fear of being discovered in the case of medical abortion at home, etc.)

\subsection*{Medical methods}

Medical abortion is a safe, efficient, affordable method that is usually well-accepted by patients. The complications associated with this method are rare. \textbf{Two main therapeutic schemes are recommended}, depending on the availability of the treatments\(^\text{115-119}\):

\begin{itemize}
\item \textit{Combination of mifepristone and misoprostol} which is efficient in 95\% of cases in the first trimester
\item \textit{Misoprostol used alone} which is efficient in 85\% of cases in the first trimester
\end{itemize}

Mifepristone and misoprostol are in the WHO list of essential medicines. The format combining mifepristone with misoprostol (combi-pack) in which the doses are exclusively adapted to the use in case of abortion is also included in the list, which was revised in 2019\(^\text{117}\).

In some countries, other drugs than mifepristone and misoprostol are still used. Those are not recommended. As it is also used in the treatment of postpartum haemorrhage, misoprostol is largely available at a global scale, making its use, even alone, the most available safe-abortion method in restrictive legal contexts. The use of this scheme is particularly used in a harm reduction strategy linked to dangerous abortion practices. Misoprostol is also recommended in the case of post-abortion care following first-trimester abortions.

Due to its exclusive use for induced abortion, mifepristone is overall much less available.

The mode of action of mifepristone and misoprostol are the following:

\begin{table}[h!]
\centering
\begin{tabular}{|c|c|}
\hline
\textbf{MODE OF ACTION} & \textbf{MIFEPRISTONE} & \textbf{MISOPROSTOL} \\
\hline
\textit{- Inhibition of the activity of progestrone in the uterus leading to the detachment of the result of conception.} & • Softens the cervix and induces contractions. & • Softens the cervix and induces contractions. \\
\textit{- Softens the cervix and induces contractions.} & • Its use alone does not lead to abortion. & \\
\textit{- Its use alone does not lead to abortion.} & & \\
\hline
\end{tabular}
\caption{Mode of action of mifepristone and misoprostol}
\end{table}

\begin{itemize}
\item \textbf{The doses required depend on gestational age.}
\begin{itemize}
\item \textbf{In the case of a combined use of mifepristone/misoprostol,} mifepristone will be administered orally during the consultation followed, 24 to 48 hours later, by misoprostol intake which can be carried out at home by oral, sublingual or vaginal administration\(^\text{116}\). Misoprostol intake will be repeated depending on gestational age.
\item \textbf{In the case where misoprostol is taken alone,} it will also be administered orally or vaginally. Several doses may be required depending on gestational age. It is to be noted that the use of misoprostol alone is not as efficient as when it is combined with mifepristone. From 10 WA, to anticipate the risk of abundant bleeding, it will be recommended that the medical abortion take place in a healthcare facility.
\end{itemize}
\item \textbf{After 14 WA, surgical abortion will be the priority choice} (dilation + evacuation), however the medical treatment is also possible (for safety reasons this will have to take place in the facility rather than at home). (See ‘Practical sheets: Management of Unwanted Pregnancies and Comprehensive Abortion Care’ for further information.)
\end{itemize}

\textbf{Manual vacuum aspiration (MVA) and electric vacuum aspiration (EVA)}
Intra-uterine aspiration is a procedure recognised as an essential service by the WHO and the FIGO (Society of Obstetricians and Gynaecologists). It is a major alternative to medical abortion. It is also the recommended method to use in the case of failure of medical abortion and for post-abortion care. Intra-uterine aspiration consists in the evacuation of the uterine content in a plastic or metal cannula linked to a vacuum. This can be achieved in two manners:

- A manual vacuum: manual intra-uterine aspiration (MVA)
- An electric vacuum: electric intra-uterine aspiration (EVA)

The choice of system will depend on the availability of technical resources. Because it does not require electricity, is easy to use and can be implemented at primary care level, MVA is the most frequently used surgical method in MdM projects. It can be carried out under general or local anaesthesia, but in the majority of MdM projects, it will be under local anaesthesia. This chapter will focus exclusively on MVA under local anaesthesia.

MVA is extremely safe and efficient (success rate between 98% and 100%). Complications related to that procedure are rare and the cost is low. The procedure is short (3 to 10 minutes) and can be carried out under local anaesthesia and in outpatient care. Moreover, it is well accepted by most patients.

The use of medical abortion or MVA will depend on the availability of the method and training of the medical staff, the clinical state of the patient (and the gestational age of pregnancy), potential contra-indications to one of the methods, and the choice/preference of the patient.

The method using dilation and curettage is no longer recommended, because it is more painful and comes with an important risk of complications. Therefore, it must be replaced with EVA, MVA or a medical method.

To summarise, the recommended methods for medical abortion depending on the stage of pregnancy are:

For incomplete abortions, the use of MVA or EVA is recommended. Incomplete abortions can also be managed using misoprostol and the choice of method will depend mainly on the patient’s clinical state (heavy bleeding, uterine infection, sepsis, etc.).

e) Counselling at every stage of safe abortion care

Providing good quality counselling to women and active listening of women needs are essential elements at every stage of safe abortion care. Counselling must be practiced by skilled personnel who do not pass judgement on or discriminate against women or couples wishing to terminate pregnancy.

Where a woman is accompanied, it is important to spend time alone with her to assess whether she is subject to pressure and if she has suffered gender-based violence, particularly if she is a minor.

Counselling and listening also ensure informed consent, free from all pressures and coercion. A woman must give her informed consent either in writing or orally, depending on the situation.

Counselling must encompass the following: different options for the outcome of this pregnancy (adoption, termination and going full-term) and different procedures for terminating pregnancy so that, where possible, the woman can choose the pregnancy termination procedure. Information should detail the different stages of the procedure and follow-up care. It must also focus on the advantages and risks as well as the side effect of the drugs, warning signs to look out for at home, contraception and preventing STI including HIV.

Moreover, it is important to guarantee confidentiality, respect for intimacy and respect for the culture of the patients. It is also crucial to protect personal data and patient medical records.

f) Post-abortion contraception

This is an essential element of comprehensive abortion care (CAC). Studies have shown that, in all countries, the higher the contraceptive prevalence, the greater the decline in the rates of induced abortions. Conversely, the greater the level of unmet contraception needs, the higher the abortion rate.

The question of contraception must be raised at each consultation (pre-consultation, immediate post-abortion and check-up control visit). This involves offering appropriate counselling (see chapter 4. II. Counselling and services providing efficient methods of contraception) by explaining to the woman when she can become pregnant again, different contraceptive methods and their risks and advantages, the

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**TABLE 8: METHODS FOR ABORTION DEPENDING ON THE STAGE OF PREGNANCY**

<table>
<thead>
<tr>
<th>≤ 14 WA</th>
<th>&gt; 14 WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical abortion:</td>
<td>Medical abortion:</td>
</tr>
<tr>
<td>- Mifepristone combined with misoprostol (or</td>
<td>- Mifepristone combined with misoprostol (or</td>
</tr>
<tr>
<td>OR</td>
<td>Mifepristone alone)</td>
</tr>
<tr>
<td>MVA/EVA</td>
<td>OR</td>
</tr>
<tr>
<td>* (Dilation and evacuation) *</td>
<td>* (Dilation and evacuation) *</td>
</tr>
<tr>
<td>*requests practitioners to receive additional training</td>
<td>*requests practitioners to receive additional training</td>
</tr>
</tbody>
</table>

---

120. IRPP, First trimester abortion guidelines and protocols. Surgical and medical procedures, 2009
existence of emergency contraception, the minimum space to leave between an abortion and a pregnancy (which is six months to allow the woman to recover physically, particularly in the case of a spontaneous abortion), STI and double protection. It is also important to discuss the issues in using contraception before this pregnancy, to provide the woman with adequate counselling. The woman must leave with a contraceptive method that suits her, is chosen by her and that she can easily obtain. Contraception is more readily accepted when offered at the first point of treatment.

The insertion of an IUD immediately after an abortion (induced or identified as spontaneous) is both safe and practical122. Likewise, an implant, contraceptive methods (pills or injections) using oestrogen and progesterone or progesterone-only, masculine or feminine sterilisation and condoms can be used immediately after an abortion123.

g) Harm reduction strategy regarding unsafe abortion practices

In situations where the legal framework and/or practices are very restrictive, where access is limited and where MdM has no direct intervention, it is possible that a harm reduction strategy might be the best option to reduce mortality and morbidity caused by harmful practices. This strategy aims at providing women and adolescents seeking an abortion with comprehensive information on the risks of certain harmful abortion practices and on the recommended medical practices, including self-administration of misoprostol.

In this case, the term ‘harm reduction’ refers to a public health intervention based on rights that seeks to reduce dangers and risks associated with a particular practice, such as abortion outside health facilities and not supervised by a skilled health professional, rather than to discourage it altogether. This intervention strategy aims at enabling women to obtain, through different sources, the information that they need to make informed decisions and adopt safer abortion practices. To make this possible, partnerships must be set up at community level, and it is also necessary to identify places, suppliers and services where quality misoprostol is provided, share evidence-based information and reinforce access to care before and after quality abortion, including counselling and access to contraception.

h) Advocacy for comprehensive abortion care

Implementation of MdM’s SRH strategy revolves around two types of complementary interventions which are a holistic healthcare provision and advocacy for respect of people’s rights to access adequate health services and respect for their sexual and reproductive rights. Access to care for unwanted pregnancies and comprehensive abortion care cannot be sustained unless the political and legal environment is supportive. Advocacy action is therefore an essential component of projects that can strengthen the long-term impact of the intervention, lift barriers to accessing comprehensive abortion care specifically legal and administrative barriers and turn good practices into sustainable policies integrating sexual and reproductive rights. Thus, the development and implementation of the advocacy strategy must be a part of the project cycle, at each stage in planning the project, during diagnosis, planning, monitoring and evaluation.

The CAC advocacy action aims at triggering sustainable change, which may consist in:

- The adoption of new policies and/or practices improving access to CAC
- Questioning, revising or amending policies and/or existing practices that have a negative impact on access to CAC
- Respecting existing policies and legislations that are not applied on access to CAC

To achieve this, it is necessary to have clear and global understanding of the legal and political environment.

4. INTERVENTION STRATEGIES

The intervention strategies proposed here are set out in relation to different areas of the Ottawa Charter for health promotion. MdM uses this Charter as a basis for project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

It is important to remind here that since this concerns healthcare provision for unwanted pregnancies and CAC, it is essential to provide responses that are adapted to needs, after an in-depth analysis of those needs but also of the legal, cultural and security context. Depending on the results of this analysis, the project teams (headquarters and field) may decide to develop activities towards care of unwanted pregnancies and comprehensive abortion care including in contexts where the legal framework regarding abortion is restrictive. The legal and security risks and any other risks must be analysed, mitigation measures must be defined and implemented, and institutional responsibility must be taken for the implemented operational strategy.

The pre-requisites and the set of operation modes are available in Appendix 4.


National protocols for safe abortion encourage services to be implemented; clear and appropriate regulations about access to CAC are encouraged; legislations that are not yet applied to CAC are adopted; policies that lead to improving access are amended; are questioned, discussed, revised or negative impact on access to CAC is developed; strategies and advocacy can be analysed so that adapted operational The existing policies with a developed; bodies, such as the Ministry of Health, actions may take the form of providing technical support to decision-making bodies, such as the Ministry of Health, or take the form of advocacy.

Abortion-related care should be considered a part of national health policies. Whatever the law, women should, as a minimum, be provided with pre- and post-abortion care. It is therefore essential to encourage governments and policies to consider and strengthen these services. These actions may take the form of providing technical support to decision-making bodies, such as the Ministry of Health, or take the form of advocacy.

The following outcomes may therefore be pursued: The political and legal environment on the topic of access to CAC is analysed so that adapted operational strategies and advocacy can be developed; The existing policies with a negative impact on access to CAC are questioned, discussed, revised or amended; Policies that lead to improving access to CAC are adopted; Respect of existing policies or legislations that are not yet applied about access to CAC is encouraged; Where abortion is decriminalised, clear and appropriate regulations encourage services to be implemented; National protocols for safe abortion care are drawn up and shared; Healthcare staff training policy relating to pre- and post-abortion care and pregnancy termination is consolidated; Emergency contraception is approved in the country and is accessible to women seeking it; Post-abortion complications are cared for free of charge and without discrimination by EmONC services; The political environment is supportive of the exercise of sexual and reproductive rights; Organisations of the civil society are supported by MdM to strengthen their advocacy for the adoption of non-restrictive laws on abortion.

b) Reducing barriers to accessing safe abortion care (element relating to ‘Creating supportive environments)

While other obstacles do exist, legislation represent a particularly significant barrier. In a large number of countries, the laws limit women’s access to safe abortion care. An equally crucial issue is to ensure that women and couples are aware of their sexual and reproductive health rights. It is important to analyse the various factors constraining access to safe and legal abortion.

The following outcomes can therefore be pursued: The status of women within the community is enhanced, empowering them to decide when to have children and how many to have; Women and their partners acquire knowledge of their rights relating to sexual and reproductive health, including those concerning abortion; Women and girls who have a legal right to an abortion have access to a medically safe and financially affordable procedure; Opinion leaders, policy makers, journalists, etc., are encouraged to question their values on abortion issues through setting up value clarification and attitude transformation activities.

c) Improving safe abortion provision (element relating to ‘Reorienting healthcare services’)

Safe abortion services must form a key part of primary health care to facilitate access to them. For this reason, in particular, MVA forms part of BEmONC. It is essential that good quality, safe abortion care is implemented to reduce abortion-related maternal mortality and morbidity.

The following outcomes may therefore be pursued: Initial training and/or continuing medical education for healthcare personnel are strengthened regarding the provision of safe abortion care and MVA; A wide range of modern contraceptive methods (including emergency contraception) is offered to women within services providing abortion care; Healthcare facilities are supplied with the equipment and drugs to.

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124 Dromer C. et al., For ethics in the field - Sensitive personal data management, MdM, 2010.
CHAPTER 4: ASPECTS OF THE CONTINUUM OF CARE

Referral to services and actors including outside the legal framework; SRH and/or primary care response, directly sets up CAC integrated in an law; relation to abortion, in accordance with strengthening access and quality of care in healthcare facilities. Women wishing an abortion receive quality care in healthcare facilities (pre- and post-abortion care, availability of medical and intra-uterine manual vacuum aspiration, post-abortion family planning).

With the aim of improving service provision or setting up a service, MdM structures its activities for care of unwanted pregnancies in its projects through 4 main intervention strategies:

- Supporting the health system to strengthen access and quality of care in relation to abortion, in accordance with the law;
- Direct intervention, where MdM directly sets up CAC integrated in an SRH and/or primary care response, including outside the legal framework;
- Referral to services and actors providing Comprehensive Abortion Care which is a minimal response in the contexts where MdM does not wish to or is not able to develop activities in relation to care for unwanted pregnancies and CAC;
- A harm reduction approach in relation to unsafe abortions using community access to comprehensive information about methods of medical abortion and self-administration of misoprostol. The set of operational modes and prerequisites are available in Appendix 4.

d) Consolidating or implementing health education for mothers, their partners, families and communities (element relating to ‘Developing personal skills’)

Consolidating health-related knowledge increases women’s access to abortion care and helps reduce maternal mortality. Indeed, increasing women’s knowledge on their sexual and reproductive rights empowers them so that they can decide how many children they wish to have and can plan their pregnancies accordingly. Women must not be the only ones to benefit from these awareness-raising activities: their partners, families and communities must also be involved. Commitment on the part of families and communities is essential for healthy behaviour to be adopted and for ensuring women and girls’ access to care.

The following outcomes may therefore be pursued:

- Women and girls, as well as men, and boys, improve their knowledge of preventing and managing unwanted pregnancies;
- Women know their rights relating to sexual and reproductive health, notably their right to access family planning and safe abortion;
- In contexts where the legal framework is restrictive and after context analysis and institutional validation, harm reduction strategies in relation to unsafe abortions are set up through creating networks (community relays, pharmacists, health centres, etc.) enhancing access to information regarding self-administration of misoprostol and access to quality misoprostol as well as necessary information on complications caused by self-abortion (where to seek quality post-abortion care) and counselling on post-abortion contraception.

e) Promoting community involvement in safe abortion care (element relating to ‘Strengthening community action’)

Discussing safe abortion projects with civil society stakeholders may be a positive way of increasing their impact. Projects are more effective when carried out as part of a concerted effort and with the combined commitment of community, civil society and government.

‘Since I have started working on the project ‘management of unwanted pregnancies’, my vision of this matter of abortion has changed. In our context, there are major inequalities to accessing safe abortion care: in the end, it is mainly people with low socio-economic status who seek unsafe abortions because they have no other choice. As a health professional, I consider the interest of the person and make a difference with my personal beliefs. Today, I can see the impact of the project in practice.’

A healthcare provider in a collaborating centre of MdM’s project in DRC.
Chers parents, n’attendez pas que tout soit gâté !
Parlez de sexualité dès maintenant avec nous !

La contraception est un choix et c’est mon droit !

CHAPTER 5
CROSS-CUTTING PROVISION OF CARE
CHAPTER 5: CROSS-CUTTING PROVISION OF CARE

I. PREVENTION OF CERVICAL CANCER
   1. DEFINITION
   2. PLACE IN THE CONTINUUM OF CARE
   3. UNDERSTANDING THE ISSUE
   4. INTERVENTION STRATEGIES

II. GENDER-BASED VIOLENCE
   1. DEFINITION
   2. PLACE IN THE CONTINUUM OF CARE
   3. UNDERSTANDING THE ISSUE
   4. INTERVENTION STRATEGIES

III. MANAGEMENT AND PREVENTION OF HARMFUL TRADITIONAL PRACTICES
   1. DEFINITION
   2. PLACE IN THE CONTINUUM OF CARE
   3. UNDERSTANDING THE ISSUE
   4. INTERVENTION STRATEGIES

IV. PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV
   1. DEFINITION
   2. PLACE IN THE CONTINUUM OF CARE
   3. UNDERSTANDING THE ISSUE
   4. INTERVENTION STRATEGIES

V. OBSTETRIC FISTULAS
   1. DEFINITION
   2. PLACE IN THE CONTINUUM OF CARE
   3. UNDERSTANDING THE ISSUE
   4. INTERVENTION STRATEGIES

VI. PROVIDING APPROPRIATE CARE TO ADOLESCENTS AND YOUNG PEOPLE
   1. DEFINITION
   2. ELEMENTS OF VULNERABILITY
   3. SPECIFIC HEALTHCARE PROVISION

VII. PROVIDING APPROPRIATE CARE TO SEX WORKERS
   1. DEFINITION
   2. ELEMENTS OF VULNERABILITY
   3. SPECIFIC HEALTHCARE PROVISION

VIII. PROVIDING APPROPRIATE CARE TO MIGRANTS
   1. DEFINITION
   2. ELEMENTS OF VULNERABILITY
   3. SPECIFIC HEALTHCARE PROVISION

IX. PROVIDING APPROPRIATE CARE TO THE LGBTIQ+ PEOPLE
   1. DEFINITION
   2. ELEMENTS OF VULNERABILITY
   3. SPECIFIC HEALTHCARE PROVISION
1. DEFINITIONS

Throughout the world, cervical cancer is the 2nd most frequent cancer for women. It is the main cause of death by cancer for women in developing countries. It reveals inequalities to accessing healthcare and its prevalence is uneven.

A persisting infection by the Human Papilloma virus (HPV) is the main risk factor for cervical cancer. The presence of HPV is a necessary condition to the development of precancerous lesions and cervical cancer. HPV is the most frequent viral infection of the reproductive tract. Most men and women with a sexual activity will be infected at one point in their life and some may be infected repeatedly. HPV is transmitted mainly through sexual intercourse and is extremely contagious. While most HPV infections disappear spontaneously, a small proportion of infections caused by certain types of HPV can persist and lead to precancerous lesions and, in the case where they are not treated, to cancer. In the absence of treatment, the evolution from HPV infection to cancerous lesions will take 15 to 20 years. Almost all cases of cervical cancer are imputable to HPV infection.

Nonetheless, each year, many deaths could be avoided by setting up primary prevention activities (such as vaccination) and making services available for screening and treating precancerous lesions as part of SRH services. Indeed, affordable and simple tools for screening and treatment of precancerous lesions exist.

2. PLACE IN THE CONTINUUM OF CARE

This table summarises the various activities regarding prevention of cervical cancer to be carried out throughout the continuum of care:

<table>
<thead>
<tr>
<th>CERVICAL CANCER ACTIVITIES IN THE CONTINUUM OF CARE</th>
<th>COMPREHENSIVE SEXUALITY EDUCATION</th>
<th>ANTENATAL CARE</th>
<th>OBSTETRIC CARE</th>
<th>POSTNATAL CARE</th>
<th>SERVICES OFFERING CONTRACEPTIVE METHODS</th>
<th>POST-ABORTION CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about cervical cancer, primary prevention, early screening, existing services, treatment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Screening of precancerous lesions in accordance with the MmM algorithm or international recommendations</td>
<td>(Only in the first trimester)</td>
<td>Up to 20 WA</td>
<td>X</td>
<td>(At least 6 weeks post-partum)</td>
<td>X</td>
<td>(At least 2 weeks post-abortum)</td>
</tr>
<tr>
<td>Treatment of precancerous lesions as per the MmM protocol or national recommendations (cryotherapy, thermocoagulation, LEEP)</td>
<td>Up to 20 WA</td>
<td>(At least 6 weeks post-partum)</td>
<td>X</td>
<td>(At least 2 weeks post-abortum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring the lost to follow-up after screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Referral system for management of the cases of cancer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

3. UNDERSTANDING THE ISSUE

a) Background information

Cervical cancer is the most frequent feminine cancer in 45 countries. Those countries are mainly situated in Sub-Saharan Africa, Asia, and for some in Central America.

Strong disparities can be noticed between women who live in high-income countries and those who live in low-income countries. In 2018, the number of new cases is an estimated 570 000 in the less developed regions, i.e. 84% of cases worldwide. That same year, 311 000 deaths consecutive to cervical cancer occurred in countries with low or intermediate income.


2. WHO. Human Papillomavirus and cervical cancer. Fact Sheets, 2019
The main reason for these differences in the relative absence of an effective national screening programme in the most affected countries. Cervical cancer is then diagnosed too late, which does not allow for efficient treatment. In high-income countries, incidence and mortality rates of cervical cancer have decreased in the past 30 years thanks to prevention programmes (anti-HPV vaccination, screening, early diagnosis and treatment of cancer cases).

According to the WHO, after 2030, cervical cancer will kill over 443,000 women each year in the world. Over 98% of deaths will occur in developing countries, among which 90% will concern Sub-Saharan Africa.

b) Human papilloma virus and risk factors

There are several types of HPV and not all of them cause problems. HPV infections usually disappear without any intervention in a few months, and around 90% will take up to two years after the date of contamination to disappear. A small proportion of infections generated by HPV at high oncogenetic risk (HR-HPV principally 16 and 18) may persist and develop into a cancer. The non-oncogenetic HPV (type 6 and 11 in particular), may lead to condyloma acuminata and respiratory papillomatosis (an illness through which tumours develop in the respiratory tracts leading from the mouth and nose to the lungs). Condyloma acuminata are very frequent and highly contagious. Thus, we can differentiate high-oncogenetic risk HPV and low-risk HPV. It is to be noted that both can coexist.

Direct transmission of HPV mainly happens through sexual contact, even without penetration. Skin-to-skin contact of sexual organs can suffice in contaminating the partner. The risk of contamination is major at the beginning of sexual activity in women and men. Due to its strong resistance to environmental conditions, HPV can also be transmitted indirectly by resisting in water, linen, objects, baths, etc.

HPV is therefore responsible for infections that are most often benign and asymptomatic. Depending on the type of virus, the associated lesions are diverse: condyloma, cutaneous warts, oral papillomatosis or - in the case of high-risk HPV - cervical, anal, vaginal, or vulvar cancer. The virus can lead to lesions appearing a few months after contamination but in certain cases, the symptoms can appear months or years later. This is called the latency period where the virus is present but dormant.

If the infection with HR HPV is necessary to the appearance of...
cervical cancer, it is not sufficient. Several cofactors are identified to date. **Exogenous factors:**
- The risk of developing cervical cancer seems to increase with the number of sexual partners.
- **Early first sexual intercourse** also seems to play a role. However, it is possible that there is a link between a young age at the first intercourse and a high number of partners.
- **Tobacco,** by its co-carcinogenous action and immunosuppressing effect.
- **Multiplicity** exposes a zone of the cervix that facilitates infection by HPV.
- A link has been revealed between the occurrence of CC and co-infection by another STI, in particular herpes (HSV-2), chlamydia trachomatis, and HIV.

Regarding HIV, evidence shows that women living with HIV are at increased risk of HPV infection and cervical cancer. Moreover, cervical cancer progresses quicker for women with HIV.

**Viral co-factors also exist.** Infection with HR HPV is a pre-requisite, but the oncogenetic potential varies depending on genotypes: HPVs 16, 18, 31, 33, 25, 45, 52 and 58 are most often present in cases of cervical cancers. The HPV 16 genotype is at major risk of developing cancer.

Finally, some factors are linked to the host. The endogenous hormones (number of pregnancies, menopausal status), genetic factors, and the individual capacity to provide an immune response (constitutional immune deficiencies) play a role in carcinogenesis.

The symptoms revealing advanced precancerous lesions are the following:
- Abnormal vaginal bleeding: out of the menstruation period or at intercourse.
- Back, leg, or pelvic pain.
- Loss of appetite and/or weight-loss.
- Extreme tiredness.


**c) Prevention strategies**

Primary prevention (vaccination) and secondary prevention (screening for precancerous lesions followed by appropriate treatment if required), are the basic approaches to prevent the 530,000 new cases of cervical cancer diagnosed each year. The WHO recently recognized the importance of engaging in prevention and screening of CC. Some countries are beginning to integrate this issue in national health programmes. However, implementing these recommendations effectively is still prevented by a lack of resources, and access by women to simple and efficient ways to prevent this pathology is still insufficient. The different prevention strategies are presented in the following figure:

**Primary prevention:** the public health objective is to reduce HPV infections.

The key interventions are:
- **Vaccination:** the WHO recommends systematically administering the HPV vaccine to young girls between the age of 9 and 14 years-old, as in most countries, they have not yet begun any sexual activity. The age range must be adjusted to the country, relying on available information about young girls’ sexual activity. Today, two types of vaccines exist: a quadrivalent vaccine also covering genital warts (6, 11, 16, 18), and a bivalent vaccine (16, 18). It is to be noted that some countries have begun to vaccinate boys; indeed, vaccination prevents genital cancers for both sexes and the two available vaccines prevent the development of genital condyloma for men and women. Today, the WHO recommends vaccinating girls between 9 and 14 years old because it is the most cost-effective public health measure against cervical cancer.
- **Integrating information about vaccination and the use of condoms.**
CHAPTER 5: CROSS-CUTTING PROVISION OF CARE

in activities around comprehensive sexuality education

Promoting the use of condoms

Secondary prevention: the public health objective is to reduce the prevalence and incidence of CC and its associated mortality, preventing precancerous lesions from becoming invasive cancers.

The key interventions are the following:

- Information on the importance of screening and its modalities
- Screening: this is the systematic use of a test detecting cervical abnormalities in an asymptomatic population, in an organised and opportunistic manner (through contact with the health system for another reason). The screening modalities depend on national recommendations and available resources: pap smear test and liquid-based cytology, visual inspection with acetic acid (VIA) and/or the HPV detection test (for which self-testing is made possible), all of which enable the search for HR HPV.

- Treatment of precancerous lesions by a variety of treatments depending on national recommendations and available resources: resection, cryotherapy or thermocoagulation.

When this is possible, the ‘Screen, triage and treat’ strategy is recommended. This involves using a detection test with rapid results (visual methods, VIA for example), immediately followed by treatment of the existing lesions (for example cryotherapy) with no further testing, except if a cancer is suspected. Detection and early treatment of precancerous lesions can prevent the majority of cervical cancers.

Tertiary prevention: the public health objective is to reduce the number of deaths caused by CC.

The key interventions are:

- Developing referral mechanisms for patients to adapted facilities. This referral network can vary from a country to another depending on the resources and organisation on the health system
- Accurate and timely diagnosis of CC
- Appropriate treatment delivered according to each stage depending on the diagnosis. Where countries do not have the resources to treat this type of cancer, it is useful to be aware of the intergovernmental agreements for transfer to neighbouring countries and make use of them.

**d) Community-based approach and awareness-raising**

One of the objectives of community approach is to maximise coverage and use of services combatting cervical cancer. This requires sharing prevention messages to priority groups:

- Adult women and men
- Young people and adolescents, girls and boys (notably regarding primary prevention)
- Certain vulnerable groups or people at risk: women with HIV, sex workers, migrants and other marginalised groups, without stigmatising
- Community leaders
- Community-based organisations of the civil society.

The key messages to deliver using different tools (leaflets, role play, radio, social networks, etc.) are the following:

- Cervical cancer is an avoidable illness
- Tests exist that enable early detection of any change in the cervix that might lead to cancer if untreated
- Safe and efficient treatments exist for these early changes
- All women aged 25 to 55 should be screened at least once for cervical cancer
- There is a vaccine destined to girls (and boys) that enables to prevent cervical cancer.

A sociocultural diagnosis with a gender approach is necessary to undertake prior to setting up community-based activities, so as to understand the barriers to accessing screening and treatment, and uncover the perceptions around cervical cancer.

**e) Screening for precancerous lesions and follow-up**

The WHO recommends strategies that enable to provide care for women within a short timescale and avoid losses to follow-up. This implies the use of rapid screening methods permitting to deliver results and provide treatment in a unique visit. This is called:

- ‘Screen, triage and treat’: one to two visits, with a screening method (HPV Test) and a triage examination (VIA) that permits immediate results and treatment if necessary
- ‘Screen and treat’: in one visit, with a screening method that enables rapid results (VIA) and treatment, if necessary
- ‘Sequential testing’: perform a first screen, if positive conduct a confirmation test and treat, if necessary. Both tests can be carried out in one visit or two sequential visits (for example HPV test + VIA).

The algorithm selection is based on the four following elements:

- Defining the population targeted by the programme: the WHO recommends to screen women between 30 and 49 years old, this time span can be widened depending on prevalence and life expectancy.

Indeed, HR HPV infections are frequent in young girls but most of them are transient and disappear spontaneously. Only a small percentage of HPV infections persist for several years and will result in CC. However, the screening programme can be offered to younger or older women depending on the risk of developing precancerous lesions. For HIV+ patients, screening should be offered to women and girls who are sexually active as soon as their seropositivity is diagnosed, regardless of their age. The target population is defined in accordance with the national programme of the country.

- Choice of screening test: the WHO recommends visual inspection with acetic acid (VIA) and/or testing for HR HPV.

This latter method is recommended by the WHO in medium-income countries when this is economically possible, as an addition or substitute for direct visualisation methods. The HR HPV test will reveal the presence or not of HR HPV, whereas VIA reveals the presence of cervical abnormalities.
of lesions. Thus, the WHO suggest the triage of patients who are HIV+ using VIA: only patients with positive results in both HR HPV and VIA will be treated, whereas patients who are HR HPV+ but VIA negative will have their test repeated after a year.

**Defining the screening strategies**: Reflection on screening strategies for CC focuses on two main areas, closely linked to the choice of screening test: the use of self-sampling in case of HR HPV screening and the possibility of developing a ‘Screen, triage and treat’ Programme.

**Defining the frequency of screening tests**: depending on the patient’s profile (HIV+ or not) and the result of the previous screening test.

In several contexts, MdM has developed a screening and treating algorithm which is reported in the following figure:

As part of this algorithm, different stages of the screening process are the following:
- **Pre-test counselling**
- **HR HPV Test** after sampling with a speculum by a healthcare professional or by vaginal self-sampling by the patient herself
- **Packaging the sample** if it is not analysed on site, and transport to the laboratory
- **Carrying out the PCR** using a GenExpert® or CareHPV® machine. These machines can be available in the health facility or in a reference laboratory.

**Delivering the result** (negative = low risk of developing CC in the next 5 years, positive = need to carry out a VIA, reassuring that HPV+ reveals the presence of the virus but not necessarily of precancerous lesions)

**Carrying out a VIA** in the cases where the HPV test is positive

**Provide post-test counselling** and information on treatment in the case of results showing HPV+ and VIA+.

For further information on screening strategies, see *Participant Handbook, Training for cervical cancer prevention, MdM, 2019*.

**f) Treatment and follow-up of precancerous lesions**

Early detection through targeted screening followed by the treatment of precancerous lesions helps prevent the majority of cases of CC. In the MdM algorithm (HPV test + VIA triage), treatment implies positive results of VIA.

The recommended techniques suggested by the WHO for the treatment of precancerous lesions are presented in the table next page.

The choice of technique for treatment will vary depending on the type of lesion, national recommendations, logistic constraints and available personnel. It is important in any case to deliver comprehensive information before and after the procedure, including post-operative recommendations, follow-up instructions, as well as referring the

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5. Polymerase Chain Reaction

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**FIGURE 7: SCREENING AND TREATMENT ALGORITHM DEVELOPED IN MDM’S PROJECTS IN BURKINA FASO AND THE IVORY COAST (2018)**

This algorithm is subject to change based on updated knowledge.
CHAPTER 5: CROSS-CUTTING PROVISION OF CARE

TABLE 9: TREATMENT TECHNIQUES OF PRECANCEROUS LESIONS
(extracted from the MdM Participant Handbook: Training for cervical cancer prevention)

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>PROCEDURE</th>
<th>ADVANTAGES</th>
<th>LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRYOTHERAPY</td>
<td>- Visible lesion</td>
<td>- 15 minutes-long procedure</td>
<td>- Success rates are lower with large lesions</td>
</tr>
<tr>
<td>- Covering less than 75%</td>
<td>- Without anaesthesia</td>
<td>- No histologic confirmation</td>
<td></td>
</tr>
<tr>
<td>- Surface of the lesion does not exceed surface of the probe</td>
<td>- Probe positioned on the cervix</td>
<td>- Unreliable supplies (requires liquid nitrogen or carbonic snow)</td>
<td></td>
</tr>
<tr>
<td>- Visible squamocolumnar junction</td>
<td>- Applying gaz twice for 3 minutes spaced by 5 minutes</td>
<td>- Expensive</td>
<td></td>
</tr>
<tr>
<td>THERMOCOAGULATION</td>
<td>- Visible lesion</td>
<td>- 2 minute-long procedure</td>
<td>- Lower success rates with large lesions</td>
</tr>
<tr>
<td>- Covering less than 75%</td>
<td>- Without anaesthesia</td>
<td>- No histologic confirmation</td>
<td></td>
</tr>
<tr>
<td>- Surface of the lesion does not exceed surface of the probe</td>
<td>- Probe positioned on the cervix</td>
<td>- Few complications</td>
<td></td>
</tr>
<tr>
<td>- Visible squamocolumnar junction</td>
<td>- Applying the probe at 100°C on the zone for 1 minute</td>
<td>- Expensive</td>
<td></td>
</tr>
<tr>
<td>LEEP</td>
<td>- Lesions over 75%</td>
<td>- 15 minutes + anaesthesia</td>
<td>- Possibility of a biopsy</td>
</tr>
<tr>
<td>- Endocervical lesions</td>
<td>- Anaesthesia (local, locoregional or general)</td>
<td>- Easy procedure</td>
<td></td>
</tr>
<tr>
<td>- the squamocolumnar junction is not visible</td>
<td>- Carried out with a scalpel</td>
<td>- Few complications</td>
<td></td>
</tr>
<tr>
<td>COHESION</td>
<td>- Lesions over 75%</td>
<td>- Anaesthesia (local, locoregional or general)</td>
<td>- Possibility of a biopsy</td>
</tr>
<tr>
<td>- Endocervical lesions</td>
<td>- Carrying out a partial resection of the cervix using a diathermy loop</td>
<td>- Anaesthesia</td>
<td></td>
</tr>
<tr>
<td>- the squamocolumnar junction is not visible</td>
<td>- Haemostasis using rollerball electrode coagulation</td>
<td>- Costly equipment</td>
<td></td>
</tr>
</tbody>
</table>

Cervical cancer is the development of abnormal cells in the uterine cervix that have the power to proliferate uncontrollably. The main risk factors are young age at the first intercourse, important number of sexual partners, tobacco consumption and immune deficiency (kidney transplant and HIV+).

It is possible that CC might cause no sign or symptom in the first stages of the illness. Indeed, cancer is an insidious illness that can remain silent. The symptoms usually appear once the tumour has developed in the neighbouring tissues and organs. Early symptoms consist in abnormal vaginal discharge, traces of blood or irregular bleeding. Late symptoms are diverse and can include weight loss, urinary signs, oedema, respiratory disorders, etc. Other medical disorders can cause similar symptoms to cervical cancer.

This is why women must be referred to a referral centre to carry out a biopsy that will permit a diagnosis. The most common diagnosis tests are biopsy, which is unavoidable to confirm diagnosis, and endocervical curettage. Clear referral pathways must be developed prior setting up activities, in relation to actors and services that are available in the country.

MdM does not specialise in treating cancer, therefore it is crucial to establish strong partnerships and coordination mechanisms with competent actors and services. Material support to existing services, and provision of an emergency fund to facilitate patient care could be envisaged.

Survival depends on the stage of cervical cancer. Generally, the earlier the diagnosis and treatment, the higher the chances of survival. Prognosis relies on many factors including the following: medical history, type of cancer, stage of
h) Pain management and palliative care

In cases of advanced cancers that cannot be treated, or in the event of treatment failure, it is important that patients and their close circle are accompanied. To achieve this, coordination mechanisms between the actors involved must be developed: community actors and civil society, primary, secondary and tertiary healthcare services. This is to ensure the following issues are addressed:

- Pain management by administration of analgesic treatments, alleviation of distressing symptoms, improvement of food hygiene and potential care using alternative medicines, specifically traditional medicines in combination with analgesics.
- Therapeutic education
- Psychosocial support for the patient and her close circle
- Family support system

While MdM is not specialised in palliative care, nor can it provide all of those elements, there remains a need to set up partnerships to get in touch with legitimate actors to address these issues. A sociocultural diagnosis to try and understand view and representations around the end of life and the community actors involved can be an interesting pre-requisite to setting up this kind of partnership.

4. INTERVENTION STRATEGIES

The intervention strategies proposed here are set out in relation to different areas of the Ottawa Charter for health promotion. MdM uses the Charter as a basis for project programming.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

- Whatever the chosen intervention strategy, it is essential that prevention of CC is provided in complete confidentiality and with respect for the patient’s privacy. Medical data must be protected. It is recommended to refer to ‘For Ethics in the Field’ by MdM on this issue.

a) Supporting the formulation of or strengthening national policies relating to prevention of CC

Preventing, screening, treating precancerous lesions and managing cases of cancers should be incorporated into national sexual and reproductive health policies. It is therefore essential to encourage governments and policies to pay particular attention to this public health issue. These actions may take the form of providing technical support to decision-making bodies, such as the Ministry of Health or the Ministry of Justice or take the form of advocacy.

The following outcomes may therefore be pursued:

- Elaborating and implementing a national action plan for prevention of CC is encouraged by MdM;
- National protocols on prevention of CC are harmonised and shared;
- Screening for CC is integrated into the continuum of care in SRH;
- The political environment is supportive of the exercise of sexual and reproductive rights.

b) Improving facilities, prevention, screening and treatment for people with precancerous lesions and referral in the case of cancer

Particular attention must be paid throughout the continuum of care to raise awareness on CC. Services in SRH are a unique point of access to detect CC.

- Healthcare personnel in SRH is trained on awareness-raising for CC, screening, treatment of precancerous lesions and referral in cases of suspicion of cancer;
- Health facilities are equipped to undertake screening activities and treatment of precancerous lesions;
- Coordination is encouraged between various actors involved in managing cancer care and palliative care.

c) Increasing the knowledge of women/adolescents and men/adolescents relating to CC

Increasing knowledge relating to rights and health reinforces access to information, screening and care. Women must not be the only ones to benefit from these awareness-raising activities: partners, adolescents, men, families and communities must also be involved:

- The topic of CC and primary prevention is integrated into curricula of comprehensive sexuality education directed at adolescents and youngsters;
- Individuals are aware of means of preventing HPV and of the importance of screening for CC and enabling early treatment of precancerous lesions, and are informed of the existing services.

In Burkina Faso, cervical cancer is the most frequent fatal cancer for women with 2600 avoidable deaths each year. To contribute to reducing mortality and morbidity caused by this cancer, MdM strengthens capacities in the district of Baskuy regarding screening and treatment of precancerous lesions. Hence, several training sessions for health agents have been conducted to improve skills in counselling, vaginal smear and sample analysis using Polymerase Chain Reaction (PCR) with GeneXpert, visual inspection of precancerous lesions with acetic acid and treatment by thermocoagulation. The implementation of this project will enable early detection and treatment of precancerous lesions which will prevent them from developing into invasive cancer.

Dr Claude Linda Traoré, Project leader CC Burkina Faso

In Burkina Faso, MdM is introducing screening of cervical cancer using self-sampling HPV test. This technique has proved effective in large clinical trials, but no study has explored the implementation of this strategy in the case of limited resources. The value of a mixed methods study associated with this project will be to provide thorough data on setting up this screening. An epidemiologic analysis will provide quantitative data on the women who go through with screening as well as the determinants associated with screening. The anthropological component will strengthen the understanding of the phenomena associated with screening (participation, completion, experience). This overall study will produce sound data that will guide the development of context-adapted strategies.

Keity Mensag, Doctoral student at the Population and Development Centre

Aline Merabtène, CAOA Programme Coordinator, Paris, France

d) Promoting community involvement in the fight against CC (element relating to ‘Strengthening community action’)

The commitment of civil society and communities is essential in the fight against CC. It is therefore essential that the community is involved in prevention and treatment programmes:

➡ A sociocultural analysis with a gender approach is carried out to provide a better understanding of perceptions and views around SRH, CC and end-of-life;
➡ Key people in the community (community health workers, leaders, traditional birth attendants and women’s groups) are made aware of the benefits of preventing CC;
➡ Men are involved in the topic of preventing CC;
➡ Community actors involved in end-of-life care are identified and strengthened.

The MdM Reception, Referral and Support Centre (CAOA) in Paris shelters a large majority of people that are in an irregular situation on the national territory, following a complex pathway to exile. Questions related to SRH are rarely the reason for them consulting the centre. However, our team takes advantage of their presence to raise these sometimes taboo topics that are at the centre of their intimate concerns. This prevention in SRH activity began with the centre’s participation to the Inca research project of MdM about screening for CC for women in precarious situations. This study has shown the benefits of facilitating access to dedicated consultations with an interpreter, as well as self-sampling of HPV tests. Self-sampling tests are not yet available in France except in the pilot project, however they can lift certain barriers to screening and turns out to be a tool that facilitates access to healthcare. Training, tools and partnerships have been set up to enable women to benefit from a global SRH care, in addition to screening. Given this research and the interest of patients for these contacts, we have decided to continue this activity that concerns 5 to 10 women each week. We are considering the possibility of extending this offer of counselling sessions in SRH to men.

II. GENDER-BASED VIOLENCE

1. DEFINITIONS

According to the WHO, violence is defined as ‘the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation’.

Gender-based violence (GBV) can be defined as ‘any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (gender) differences between men and women.’

GBV is defined in the Beijing 1995 Fourth World Conference on Women as ‘the manifestation of the historically unequal power relations between men and women’ and is rooted in the beliefs and cultural behaviours that feed and perpetuate these inequalities. The term gender-based violence was initially used to refer to violence against women and girls. Nowadays, the term has evolved into referring to any act of violence perpetrated against a person due to his sex and the place that society gives to his sex/gender. Men and boys can therefore also be victims of gender-based violence, specifically sexual violence. However, women and girls continue being the most exposed to this type of violence. Gender-based violence are a violation of human rights and the WHO considers it a public health issue. It can take many forms depending on the sociocultural and historical context in which they take place, and depending on the age, social class, sexual orientation, gender identity and health situation (by the presence or not of a handicap) of the victims.

Classification of violence

Violence may be categorised differently depending on the following:

➡ Nature of the aggression: Violence that is physical, sexual, moral and psychological, economic and social;
➡ Link between victim and aggressor: Domestic violence, intra-family violence, civil, community, state or institutional violence.

8. IAWG. Inter-agency Field Manual on Reproductive Health in Humanitarian settings, 2016
2. PLACE IN THE CONTINUUM OF CARE

GBV may have damaging consequences on sexual and reproductive health such as STI and HIV/AIDS, unwanted or under-age pregnancies, unsafe abortions, fistulas, genital mutilations and its effects, attacks on the individual as a whole, etc. Given the significant relationship between gender-based violence and sexual and reproductive health, all SRH projects must take GBV into account.

The subject of GBV is integrated into an intervention to varying degrees depending on context. All projects with an SRH element must, however, incorporate the following minimum activities:

- Identifying survivors and providing them with a quality first contact without discrimination and respectful of confidentiality;
- Referring survivors of sexual and/or physical violence to identified specialised services in the case where medical care is not possible, aiming at a multidisciplinary care that will address survivors’ needs;
- Accompanying and taking into account survivors of violence in sexual and reproductive health care.

When possible, MdM recommends that professionals are trained on the following elements:

- Identification of victims of violence;
- Medical care, including establishing a medical certificate;
- Providing first-hand psychosocial support;

MdM has developed a model for intervention in crisis contexts, centered around holistic care for survivors. It comprises a core set of activities that are the minimum actions to set up in all emergency projects:

- Medical care including mental health and psychosocial support
- Coordination with different stakeholders involved in the topic
- Management of confidentiality: secure location of care provision, protected personal data


3. UNDERSTANDING THE ISSUE

a) Background information

GBV are a crucial public health issue on a global scale. They also represent a serious violation of human rights. GBV can be encountered in all social and economic backgrounds. In crisis situations caused by conflicts or natural disasters GBV, and specifically sexual violence, increases. There is a global lack of data but it is estimated that 1 in 3 will experiment physical and/or sexual violence in her life, and 1 in 5 women will experience rape. Sexual abuse during childhood concerns 20% of girls and 10% of boys. On a global scale, 38% of murders on women are the fact of their intimate male partner.

b) Causes and risk factors and vulnerability

No stand-alone factor can explain why some people are violent against others and why violence is more frequent in some situations. However, it is possible to determine a set of common causes to diverse types of violence, the main cause being gender inequalities. The identification of these causes and factors does not diminish the responsibility of the person who commits the violent act. Any act of GBV is an exercise of power.

Some vulnerability factors, such as an environment that violates human rights, power abuse, socio-economic vulnerability, discrimination, stigmatisation, can be predictive of acts of violence resulting from the complex interaction of individual, relational, social, cultural and environmental factors:

- situations of natural disaster, conflict, post-conflict, population migration, cause an increase of violence and trigger new types of violence towards vulnerable populations and more specifically women and minors. Numerous factors explain that increase: population transfer, promiscuity, climate of impunity, lack of a protection system, absence of public order, shift in traditional gender roles in the community, etc.
- during pregnancy, violence against women has proven to be more frequent, especially domestic violence. This type of violence concerns between 4 and 12% of pregnant women worldwide.
CHAPTER 5: CROSS-CUTTING PROVISION OF CARE


in 2002, and 50% of these women experience violence for the first time; for people infected with a sexually transmitted infection (STI) or HIV, the revelation of the serological status is a moment where the infected person is particularly at risk of GBV, notably physical and psychological violence; While there is little data available today, several studies reveal the magnitude of violence against LGBTQ+ people. In many contexts, they are more exposed to gender-based violence in relation to their sexual orientation and/ or their gender identity: psychological violence and discrimination, physical and sexual violence, etc.; Several studies have shown the importance of the issue of GBV for migrant people, which can consist in acts of violence during the migration or in the host country; Sex workers, male or female, are strongly exposed to multiple types of GBV; Adolescents and young people, due to the socio-economic and psycho-affective vulnerability, are also very exposed to GBV, whether intra-family or extra-family including in school settings.

c) Consequences

Violence can lead to short and long-term severe physical consequences on physical, mental, sexual and reproductive health, and can lead to death. The effects on health can be physical disorders (lesions, infections, handicaps, chronic pain), and psychosomatic consequences (headache, back pain, abdominal pain, etc.), chronic illnesses (impairment, HIV/AIDS, obstetric fistulas, etc.)

Regarding sexual and reproductive health, violence can lead to unwanted pregnancies, gynaecological problems, unsafe abortions and their consequences, and sexually transmitted infections including HIV.

GBV also hold consequences on mental health (anxiety, depression, posttraumatic stress disorder, sleeping disorders, eating disorders, emotional disturbance and suicide attempts).

Violence can lead to unhealthy behaviours such as increase in tobacco consumption, use of drugs and alcohol, and unsafe sexual behaviours later in life. Violence can also have social and economic consequences such as rejection, isolation, loss of income...

d) Prevention

Promoting acts of primary prevention in one of the key actions towards reducing gender-based violence. It is important to conduct health education using culturally adapted material for information, education and communication (IEC). Information campaigns through media, comprehensive sexuality education, implication of men in fighting against GBV can also be set up to prevent violence. Primary prevention must encompass tackling discrimination against women, promoting gender inequality and evolution of cultural norms so as that there is no place for violence. Prevention measures are important to set up in health facilities (confidentiality of data management, fighting against stigma, setting up secure facilities) alongside measures to prevent exploitation and sexual abuse.

Primary prevention will, of course, be conducted alongside a holistic approach to caring for survivors of GBV and preventing short and long-term consequences of violence.

e) Treatment and care

MdM seeks to develop pluridisciplinary strategies to enable the identification of survivors to GBV and facilitate their access to medical services, mental health care and psychosocial support, legal support, and social and economic reintegration services. MdM cannot guarantee alone all aspects of care, therefore it is essential to coordinate our response with other actors and develop referral systems that encourage a partnership approach.

It is important that healthcare personnel are able to identify survivors of violence. For this, they must be aware of signs that can lead to suspecting acts of violence and be proactive in searching for those signs. Moreover, healthcare personnel should know how to care for identified victims, whether directly or by referral to other services.

Depending on context, medical services are often the point of entry for care of survivors of violence. The ability to identify these people and the quality of the first contact and the subsequent provision of care are crucial to guarantee the compliance to a holistic management of the problem.

It is essential to ensure confidentiality and respect for the intimacy of the victims. The healthcare personnel must have an appropriate behaviour, provide care without discrimination, collect informed and free consent, and provide protection if necessary. The ethical principles in medical practices are more thoroughly explained and defined in the document “For ethics in the field”, by Médecins du Monde.


The main components of medical care in the case of violence are the following:

- Medical history (family and personal history, identifying and describing fact);
- Disclosing full information to obtain free and informed consent for examination and care;
- Clinical examination to document injuries and paraclinical tests if necessary (the unavailability of tests must not delay the course of care);
4. INTERVENTION STRATEGIES

The intervention strategies proposed here are set out in relation to different areas of the Ottawa Charter for health promotion. MDM uses the Charter as a basis for project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

16 Whatever the chosen intervention strategy, it is essential that care is provided for individuals who are victims of violence in complete confidentiality and with respect for the patient’s privacy. Medical data must be protected. It is recommended to refer to ‘For ethics in the Field’16 by MDM on this issue.

4.1 Supporting the formulation of or strengthening national policies relating to gender-based violence
(element relating to ‘Building healthy public policy’ in the Ottawa Charter)

Preventing violence and receiving, identifying and caring for people who are victims of violence must be incorporated into national sexual and reproductive health policies. It is therefore essential to encourage governments and policies to pay particular attention to this public health problem. These actions may take the form of providing technical support to decision-making bodies such as the Ministry of Health and Ministry of Justice or take the form of advocacy.

The following outcomes may therefore be pursued:

- A national action plan to prevent violence is drawn up and implemented with the encouragement of MDM;
- Services providing holistic care for victims of violence are developed by the government;
- Victims of violence have easier access to the justice system and to a free medical certificate (advocacy);
- National protocols concerning the treatment and care of victims of sexual violence are harmonised on the basis of recent international recommendations, and made aware of;
- Policy-makers show zero-tolerance to perpetrators of violence and combat impunity;
- Caring for victims of GBV is incorporated into the curriculum of health professionals (doctors, midwives and nurses);
- The political environment is supportive of the exercise of sexual and reproductive rights.

4.2 Improving facilities, prevention, screening and care for victims of gender-based violence
(element relating to ‘Reorienting health services’)

Particular attention must be paid throughout the continuum of care to preventing violence and to identifying and caring for people who are victims of gender-based violence. SRH services provide a unique point of access to care for these individuals.

The following outcomes may therefore be pursued:

- Health personnel in sexual and reproductive health services are trained in prevention and in receiving, identifying and providing medical care and initial psychosocial support to victims of violence;
- Survivors of GBV and their families have access to mental health care and psychosocial support;
- Healthcare facilities are equipped to care for people who are victims of GBV (equipment and drugs, notably PEP and emergency contraception);
- Coordination exists between different stakeholders involved in caring for victims of GBV and facilitate referral for survivors whilst preserving complete confidentiality.

4.3 Increasing the knowledge of women/adolescents girls and men/adolescent boys relating to human rights and gender-based violence
(element relating to ‘Developing personal skills’)

Increasing knowledge relating to sexual and reproductive health rights and gender rights helps prevent GBV and to extend access by those who are victims of violence to the different service providers. Women must not be the only ones to benefit from these awareness raising activities: partners, adolescents, men, families and communities must also be involved. Commitment on the
part of families and communities is essential for health behaviours to be adopted and to ensure access to care for victims of violence.

The following outcomes may therefore be pursued:
- Comprehensive sexuality education programmes for adolescents on SRHR, gender inequalities and GBV are developed;
- Individuals know about their rights and children’s rights and also the available facilities and organisations in the event of violence.

E) Promoting community involvement in the fight against gender-based violence (element relating to strengthening community action)

The commitment of civil society and communities is essential to put an end to GBV. Inequalities and discrimination within a community are factors which encourage violence. It is therefore crucial that the community participates in the fight against GBV.

The following outcomes may therefore be pursued:
- Refugee camps are devised and planned in such a way as to prevent gender-based violence;
- Community intermediaries are trained and convey messages regarding GBV and available services;
- A partnership is established with local organisations which deal with gender-based violence in order to support their advocacy work;
- Mass campaigns on issues of gender, SRHR, positive masculinity and fight against GBV are implemented by local organisations supported by MdM;
- Actions directed at men and boys in the community are set up to work on examples of positive and egalitarian masculinities, and to involve them in movements that refuse gender-based violence.

In 2015 in France, we launched a programme for prevention and care of violence against sex workers, which included GBV. The programme was elaborated in partnership with different stakeholders of the civil society such as the MdM Lotus Bus, the Sex Workers’ Union and the Amis du bus des femmes (Friends of the ‘Women’s Bus’ organisation) …  The starting point was to mutualise our forces on the issue of violence in a context where resources were lacking on that topic. We developed tools and information workshops directed at sex workers on what to do in the case of an aggression, what are the available services. We organised a training for trainers in feminist self-defence by and for sex workers. We also developed training sessions on legal support directed at social workers. We also set up psychosocial support services. Recently, the Jasmine Programme has launched an alert system to share information to combat violence against sex workers. This involved setting up an online platform which facilitates sharing information on aggressors and prevent potential new violence.’

Sarah-Marie Maffesoli, Jasmine Programme Coordinator, France
**III. MANAGEMENT AND PREVENTION OF HARMFUL TRADITIONAL PRACTICES**

**1. DEFINITION**

Harmful traditional practices are a part of GBV and are a violation of human rights. The consequences on health are severe, and they also hold economic and social consequences. While female genital mutilation is largely discussed in the literature, other types of harmful practices, mainly directed at women, are also described:

- Breast-ironing
- Early and/or forced marriage
- Women force-feeding
- Practice of dry sex
- Honour crime
- Dowry-related violence
- Etc.

There is no official definition of harmful traditional practices and little data is available regarding certain practices.

Female genital mutilation (FGM) refers to ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organ for non-medical reasons’. Female genital mutilation is harmful in many ways to girls and young women. It involves the removal of normal, health genital tissue or damage to this tissue and hinders the natural functioning of the female body and its capacity to enjoy satisfying sexuality.

WHO classifies four types of such mutilation:

- **type I**: clitoridectomy - partial or total removal of the clitoris and, more rarely, just the prepuce (fold-skin surrounding the clitoris);
- **type II**: excision - partial or total removal of the clitoris and labia minora, with or without excision of the labia majora;
- **type III**: infibulation - narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris;
- **type IV**: all other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterisation.

**2. PLACE IN THE CONTINUUM OF CARE OF HARMFUL TRADITIONAL PRACTICES**

The following table summarises the activities regarding harmful traditional practices that are to be considered throughout the continuum of care:

<table>
<thead>
<tr>
<th>ACTIVITIES RELATED TO HARMFUL TRADITIONAL PRACTICES</th>
<th>COMPREHENSIVE SEXUALITY EDUCATION</th>
<th>ANTENATAL CARE</th>
<th>OBSTETRIC CARE</th>
<th>POSTNATAL CARE</th>
<th>SERVICES PROMOTING CONTRACEPTION</th>
<th>POST-ABORTION CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information message regarding existing harmful traditional practices in the context, their impact on health, available support services, defibulation.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Education message regarding feminine anatomy including clitoris (based on recent scientific data), and the consequences of FGM</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identification of survivors of harmful traditional practices.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Referring survivors to existing services according to their needs.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Information of the woman and the couple on the complications of FGM and on the reasons and timing for opening type III FGM and the reasons for not re-infibulating after birth.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening of type III FGM during the 2nd trimester of pregnancy to prevent complications during birth. No re-infibulation after birth.</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking account of the higher rate of complications in the case of FGM and elaborating a strategy to minimise perineal trauma depending on the type of FGM, including opening the FGM if it was not done during pregnancy.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to a CEmOC for a c-section in the case of complication.</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to holistic care services notably psychosocial support services, sexuality counselling services, and reconstruction services if they exist.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>


18. IAWG, Inter-Agency Field Manual on Reproductive Health in Humanitarian settings, 2018

19. IAWG, Inter-Agency Field Manual on Reproductive Health in Humanitarian settings, 2018

3. UNDERSTANDING THE ISSUE

a) Background information

Little data exists on certain harmful traditional practices however, it is estimated that 200 million young girls and women currently suffer from the consequences of genital mutilation practice in 30 countries of Africa, the Middle-East, and Asia. The mutilation can be performed on the newborn, during childhood, adolescence, at the moment of the wedding or during the first pregnancy depending on the geographical areas. They are mostly practiced on young girls between childhood and the age of 15. Those practices most often take place within communities and are performed by traditional excisioners. However, over 18% of female genital mutilations are carried out by healthcare practitioners, and this trend is increasing. In France, while the practice is banned, it still occurs during the holidays, particularly in immigrant communities originating from countries where FGM is practiced. For the organisation ‘Excision, parlements’ (Let’s talk about excision), female genital mutilation concern ‘around 60 000 adult women when it was 54 000 in 2009’ (there is currently no data on children and adolescents in France).

Regarding early marriage, there is an estimated 14.2 million girls who are married every year before the majority. This represents, on a global level, 1 of 5 girls. In developing countries, 40% of young girls are married between the age of 18; 12% before the age of 15.

Other practices, such as breast-ironing, are more geographically localised. This practice is present in Cameroun, Guinea and Togo, and is less talked about than FGM however it also holds severe consequences. According to a study carried out in 2013, it concerns 12% of young girls and women in Cameroun.

b) Causes

The reasons for these practices vary depending on the practices, according the geographical area and they evolve in time. Various sociocultural factors within families and communities are at stake. The most frequently reported reasons are the following:

- Social conventions: social pressure that encourages to imitate what others do or what they have always done, the need for social inclusion and fear of rejection by the community are a strong motivation to perpetuate this practice;
- Certain practices are considered a useful part of a young girl’s education, and her preparation to adulthood or marriage, or to protect her from early marriage or pregnancy (breast-ironing);
- Female genital mutilation is often justified by beliefs about what is considered an appropriate sexual behaviour and aim at ensuring virginity until marriage and marital fidelity. According to beliefs in many communities, these practices are likely to reduce extra-marital sexual intercourse. In the case of infibulation, the fear of pain in the case of re-opening and the fear that this re-opening might be discovered are also supposed to discourage women from having extra-marital relationships;
- Certain practices can be associated to cultural ideals of beauty and femininity (force-feeding);
- Practitioners often think that there is a religious justification, despite the fact that no religious text recommends female genital mutilation for example;
- These practices are considered a cultural tradition, and this argument is often used to explain their perpetuation.

For all those practices, the deep main cause remains gender inequalities.

c) Consequences

Consequences can vary depending on the type of harmful practices. There are immediate as well as long-term consequences on health but also on social and psychological well-being.

- Consequences of FGM: acute pain, shock, haemorrhage, tetanus or septicaemia (bacterial infection), urine retention, genital ulcer and lesion of neighbouring tissues, all of which can lead to death, risk of HIV and hepatitis transmission, psychological trauma, gynaecological and long-term obstetric complications causing higher risk of neonatal and obstetric complications (labour dystocia, haemorrhage, uterine rupture), infections, urinary disorders, secondary infertility, alteration of sexual pleasure, low self-esteem, etc.;
- Consequences of early marriage: early pregnancy and its associated obstetric complications such as obstetric fistulas, unsafe abortions, neonatal mortality and morbidity, break in lifepath, school drop-out and its socio-economic consequences;
- Consequences of breast-ironing: infections, burns, cysts, abscess, breast deformity, chronic pain, psychological trauma, low self-esteem, etc.

4. INTERVENTION STRATEGIES

The intervention strategies proposed here are set out in relation to different areas of the Ottawa Charter for health promotion. MdM uses the Charter as a basis for project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element in the continuum of care so that none is omitted.

△ Whatever the chosen intervention strategy, it is essential that care is provided for individuals who are victims of harmful tradition practices in complete confidentiality and with respect for the patient’s privacy. Medical data must be protected. It is recommended to refer to ‘For Ethics in the Field’ by MdM on this issue.

21. WHO, Female Genital Mutilation, Fact Sheet, 2018
22. WHO, Child marriages: 39 000 every day, 2013
23. Institut pour la Recherche, le développement Socio-économique et la Communication, Etude portant sur le repas sage des seins au Cameroun [Study on breast-ironing in Cameroun], 2013
CHAPTER 5: CROSS-CUTTING PROVISION OF CARE

The fight against harmful traditional practices, as well as receiving, identifying and caring for people who have survived those practices should be integrated into national policies in SRH. It is therefore essential to encourage governments and policies to pay particular attention to this public health problem. These actions may take the form of providing technical support to decision-making bodies such as the Ministry of Health or the Ministry of Justice or take the form of advocacy.

The following outcomes may therefore be pursued:

- A national action plan to prevent harmful traditional practices is drawn up and implemented with the support of MdM;
- Holistic services providing care for survivors of harmful traditional practices are set up by the government;
- Policy-makers support criminalisation of harmful traditional practices, specifically FGM, and support the fight against the medicalisation of these practices. They are encouraged to determine a legal age for marriage;
- National protocols concerning the care and treatment of survivors of harmful traditional practices are developed and implemented;
- Care of victims of harmful traditional practices is integrated in the curriculum of health professionals (doctors, midwives and nurses);
- The political environment is supportive to the exercise of sexual and reproductive rights.

b) Improving facilities, prevention, screening and care for victims of harmful traditional practices

(element relating to ‘Reorienting health services’)

Particular attention must be paid throughout the continuum of care to preventing, identifying and caring for victims of harmful traditional practices. SRH services are a unique point of access to care for these individuals:

- Health personnel in sexual and reproductive services are trained in prevention and in receiving, identifying and providing care to victims of harmful traditional practices;
- Medical personnel are trained to provide obstetric care for women who present female genital mutilation and they are trained for defibulation;
- Individuals who have undergone harmful traditional practices have access to mental health services and psychosocial support;
- Coordination pathways between different stakeholders in the course of care (psychosocial support, economic reintegration, specialised medical care, legal assistance) for people who have undergone harmful traditional practices are implemented to facilitate referral.

c) Increasing the knowledge of women/adolescents girls and men/adolescent boys relating to human rights, SRHR, gender-based rights and harmful traditional practices

(element relating to ‘Developing personal skills’)

Increasing knowledge relating to SRHR helps prevent harmful traditional practices and extend access to different care services for people who are victims of those practices. Women must not be the only ones to benefit from these awareness-raising activities: parents, partners, adolescents, men, families and communities must also be involved. Commitment on the part of families and communities is essential for health behaviours to be adopted and to fight against harmful traditional practices. It is therefore crucial that the community participates in prevention programmes:

- A sociocultural diagnosis with a gender approach is carried out to provide a better understanding of the issue of harmful traditional practices and of the barriers to accessing holistic care;
- Key people in the community (community health workers, leaders, traditional birth attendants, women’s groups, school societies, etc.) are made aware of the ban on harmful traditional practices;
- Intermediaries are identified and are made aware of how to support people who are victims of harmful traditional practices within the community;
- Men are involved in the fight to combat harmful traditional practices via information campaigns, discussion groups, etc.
e) Encouraging social change and enhancing the position of women/adolescent girls within the community (element relating to ‘Creating supportive environments’)

The question of gender and the position of women in society greatly influence gender-based violence. By taking these factors into account and by supporting social change, gender-based violence can be prevented. The following outcomes can therefore be pursued:

- Community intermediaries are trained and convey messages supporting an end to harmful traditional practices;
- A partnership is established with local organisations which deal with gender-based violence in order to support their advocacy work;
- Mass campaigns on issues of gender, SRHR for women and children and opposing harmful traditional practices are implemented by local organisations support by MdM.

IV. PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT)

1. DEFINITION

The Human Immunodeficiency Virus, better known as HIV, is a retrovirus which progressively damages the immune system. AIDS (acquired immunodeficiency syndrome) is the final phase of evolution of the disease, characterised by a certain number of symptoms and so-called opportunistic pathologies. HIV is transmitted by unprotected sexual relations (vaginal, oral or anal), blood contact (needle sharing or by transfusion of contaminated blood products) and mother-to-child transmission (now also called parent-to-child transmission). The three phases of the infection are: primary infection, the clinical latency period characterised by minor clinical symptoms and, finally, the AIDS phase which features major opportunistic infections. The latency period may last an average of ten years with no medication being required or may be prolonged with antiretroviral therapy being used before the symptoms associated with opportunistic infections appear. The infection is monitored on the basis of symptoms (the WHO’s four clinical stages), the presence of opportunistic infections, the CD4 count and, where feasible, the viral load.

Parent-to-child transmission of HIV is when the virus is transmitted from an infected mother to her child during pregnancy, labour, delivery or breastfeeding. This is also called vertical or perinatal transmission. In the absence of an intervention, transmission rates range from 15 to 45%. Globally in 2017, the WHO estimated that 80% of the 1.1 million women infected with HIV had received antiretroviral treatment. Thanks to PMTCT, the risk of transmission of HIV from a seropositive woman to her child can be reduced to less than 2% for non-breastfeeding women and 5% for breastfeeding women.

A growing number of countries have achieved very high rates of prevention of transmission by considering elimination of parent-to-child transmission a public health priority. Conversely, considerable efforts are still required in certain countries where HIV infection represents an important issue.

Preventing vertical transmission of HIV or PMTCT refers to all services and interventions employed to reduce the risk of vertical transmission of HIV and is a part of the continuum of care in SRH.

The notion of prevention of parent-to-child transmission includes the partner and not only the mother, which is why MdM now uses this terminology.

Today, the WHO recommends, when possible, to use life-long antiretroviral treatment for all people living with HIV, regardless of the clinical stage of the illness (according to the CD4 count); this recommendation also includes pregnant and breastfeeding women (option B+)27.

2. PLACE IN THE CONTINUUM OF CARE

It is recommended that prevention of vertical transmission be considered a part of a global strategic approach, founded on four basic essential principles28.

Principle 1: Primary prevention of HIV infection

Efforts aimed at preventing HIV infection must be reinforced by efforts to prevent transmission via sex or drug injection. Primary HIV prevention must also be incorporated into SRH services and must also target young adolescents using adequate comprehensive sexuality education, encouraging double protection and testing for HIV and other STIs.

Principle 2: Preventing unwanted pregnancies in women living with HIV

Access for women living with HIV to services offering contraception must be increased to reduce unmet contraceptive needs. These services help women avoid unwanted pregnancies and optimise other factors that have an impact on the health such as nutrition, recovery time between pregnancies, etc. These services must also provide support for seropositive women and couples or serodiscordant couples who wish to have a child, so that they can identify the best moment to conceive (immune status and viral load, absence of ongoing opportunistic infections, appropriate choice of ARV, etc.)

Principle 3: Preventing transmission of HIV from parents living with HIV to their children

Pregnant women and their partners must regularly be offered HIV testing and counselling, while seropositive pregnant women or those who have just given birth and their newborns must benefit from guaranteed access to antiretroviral drugs to reduce the risks of HIV transmission during pregnancy, childbirth and breastfeeding. Counselling and support must be offered concerning infant feeding and other elements that are essential for the health of the mother and newborn.

Principle 4: Providing appropriate treatment, care and support to women living with HIV, their children and their families

HIV care, treatment and psychosocial support must be accessible to women, their children (whether or not they are living with HIV) and their families. Not only must early diagnosis of newborns be included but so must life-long prescription of ARV where needed by seropositive women who are pregnant or who have just given birth.

Regarding principle 3, since 2016, the recommended approaches are the following29 30:

- **Option B+:** ARV treatment using 3 ARV on a lifelong basis for HIV positive women who need a treatment, as well as treatment for the child regardless of the clinical stage of the illness determined by the CD4 count;
- **Option B:** treatment with 3 ARV continued throughout the period at risk of parent-to-child transmission. The women who satisfy the criteria (CD4 < 500 cells/mm³) will receive lifelong treatment with ARV.

**Option B+ is recommended by the WHO.** In July 2018, 163 countries had already adopted this recommendation.

27. WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016
29. WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016
31. WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016
## Activities to Be Undertaken During the Continuum of Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Comprehensive Sexuality Education</th>
<th>Antenatal Care</th>
<th>Obstetric Care</th>
<th>Postnatal Care</th>
<th>Newborn Care</th>
<th>Services Providing Contraception</th>
<th>Abortion Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education on the consequences of unprotected sex, masculine and feminine condoms, double protection, STI and HIV/AIDS, negotiating the use of a condom</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Counselling and HIV testing on a voluntary basis for pregnant women and their partners (suggested by the carers)</td>
<td>X</td>
<td>X</td>
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<tr>
<td>CD4 Count and monitoring WHO clinical stages for seropositive women</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Start appropriate ARV treatment for the woman and her partner (or refer for treatment) during pregnancy in case of seropositive status and continue for life regardless of the clinical stage (option B+)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Cotrimoxazole prophylaxis for seropositive women with CD4&lt;350cell/mm³ or in contexts where malaria and severe bacterial infections are endemic</td>
<td>X</td>
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<tr>
<td>Health education, support and care for mothers infected with HIV (including psychosocial care, treatment of opportunistic infections, help with adherence to treatment and nutritional counselling for mother and child)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Observe practices which reduce the risk of transmission (avoid artificial rupture of membranes, episiotomies and invasive methods and reduce the risk of postpartum haemorrhage)</td>
<td>X</td>
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<tr>
<td>ARV therapy during labour (prophylaxis or ongoing ARV treatment)</td>
<td>X</td>
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<tr>
<td>Advising on, instigating and supporting a method for feeding the newborn</td>
<td>X</td>
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<tr>
<td>Voluntary counselling and testing for HIV infection for women with unknown serology and their partners</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Prophylactic ARV treatment for the newborn</td>
<td>X</td>
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<tr>
<td>Cotrimoxazole prophylaxis for opportunistic infections from 6 weeks of age until test result is confirmed negative</td>
<td>X</td>
<td></td>
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<tr>
<td>Carry out PCR HIV virology test on the child between 4 and 6 weeks and refer for ARV therapy if positive</td>
<td>X</td>
<td></td>
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<tr>
<td>Carry out serology test 6 weeks after the end of breastfeeding</td>
<td>X</td>
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<tr>
<td>Test children with clinical suspicion of HIV infection</td>
<td>X</td>
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</tr>
<tr>
<td>Support seropositive women with an unwanted pregnancy</td>
<td>X</td>
<td></td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Provide information, counselling and contraceptives to suit the needs of women and couples</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>X</td>
</tr>
</tbody>
</table>
3. UNDERSTANDING THE ISSUE

a) Background information

In 2017, an estimated 36.9 million people were living with HIV worldwide, of which 1.8 million were children and 1.1 million were pregnant women. In 2017, an estimated 940,000 people died of one or more consequences of HIV. Currently, only 75% of people living with HIV are aware of their serological status. In 2017, 21.7 million people living with HIV in the world received antiretroviral therapy. There were 25.7 million of infected people living in Africa.

Between 2000 and 2017, the number of new infections dropped by 36% and the number of deaths caused by HIV dropped by 38%. In 2017, 46% of new infections occurred in members of key populations.

It is estimated that 9 out of 10 pregnant women and children with HIV live in Africa. Thanks to considerable efforts regarding PMTCT and the more effective integration of services, in 2017, 80% of seropositive pregnant women accessed ARV treatment. Since 2016, many countries of Asia and the Caribbean received WHO validation regarding parent-to-child transmission of HIV.

Nonetheless, efforts are still required on a global scale. Eastern and Southern Africa, where 50% of new cases occur in children, show the highest rates of effective antiretroviral treatment for pregnant women for PMTCT, i.e. 88%. Conversely, Western and Central Africa only reaches PMTCT coverage of 49%, representing 38% of new infections in children.

While prevention of HIV in children is a success, testing and treating the virus in that population is largely insufficient. In 2016, only 43% of infants exposed to HIV were tested in the first 2 months of their life. Similarly, only 59% of children living with HIV in the world received antiretroviral treatment in 2017. Slow progress can be generally observed in the area of prevention of new cases in adolescents, which makes improving testing a priority. Today, the WHO considers that efforts are necessary to widen access to treatment, in particular for children and adolescents.

There is international consensus on the fact that the planet must take every possible action to eliminate any new infection. UNAIDS states that tackling HIV/AIDS has a direct impact on 10 of the 17 Sustainable Development Goals.

Further remarks: When the maternal viral load is high, birth by elective c-section, in so far as such a procedure is possible (staff resources and equipment available) and safe, can reduce the risk of mother-to-child transmission of HIV. However, the morbidity in postpartum is higher after a c-section than after a vaginal birth.

32. WHO, HIV/AIDS Key facts, 2019
33. UNICEF, Children and Aids, Statistical update 2017, 2017

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CARTMAP 2: COVERAGE OF PREGNANT WOMEN WITH ACCESS TO ANTIRETROVIRAL TREATMENT IN THE FRAMEWORK OF PMTCT IN THE WORLD IN 2017

Coverage of pregnant women receiving antiretroviral drugs (ARV) for preventing mother-to-child transmission (MTCT), 2016

Percentage of pregnant women with HIV/AIDS who received antiretroviral (ARV) drugs for preventing mother-to-child transmission (MTCT) of HIV. Coverage may exceed 100% where the number of mothers receiving ARV (such as a preventative measure) is greater than the number with HIV.

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TABLE 10: RISK FACTORS FOR MOTHER-TO-CHILD TRANSMISSION OF HIV

<table>
<thead>
<tr>
<th>DURING PREGNANCY</th>
<th>DURING LABOUR AND DELIVERY</th>
<th>DURING BREASTFEEDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High viral load (new infection, reinfection or advanced stage)</td>
<td>• High viral load</td>
<td>• High viral load</td>
</tr>
<tr>
<td>• Viral, bacterial or parasitic placental infection, including malaria</td>
<td>• Invasive delivery procedure which increases contact with maternal blood or bodily fluids (episiotomy, artificial rupture of membranes, vacuum extraction)</td>
<td>• Breastfeeding in the absence of antiretroviral treatment</td>
</tr>
<tr>
<td>• STI</td>
<td>• Chorioamnionitis (caused by STI or other infection)</td>
<td>• Mixed feeding (consumption of water, other liquids or solid foods in addition to breastfeeding)</td>
</tr>
<tr>
<td>• Invasive delivery procedure which increases contact with maternal blood or bodily fluids (episiotomy, artificial rupture of membranes, vacuum extraction)</td>
<td>• Premature birth</td>
<td>• Breast abscess, breast cracks, mastitis</td>
</tr>
<tr>
<td>• Chorioamnionitis (caused by STI or other infection)</td>
<td>• Pregnancy with twins</td>
<td>• Mouth infection of the newborn (wounds, thrush)</td>
</tr>
</tbody>
</table>

* Our World in Data, based on UNAIDS Data 2017
To prevent mother-to-child transmission, it is therefore important to ensure quality antenatal care, antiretroviral treatment and ensure that delivery is conducted by skilled personnel trained on managing HIV. Efficient follow-up of the mother in postpartum and of the newborn in the first months of life is also necessary (up to the end of breastfeeding). It is also essential to reinforce health education: prevention of STI and malaria, maternal and newborn nutrition and how to breastfeed, if this is the chosen method.

It is therefore a matter of making PMTCT an integral part of the overall continuum of care.

b) Barriers to PMTCT

Access to PMTCT services

One of the major problems for PMTCT is inadequate access by pregnant women to antenatal care. In developing countries where this care provides a special means of accessing testing and treatment, only 70% of women benefit from antenatal consultations. Various studies have demonstrated the value of including PMTCT in SRH services. Numerous surveys, notably in South Africa, have shown that beginning antiretroviral therapy during antenatal care is effective and safe.

For PMTCT to be successful, women must have broader access to antenatal care, delivery assisted by skilled personnel, postpartum care and quality family planning. Pregnant women must also make use of existing services more frequently and at an earlier stage than they currently do. The regularity of their attendance at the health services can help with adherence to treatment.

Strengthening PMTCT provides an excellent opportunity to improve the quality of sexual and reproductive health services and to increase the use of the wide range of care offered by these services. Lastly, projects should view their contact with pregnant women as an opportunity to reach families, particularly by offering counselling and testing to couples. Reinforcing PMTCT is an excellent opportunity to improve the quality of sexual and reproductive health service and to enhance the use of the large panel of interventions these services offer.

Access to quality SRH services must therefore be increased in order to strengthen PMTCT.

In addition, decentralising the overall package of PMTCT is an important factor in successfully reducing geographical barriers to accessing PMTCT. It is equally important to support free testing and ARV therapy to minimise financial barriers.

Quality of treatment

An African study showed that when mothers were treated by tri-therapy antiretroviral treatment during pregnancy and while breastfeeding, the risk of HIV transmission was virtually halved in comparison with women who were taking only two drugs. If the 22 countries identified as a priority in terms of the HIV epidemic offered all women on the programmes designed to reduce mother-to-child transmission the chance to move from their current treatment to those recommended by the WHO in 2010, there would be an immediate 20% reduction in the number of new infections in children.

Thus, to reduce the risk of mother-to-child transmission, pregnant women must receive treatment in line with the WHO’s recommendations.

Stigmatisation

It is essential that the care provided does not stigmatise women: they must feel comfortable and must not be lost-to-follow-up once their seropositivity has been confirmed.

A common reason for abandoning treatment is the difficulty women have in revealing their serological status to their partners or close family. This problem is associated with gender inequality as well as with the beliefs, stigmas and discrimination around HIV/AIDS and seropositive people. It has long been known that the stigmatisation associated with HIV/AIDS is a major obstacle to effective public health measures.

Fear of rejection or abuse dissuades many people from having a test or from beginning and following treatment. Eliminating stigmatisation represents a key factor in promoting access to care and adherence to treatment.

It is also important to set up community-based activities aimed at lessening the stigma towards people living with HIV, making it easier for individuals to adhere to treatment and for women and children to be monitored as a part of PMTCT.

c) Consequences for the child

Life expectancy in children infected with HIV

Children infected with HIV have a weak immune system and are therefore much more vulnerable to infections. The rate of development of the disease varies but, in general, if a child does not have access to treatment, he/she will die before the age of five. Appropriate care and treatment improve the life expectancy of infected children, living into adulthood.

Feeding the newborn

Choosing how to feed a child is very important, as breastfeeding is believed to be responsible for 50% of cases of mother-to-child transmission of HIV.

Using formula milk is the best way to reduce the risk of transmission, but while this method is readily accessible in high-income countries, this is not always the case in developing countries where there are problems with availability or with risks to the child as a result of how it is used (hygiene, clean water, etc.). The WHO has drawn up
Afass criteria (acceptable, feasible, affordable, safe and sustainable) to provide a means of assessing whether formula feeding is an option. To help decide if seropositive mothers should breastfeed or not, the WHO recommends comparing the risk of mother-to-child transmission of HIV through breastfeeding with the increased risk of death through malnutrition, diarrhoea and pneumonia, which the child faces if he/she is not exclusively breastfed. Research is developing, showing that administering antiretroviral treatment to the mother significantly reduces the risk of transmission of HIV through breastfeeding with the child can significantly reduce antiretroviral treatment to the mother developing, showing that administering antiretroviral treatment to the mother under ARV therapy breastfeeds exclusively for the first 6 months, before introducing additional adequate foods, and that she continues breastfeeding until the child turns one.

In developing countries, where formula feeding often does not meet the Afass criteria, exclusive breastfeeding, which helps reduce the risk of mother-to-child transmission compared to mixed feeding, is recommended. Indeed, formula feeding that does not meet the Afass criteria is associated with a higher risk of infant mortality than that observed in breastfed newborns. Similarly, mixed feeding is associated with a higher risk of mother-to-child transmission of HIV via the mother’s milk. It will then be recommended that the seropositive mother under ARV treatment breastfeeds exclusively for the first 6 months, before introducing additional adequate foods, and that she continues breastfeeding until the child turns one.

### 4. INTERVENTION STRATEGIES

The key elements in terms of PMTCT - as described in the 4 principles defined by the WHO - can be applied throughout the continuum of care, it is therefore essential that they are taken onboard in the interventions. Depending on the project, a specific focus on one or several principles might be chosen. MdM’s activities must respect patients’ rights to confidentiality, privacy, informed choice and non-discriminatory care, regardless of their HIV status.

The intervention strategies proposed here are set out in relation to different areas of the Ottawa Charter for health promotion. MdM uses the Charter as a basis for project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project which includes this element of the continuum of care so that none is omitted.

#### a) Supporting sexual and reproductive health policies including PMTCT

(Element relating to ‘Building healthy public policy’ in the Ottawa Charter)

Health policies must support the development of PMTCT as a way of integrating these practices more effectively into existing SRH services and of improving their sustainability. In addition, MdM supports implementation of appropriate, effective and good quality antiretroviral therapies.

The following outcomes may therefore be pursued:

- The political environment is supportive of the exercise of sexual and reproductive rights;
- Access to services offering contraception is possible throughout the territory to help prevent unwanted pregnancies for seropositive women;
- National protocols for services providing contraception are implemented and shared; this includes emergency contraception;
- Existing policies encourage activities around primary prevention of HIV, specifically directed at adolescents (comprehensive sex utility education, availability of condoms, information and testing services available on a voluntary basis);
- PMTCT is integrated into the national strategy for sexual and reproductive health and implemented as such;
- Efficient PMTCT protocols are set up and shared, and they use treatment in line with the most recent WHO recommendations.

#### b) Reducing the barriers to accessing healthcare

(Element relating to ‘Creating supportive environments’)

Barriers to accessing healthcare must be reduced by taking account of the fact that people living with HIV may be more vulnerable than others and may sometimes be stigmatised by the rest of the population or by the healthcare system.

The following outcomes may therefore be pursued:

- A sociocultural analysis is carried out to identify the sociocultural barriers to accessing care and how HIV/AIDS is perceived;
- Financial barriers to accessing healthcare for women living with HIV are removed;
- The link between carers and communities is strengthened via community-based health education activities.

#### c) Supporting the implementation or strengthening of PMTCT in sexual and reproductive health services

(Element relating to ‘Reorienting healthcare services’)

PMTCT must be included in SRH services. To achieve this, quality SRH services have to be available along with the required medical equipment and drugs. Healthcare practitioners must be competent in both medical and psychosocial care.

The following outcomes may therefore be pursued:

- Availability and quality of sexual and reproductive health services (including comprehensive sexuality education directed at youngsters and adolescents,
information and testing services on a voluntary basis, and family planning services;

- Healthcare professionals are trained on the specific SRH needs of seropositive women;
- Counselling and HIV testing by healthcare professionals are integrated in sexual and reproductive health services, specifically those providing contraception and antenatal care;
- Women living with HIV, their partners and their children have access to antiretroviral in accordance with national recommendations on PMTCT;
- Psychosocial support is available within SRH services for women living with HIV and their partners;
- Basic and continuous training of healthcare professionals on PMTCT are strengthened;
- Healthcare facilities supplied with the necessary equipment, test and drugs to care for HIV+ mothers and exposed newborns.

d) Strengthening health education relating to PMTCT and SRH
(element relating to ‘Developing personal skills’)

The aim of these activities is to improve individuals’ knowledge so that low-risk practices relating to HIV transmission are adopted and care is tailored to individual needs.

The following outcomes may therefore be pursued:
- Knowledge of individuals, specifically adolescents regarding HIV/AIDS and STI (prevention, testing and treatment) and prevention of parent-child transmission of HIV are improved via health education activities run by healthcare professionals or community health workers;
- Use of male and female condoms is encouraged within communities, particular attention being paid to counselling and information about negotiating the use of a condom.

e) Promoting community involvement in PMTCT activities
(element relating to ‘Strengthening community action’)

It is important to involve the community in PMTCT as a means of educating about health, supporting seropositive women and combating the psychosocial problems and stigmatisation they encounter within their community.

The following outcomes may therefore be pursued:
- Awareness-raising activities directed at communities reduce stigmatisation of people living with HIV;
- Intermediaries identified within the community are trained in HIV and STI prevention and in adherence to treatment (peer workers, community health workers or other key people in the community), with a particular focus on primary prevention activities directed at adolescents and youngsters;
- Community-based organisations (non-governmental organisations, associations or networks of people living with HIV) are helped in setting up PMTCT-related interventions, notably dealing with nutritional and psychosocial support.

V. OBSTETRIC FISTULAS

1. DEFINITION

The obstetric fistula (OF)\textsuperscript{43} is an abnormal passageway between the vagina and the bladder and/or rectum, through which urine and/or faecal matter constantly leak.

Fistulas are often the result of early pregnancies or important difficulties in accessing healthcare during labour, however they could be avoided. The principal cause is dystocic and prolonged labour which may last up to several days. Indeed, when labour is prolonged, the constant pressure of the baby’s head against the pelvic walls can drastically reduce blood flow to the soft tissue surrounding the bladder, vagina and rectum. Where the mother survives, this type of labour often ends when the foetus dies and gradually disintegrates, sufficiently to be expelled by the vagina. The pelvic tissue impaired by the ischaemia develops scarring and breaks down leaving a hole, or fistula, through the adjacent organs. Women with an obstetric fistula therefore suffer urinary and/or faecal and flatulence incontinence.

Numerous OF classifications exist, not all of them providing a prognosis for the outcome after treatment. Within its projects, MdM recommends using classifications that are used by national health authorities. Most of the times, the classification used is that of the Association for the treatment of obstetric fistulas in Africa (AFOA-Association de traitement des fistules obstétricales en Afrique) or the WHO classification.

The AFOA classification identifies three groups of fistulas of increasing complexity:

- Simple vaginal fistula (SVF), which is a vesicovaginal fistula between the bladder and the vagina, located in the flexible tissue on the rear wall of the bladder, at a distance from the cervix, and measuring less than 3 cm;
- Complex bladder fistula (CBF), which groups together:
  - Fistula involving the trigonal/cervical/urethral region, following the continuity of the anterior bladder wall with the anterior wall

\textsuperscript{43} WHO, Obstetric Fistula, Guiding principles for clinical management and programme development, 2009.
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of the cervix and urethra;
• Fistula involving neither the cervix nor the urethra, but which has either already been operated on or measures more than 3 cm;

 Serious bladder fistula (SBF), which groups together:
• Total destruction of the urethra;
• Destruction involving anterior and posterior walls of the bladder (transecting or circular section) with the urethra partially destroyed and often sealed off;
• Total destruction of the vagina associated with significant sclerosis;
• High positioned and rectovaginal fistulas are classified separately: uterovaginal fistula, vesicouterine fistula, high rectovaginal fistula, low rectal fistula.

The consequences of OF are severe. Women presenting this disorder suffer from permanent urinary and/or faecal incontinence. This often leads to situations of social isolation and of psychological distress, which can be the cause of cutaneous infection, kidney disorders and death in the absence of treatment.

2. PLACE IN THE CONTINUUM OF CARE

Prevention of obstetric fistula must be pursued throughout the continuum of care via health education not only for women, but also for their husbands and communities. It is important to know what a fistula is, how it is formed and how to prevent and treat it. It is therefore essential to encourage pregnancy care and delivery at a healthcare facility with skilled personnel. Efforts made to prevent unwanted pregnancies or early pregnancies and activities implemented in Comprehensive Sexuality Education are crucial to prevent OF.

Thorough knowledge of the issue of OF is essential to accompany women throughout the continuum of care. Thus, healthcare professionals can quickly identify cases of OF and organise referral towards adequate services.

Services that manage fistulas should offer health education, surgical interventions with trained medical surgeons, psychosocial care, quality postoperative care, follow-up consultations and rehabilitation (by a physiotherapist). It is important to note that this care requires a multidisciplinary team (surgeons, anaesthetists, nurses, psychosocial workers, midwives, etc.). Surgical treatment of fistulas involves advanced procedures and may require several surgeries spaced in time (healing). Training local surgeons is a crucial element of management. This is why training centres exist with specialised practitioners on this issue. Quality postoperative care is also a crucial element of success of treatment and it may continue for up to a month after each surgery. Implementing activities in perineal rehabilitation - and, in some cases, motor rehabilitation - is necessary.

Finally, psychosocial care for women living with fistula is essential. The appearance of a fistula often

This table summarises the various activities that must be developed in relation to fistulas throughout the continuum of care:

<table>
<thead>
<tr>
<th>ACTIVITIES RELATING TO FISTULAS IN THE CONTINUUM OF CARE</th>
<th>COMPREHENSIVE SEXUALITY EDUCATION</th>
<th>ANTEPARTUM CARE</th>
<th>OBSTETRIC CARE</th>
<th>POSTNATAL CARE</th>
<th>SERVICES PROVIDING CONTRACEPTION</th>
<th>POST-ABORTION CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education about fistulas, in particular providing information on the risk of early pregnancies and harmful traditional practices, promoting antenatal and obstetric care by skilled personnel</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Screening for cases of gender-based violence</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Setting up BEmONC and CEmONC centres with skilled personnel and adequate equipment</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Use of the partograph and appropriate management of dystomic labours (e.g. c-section)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Effective referral system from the community to BEmONC centres and from BEmONC to CEmONC centres</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Insertion of a urinary catheter for a week in women at risk of developing OF</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting access to contraception</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Preventing early pregnancies</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling and providing contraceptive methods for women who have just been operated on for an OF</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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Marginalises them in society which is why their reintegration must be supported. A variety of activities may be implemented, such as support groups, individual interviews, family mediation, awareness-raising on the subject of fistulas in the woman's village, support for organisations of women suffering from a fistula (cured or otherwise) and support for microfinance or income-generating activities. To achieve this, it is important to develop coordination mechanisms between the different stakeholders providing these activities and health services.


3. UNDERSTANDING THE ISSUE

a) Background information

It is estimated that more than 2 million women suffer from an untreated obstetric fistula and at least 50,000 to 100,000 new cases occur each year44. It is extremely difficult to obtain precise data on fistulas as the majority of women with a fistula have not been diagnosed. These figures are probably an underestimate. It is estimated that 1 out of 50 women suffering from OF have access to surgical treatment45. Prevention is the best way to eliminate OF. To achieve this, it is essential that sexual and reproductive rights are respected, with specific attention to the following:

- Preventing early pregnancies and providing universal access to contraceptive methods;
- Enabling universal access to EmONC;
- Putting an end to harmful traditional practices, some of which being risk factors for OF;
- Enabling access to quality comprehensive abortion care;
- Preventing and managing GBV.

b) Causes and epidemiological data

So as to prevent OF, simple measures must be implemented:

Delaying the age of a woman’s first pregnancy

Early pregnancies are often linked to early marriages and lack of access to Comprehensive Sexuality Education and to services providing efficient contraceptive methods, specifically adapted to adolescent boys and girls; early pregnancies increase the risk of OF because women under the age of 18 are at higher risk of dystocic labour due to their physical immaturity. In Ethiopia and Nigeria46, for example, more than 25% of patients living with an OF were pregnant before the age of 15 and more than 50% before the age of 18. In 65% of women suffering from fistula, this was a result of a teenage pregnancy47. An OF generally develops during a first pregnancy. In developing countries, many adolescents may also suffer from under-nutrition and be underweight, which also increases the risk of an OF.

Enabling access to quality sexual and reproductive health services

In developed countries, OF due to mechanical dystocia and stalled dilation are now a thing of the past with foetal-pelvic disproportion being assessed during antenatal consultation, labour abnormalities diagnosed using the partograph and c-sections performed when necessary.

In countries without the resources, the reality is quite different: the great majority of women who die or who develop OF during childbirth do not have access to the required obstetric care, either because the service is unavailable or because of difficulties in accessing it. In Africa, only 8 to 35% of women presenting complications during labour are reported to receive care in a suitable health facility. In Sub-Saharan Africa, the incidence of obstetric fistula has been estimated to be around 124 cases per 100,000 births in rural areas, whereas in large towns and cities it is virtually zero48. Most women who develop an untreated OF give birth at home, without the assistance of a skilled healthcare professional.

Unwanted pregnancies, lack of access to family planning and gender inequalities (uneven access and control over SRH) also impact the demand and access to care and thus the occurrence of OF. Female genital mutilation is also a risk factor for OF.

Other medical causes for a fistula may be complications from an abortion carried out in poor medical conditions or surgical trauma (usually bladder lesion during c-section or hysterectomy).

Gender-based violence such as sexual abuse and rape can also cause OF. In war situations, sexual violence is common, and rape is used as a means of intimidation or control. It can even be a war weapon and mass destruction weapon directed at women and their communities.

c) Consequences

Women living with an OF are extremely embarrassed by the fact that they can no longer control their bodily functions, that they are constantly soiled and wet, and that they smell bad.

They are often stigmatised, discriminated against and, ultimately
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excluded from society. This exclusion ranges from non-participation in key social events, such as ceremonies, to repudiation or banishment from the community. The social repercussions are greater or lesser depending on the context.

This not only has psychological consequences for the individual but also means that women living with an OF are often hidden, thus, more difficult to reach when OF surgical services are available.

Their pain and shame may be increased by recurrent infections, infertility, vaginal lesions that make sex painful or impossible and, occasionally, muscular paralysis of the lower limbs and walking difficulties resulting from prolonged dystocia.

4. INTERVENTION STRATEGIES

Given the severe medical, psychological and social consequences of OF, it is essential to take them into account throughout the continuum of care. MdM’s strategy regarding OF is mainly centred on prevention, focusing specifically on unwanted pregnancies - for adolescents in particular - and reinforcing access to quality SRH services, including EmONC and comprehensive abortion care, by offering activities for prevention and management of GBV. Since the modalities of surgical treatment remain highly specialised, it is important to enhance partnerships, collaborations and coordination mechanisms with qualified practitioners for surgery and postoperative follow-up. Finally, MdM also aims at collaborating with community actors to fight the stigmatisation and isolation of women suffering from OF.

The intervention strategies proposed here are set out in relation to different areas of the Ottawa Charter for health promotion. MdM uses the Charter as a basis for project planning.

While it is not a question of implementing every intervention strategy proposed, it is important to be able to consider them all when planning a project that includes this element of the continuum of care so that none is omitted.

△Whatever the chosen intervention strategy, it is essential that care in relation to OF is delivered in complete confidentiality and with respect for the patient’s privacy. Medical data must be protected. It is recommended to refer to ‘For Ethics in the Field’ by MdM on this issue.

a) Supporting the formulation of or strengthening national policies relating to obstetric fistula
(element relating to ‘Building healthy public health policy’ in the Ottawa Charter)

It is essential that existing national policies and strategies be supportive of access to SRHR. Preventing, screening for and managing obstetric fistulas must be considered a part of national sexual and reproductive health policies. Where this is not the case, providing technical support to decision-making bodies such as the Ministry of Health or taking advocacy actions in SRHR may be envisaged.

The following outcomes may therefore be pursued:

✈ Access to comprehensive quality SRH services offering contraception methods, EmONC services, comprehensive abortion care and care for survivors of GBV is possible in the entire geographical territory, including for the most vulnerable populations, so as to prevent OF;

✈ The political environment is supportive of the exercise of sexual and reproductive rights.

b) Reducing barriers to accessing healthcare
(element relating to ‘Creating supportive environments’)

Barriers to accessing care must be reduced as OF is associated with reduced access to emergency obstetric care. In addition, women with an OF are often not informed of the existence of treatment for their condition.

The following outcomes may therefore be pursued:

✈ The quality of sexual and reproductive health services is improved to enable every pregnant women to access antenatal consultations and emergency obstetric care;

✈ Comprehensive sexuality education activities are implemented to help prevent early pregnancies;

✈ SRH services are adapted to the specific needs of adolescents and effective contraception methods are available which will participate in preventing early pregnancies;

✈ Prevention and treatment of OF (including management of labour, use of partograph, dystocia labour, etc.) are integrated in the healthcare practitioners’ basic and continuous training;

Partnerships are set up with specialised practitioners who master surgical treatment of OF and rehabilitation, and referral systems are organised to manage care of patients identified in our projects; Effective integration of women suffering from fistula within their community is facilitated by psychosocial support, for which partnerships can be elaborated.

d) Consolidating or implementing health education for mothers, their partners, families and communities (element relating to ‘Developing personal skills’)

Consolidating health-related knowledge strengthens women’s access to different services within the care continuum and reduces maternal and neonatal morbidity. Indeed, increasing women’s knowledge of their sexual and reproductive health rights empowers them so that they can decide how many children they wish to have and can plan their pregnancies. Women must not be the only ones to benefit from these awareness-raising activities: their partners, families and communities must also be involved. Commitment on the part of families and communities is essential for healthy behaviours to be adopted and for ensuring women’s access to sexual and reproductive care. Moreover, if everyone knows about obstetric fistulas, the burden of discrimination and social rejection borne by these women can be lessened and access to treatment facilitated.

The following outcomes may therefore be pursued:

- Women and their families improve their knowledge of what causes OF, how to prevent it - in particular on the risk of early pregnancies - and they are aware of the available services providing care of OF;
- The community has improved knowledge on sexual and reproductive rights;
- Men are made aware (as part of a gender and co-responsabilisation approach) of the importance for women of accessing comprehensive SRH services and the importance of accessing EmONC for delivery.

e) Promoting community involvement around the issue of obstetric fistulas (element relating to ‘Strengthening community action’)

Communities have scant knowledge of obstetric fistulas. This has an impact on the way a community views and behaves towards women with a fistula and on preventing and screening obstetric fistulas. It is therefore essential to involve community in activities in relation to this subject.

The following outcomes may therefore be pursued:

- Leaders and other influential people in the communities (traditional birth attendants, religious leaders, traditional healers, etc.) support the health education messages regarding sexual and reproductive health such as the risk of early pregnancy, the danger of unsafe abortions, the importance of antenatal, obstetric and postnatal care, contraception, prevention and referral of women suffering from fistula;
- Community health workers are trained in key prevention messages regarding OF, specifically the importance of delaying the first pregnancy, the identification and referral of women suffering from obstetric fistula;
- A community referral system is set up to enable the transportation of pregnant women presenting complications.

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VI. PROVIDING APPROPRIATE CARE TO ADOLESCENTS AND YOUNG PEOPLE

1. DEFINITION

The WHO defines adolescence as the period between the ages of 10 and 19 years-old and young people are the humans aged 20 to 24. This period of time is a continuum of physical, cognitive and behavioural changes that is characterised by an increase in individual levels of autonomy, a strong sense of identity, and reinforced self-esteem leading to progressive independence from adults. Experimentation and risk-taking are normal attitudes during adolescence and are a part of the process that enables to develop skills in decision-making. It is to be noted that the terms adolescents and young people are frequently used in programmes but do not always make sense to populations, as they reflect a variety of realities. For example, in some contexts, the term adolescent will not be used, and the term young person can designate people until 30-35 years-old.

2. ELEMENTS OF VULNERABILITY

Adolescents make up one fifth of the world’s population. Many are in good health but a large number of them face a whole series of difficulties which have an immediate or ultimate impact on their health, and which have implications not only for this generation but also the next one. These difficulties may be related to HIV infection, early pregnancy, violence, consumption of tobacco, alcohol or other substances, trauma or mental health problems. Unmet contraceptive needs are twice as high in adolescents in comparison to married women. In developing countries, 19% of young women are pregnant before they turn 18. In Western and Central Africa, this represents 28% of women. Worldwide, 16 million girls aged 15 to 19 and 1 million girls under the age of 15 give birth every year (11% of births in the world). Among these underaged births, 95% occur in developing countries. Every year, 70,000 adolescents die as a result of complications in pregnancy and birth, and 3.2 million adolescents (15 to 19 years old) undergo unsafe abortion procedures. There are 40% of abortions in the world that concern women aged 15 to 19. Moreover, girls under the age of 14 represent a neglected vulnerable group, projects usually being directed mainly at adolescents aged 15 to 19 years old. There is a lack of data regarding the adolescents under 14 years old who are often not included in health surveys. Early pregnancies have an impact at different levels: health, socio-educative, economic and psychological. Amongst many factors, adolescent pregnancy might be due to a lack of comprehensive sexuality education; gender norms that reinforce early pregnancy; early marriage; high levels of sexual violence and/or transactional sex; a lack of youth friendly services; lack of affordable and accessible contraception; or a combination of the above.

There are multiple causes to teenage pregnancy: early marriages, gender inequalities, poverty, lack of access to health education and services, national policies limiting comprehensive sexuality education or contraceptive methods, limited power of control and decision of adolescents over their sexuality... A large number of adolescents have early and unsafe sexual intercourse in an environment that limits their ability to act to prevent unwanted pregnancies.

a) Early marriages

In low or medium-income countries, over 30% of young girls marry before the age of 18, and over 14% before the age of 15 (60 million women are married before the age of 18 in the world) and 9 out of 10 adolescent girls who give birth are married. According to UNICEF, in Bangladesh, Tchad and Niger, around 1/3 of women aged 20 to 24 years old were already married at the age of 15. An adolescent’s marriage or union may take place prior to pregnancy but can also be a consequence of an unwanted pregnancy that requires to be legitimized.

b) Peer influence and pornography

Generally, parents, socio-educative referents and carers do not talk spontaneously to adolescents and young people about sexuality. When dealing with the questions around sexuality, adolescents and young people seek answers from peers, media, social networks and pornography. Messages on sexuality shared by peers, media, social networks and pornography therefore become the first ways of learning the codes underwriting sexuality. The hyper sexualisation presented by the media (advertisements, musical videoclips, etc.) and pornography, all of which are widely watched by adolescents, contribute to convey norms inciting to early sexuality with multiple partners. It encourages seeking individual masculine pleasure by objectifying women’s body and sexuality. Inequalities and gender-based violence, including rape, are trivialised. Adolescents and young people therefore receive their first information of the codes underwriting emotional and sexual relationships in a manner that is contrary to relationships based

50. UNFPA, Motherhood in Childhood - Facing the challenge of adolescent pregnancy, 2013
51. UN, High Commissioner for Human Rights, Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, 2012
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5.1. UNFPA, Motherhood in Childhood - Facing the challenge of adolescent pregnancy, 2013
5.2. UNESCO. Gender-based violence in schools, a significant barrier to the right to education, 2017

on non-violence, respect and mutual consent.

c) Lack of adequate services

Sexuality for adolescents and young people is often viewed by communities as encouraged by the lack of adequate facilities that would be capable of taking over from families and traditional units to supervise adolescents and young people. Communities can thus perceive the lack of schools, training centres, employment or day-care centres as a cause of early pregnancies.

d) Barriers to accessing services providing effective contraception methods

The low quality of family planning services in healthcare centres also participates in reducing access to contraception for adolescents and young people. Lack of confidentiality, bad reception, value conflicts, requests for parental approval, cost (advertised free care may not be effective), lack of trust in the quality of drugs, inadequate schedules and waiting times for adolescents and young people are some of the obstacles to accessing services providing effective contraception methods.

e) Psychological, emotional and socio-economic vulnerability

Socio-economic vulnerability of families with adolescents and young people, the frequency of conflicts and intra-family violence or simply the absence of any family support are elements of psychological, emotional and socio-economic vulnerability for adolescents and young people. Their decision to engage in sexual intercourse may be a part of their search for moral and emotional support and/or be in search of material benefits. Certain parents or tutors may also exert pressure on an adolescent or a young person participating in the household expense through paid sexual relationships. Various studies have demonstrated the reality of this search by adolescents and young people for material benefits through sexual relationships.

f) Obstetric and neonatal complications

Adolescent pregnancies represent 13% of maternal mortality in the world. Complications in pregnancy and birth are the second cause of death for girls aged 15 to 19 in the world and the first cause in low or medium-income countries. The risk of maternal deaths for adolescents is twice the risk of older women, and for girls aged 10 to 15, it is five-fold. Neonatal mortality at birth and up to one month after birth is two-fold compared to mothers aged 20 to 29. Of all the victims of obstetric fistula, 65% are concerned by adolescent pregnancy. In the case of unsafe abortion, complications are more frequent for adolescents. The characteristics of adolescent mothers are the same all over the world: they do not attend school, live in rural areas and live in poverty. For all those reasons, adolescent pregnancies are considered high-risk pregnancies and require close monitoring.

g) GBV

Given their socio-economic, psychological and emotional vulnerability, adolescents are more exposed to sexual violence, whether intra or extra-family violence. Studies on sexual violence show that a large majority are perpetrated by a familiar person who has authority over him/her, with the exception of systematic rape in war contexts. Periods of social instability are known to present a rise in sexual violence. Moreover, in many countries, studies have shown the frequency of sexual violence in school settings and their impact on school drop-outs as well as on the number of unwanted pregnancies amongst pupils.

h) STI and HIV/AIDS

Half of the new infections with HIV occurs among young people aged 15 to 24, with a higher vulnerability of young girls compared to boys. Indeed, in that age range, infections with HIV are higher for young girls. Adolescents often lack information about STIs, including HIV, but also lack means to protect themselves. Moreover, gender-based inequalities and pressure on young girls make them generally unable to refuse sexual intercourse or to negotiate the use of condoms. Addiction issues being more prevalent in young people (drugs, alcohol, tobacco), the risk of contamination of adolescent girls and boys with HIV or other STI (hepatitis B) caused by the use of intravenous drugs via sharing injection equipment is also very high.

i) Value conflicts

Granting access to information in SRH and contraception for adolescents and young people can cause value conflicts, especially when social and religious norms are against active sexuality before marriage and/or against access to contraception. These potential value conflicts experienced within society, partners and programmes when it is the question of considering adolescents’ active sexuality will slow down the implementation of effective actions to inform adolescents and young people in SRH (Comprehensive sexuality education, preventing STIs and unwanted pregnancies, contraception, etc.). As a result of this reluctance,
adolescents and young people facing an unwanted pregnancy will be exposed to dropping out of school, engaging in early marriage or facing the stigmatisation of single mothers.

3. SPECIFIC HEALTHCARE PROVISION

Adolescents comprise a vulnerable population in terms of sexual and reproductive health. Almost all countries have signed up to the United Nations Convention on the Rights of the Child, which clearly states that adolescents have the right to the health information and health services that they need. Yet, healthcare services are not always welcoming towards adolescents and do not always take account of their specific health needs.

So as to improve SRH for adolescents and young people (SRHAYP), it is essential to set up multisectoral approaches based on empowering girls and reducing gender inequalities while respecting SRHR. It is therefore essential to take into account various elements within projects:

- Adopting a health promotion approach based on a gender approach enhancing empowerment
- Protecting free exercise of health, education, safety rights and promoting a legal framework enabling SRHAYP
- Strengthening comprehensive sexuality education
- Providing SRH services that are adapted to adolescents and young people, in an easily accessible location
- Planning preventative interventions directed at teenagers aged 10 to 14 years old
- Involving men and boys to help them contribute to solving the problem by encouraging actions promoting positive and egalitarian masculinity and actions in favour of co-responsibility regarding sexual and reproductive health
- Acting in partnership with local stakeholders and public services
- Promoting the involvement of the education sector in preventing unwanted and early pregnancies and in the fight against gender inequalities and GBV
- Working with peer educators in school settings and non-school settings to strengthen knowledge and skills
- Involving adolescents in the development of projects that benefit them
- Taking account of groups of most vulnerable adolescents and young people who are harder to reach in programmes (those who have dropped out of school, etc.)
- Tackling the psychological, emotional and socio-economic vulnerabilities of adolescents and young people
- Linking services providing contraception for adolescents and young people with complementary interventions such as comprehensive sexuality education, family and community support, girls’ empowerment and multisectoral coordination.

a) Improving the quality of healthcare services

Eight global criteria defining the standards for quality expected from services providing care for adolescents and young people were defined by the WHO in 201655 and are presented in the following table.

| TABLE 11: GLOBAL STANDARDS FOR QUALITY HEALTHCARE SERVICES FOR ADOLESCENTS (SOURCE WHO) |
|-----------------|---------------------------------------------|
| **ADOLESCENTS’ HEALTH LITERACY** | **Standard 1:** The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services. |
| **COMMUNITY SUPPORT** | **Standard 2:** The health facility implements systems to ensure that parents, guardians and other community members and community organisations recognise the value of providing health services to adolescents and support such provision and the utilisation of services by adolescents. |
| **APPROPRIATE PACKAGE OF SERVICES** | **Standard 3:** The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach. |
| **PROVIDERS’ COMPETENCIES** | **Standard 4:** Healthcare providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents’ rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect. |
| **FACILITY CHARACTERISTICS** | **Standard 5:** The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents. |
| **EQUITY AND NON-Discrimination** | **Standard 6:** The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics. |
| **DATA AND QUALITY IMPROVEMENT** | **Standard 7:** The health facility collects, analyses and uses data on service utilisation and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement. |
| **ADOLESCENTS’ PARTICIPATION** | **Standard 8:** Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of services provision. |

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In terms of contraception, it is important to remember that age - as well as nulliparity - does not constitute a contra-indication to contraceptive methods and that the medical criteria of accessibility are the same as for adults. Social and behavioural aspects are important to consider when choosing contraception for adolescents. The choice of method can also be driven by determinants such as the sporadic occurrence of sexual intercourse, the need to conceal sexual activity and the use of contraception. It is essential to reinforce counselling for adolescents to help them choose a contraceptive method adapted to their needs and suitable to them. The contraceptive discontinuation rates are higher for adolescents than for adults. Adolescents may also seek, within services offering contraceptive methods, information on body changes in relation to puberty, menstruation, sexuality, STIs, etc.

b) Promoting comprehensive sexuality education (CSE)

CSE is a teaching and learning process based on a curriculum taking account of cognitive, emotional, physical and social aspects of sexuality. It aims at providing children, adolescents and young people with factual knowledge, capacities, attitudes and values that will empower them with the ability to thrive while respecting their health, well-being and dignity, to develop respectful social and sexual relationships, to reflect on the consequences of their choices on their personal well-being and that of others, and, finally, to understand their rights and stand up for them throughout their life.

Different studies have pointed out the effects of CSE on sexual behaviours and health for adolescents and young people. CSE increases the knowledge of adolescents/young people and improves their attitudes in terms of sexual and reproductive behaviours. It develops their ability to make informed decisions and stick to them. It enhances communication with parents and other trusted adults. CSE does not lead to an increased sexual activity, unsafe sexual behaviour nor does it cause a rise in STI and HIV rates. Programmes centered on abstinence did not delay the age of the first sexual intercourse, nor did they reduce the frequency of intercourse or number of sexual partners. On the contrary, aiming simultaneously at delaying sexual activity along with promoting the use of condoms and contraceptive methods has proven to be effective.

Developing CSE programmes with a gender approach and while promoting gender equality increases their efficiency, notably regarding reducing rates of STI, GBV and unwanted pregnancies. CSE has a stronger effect when the programmes offered at school coexist with adequate services adapted for adolescents and young people and involve parents and teachers. To improve sociocultural acceptability and enhance effectiveness of CSE, it is a matter of involving adolescents/young people as well as parents, community and religious leaders, healthcare professionals, teachers and other socio-educative referents in the reflection and decision-making throughout all stages of the CSE project. In many contexts it is adequate to collaborate more specifically with adolescent’s/young people’s peers, parents and teachers. Awareness-raising and training activities around intergenerational dialogue and implementation of CSE improves CSE in school settings, family settings and between peers. For further information on CSE (see chapter 4.1. Comprehensive sexuality education).

c) Promoting the involvement of the education sector in preventing unwanted pregnancies for adolescents and young people and in the fight against gender inequalities and GBV

The education sector has an important role in the prevention and care of early and unwanted pregnancy as well as in the fight against gender inequalities and GBV. UNESCO has developed recommendations directed at the education sector towards that venture. It is important to envisage parallel strategies that are intended to reach out to adolescents and young people who have dropped out of school and are usually more vulnerable and less impacted by programmes.

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57. UNESCO, Early and unintended pregnancy and the education sector. Evidence review and recommendations, Education 2030, 2018

Florence Koni Kouadio, Field Coordinator, Republic of Ivory Coast

‘In our context, when it comes to accessing contraception, many barriers exist, especially for young people and adolescents. To facilitate access to quality services for this population, we have decided to set up a dedicated space for adolescents and young people within a pilot health centre. Midwives were trained on the topic of contraception for young people and the specific needs of this population. Numerous false beliefs are conveyed around contraception for adolescents and it was important to share accurate information. This centre is functioning and attendance rates by adolescents are high.’
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VII. PROVIDING APPROPRIATE CARE TO SEX WORKERS

1. DEFINITION

Sex worker (male or female) is a term used to describe a person who offers sexual services, willingly or not, in return for monetary payment or implicit rewards (protection, shelter, drugs, help in migration, etc.) MdM has chosen to use this terminology in accordance with other international institutions and organisations of the people concerned. The majority of sex workers are women, but they also include men and transgender individuals.

It is important to note that sex work is very varied and covers a host of profiles and practices. While some people practice this profession as consenting and responsible adults, others are coerced or even exploited. Thus, there are as many different situations as there are sex workers, and sex work can take many forms in France and around the world, in terms of location (inside/outside, streets, brothels, bars...), duration and temporality (long periods, occasional, evening, daytime...) and organisation (independent, groups, exploitation networks, migration channels...). There is also a variety in the incomes relating to sex work. Therefore, it is important that sex workers are not considered as one group, given the variety of their lives, their statuses and their needs.

In December 2017, MdM wrote a position paper relating to the health and rights of sex workers. The present document is based on the fundamental principles stated in that position paper. In this document, MdM rejects any victimising approach and refuses to consider sex workers as being delinquents, sick people or victims by nature.

2) ELEMENTS OF VULNERABILITY: STIGMATISATION AND CRIMINALISATION

In many contexts, including emergency and crisis situations, sex workers are socially stigmatised and rejected, and are often accused of being the cause of disease transmission in particular of HIV, of increased crime and even of degrading the image of women. These accusations are reinforced by gender inequalities. Sex workers encounter difficulties in asserting their right to accessing healthcare services because of their occupation. Moreover, in many countries, sex work is criminalised; this has a negative impact on the health of people offering sexual services in exchange for payment. As a result of being stigmatised, marginalised and criminalised, sex workers are at higher risk of STI, cervical cancer, unwanted pregnancy, violence, police harassment, exploitation (child prostitution, human trafficking and exploitation of migrants). This, in turn, can lead to low self-esteem, psychosocial disorders, use of psychoactive substances and reduced access to public services, notably health services. This also has a major impact on social ties and may lead to rejection by family and/or friends and to problems with lodging and transportation.

The risks are therefore not limited to an increased exposure to viruses such as STI/HIV or hepatitis but may be viewed globally in terms of safety and health, social and economic repercussions. Staff at healthcare facilities may also discriminate against sex workers, thus affecting their access to care.

The approach developed by MdM with male and female sex workers is one of harm reduction (HR) based on public health and human rights. In addition to their adequacy in terms of public health, the programmes implemented for and with the people aim at developing a community response, empowering individuals to act freely and actively participate in drawing up responses in health and to fight rejection, exclusion, criminalisation and other forms of violation of their rights. So as to guarantee unconditional access to health and rights, MdM advocates reforming laws and regulation as well as policies that criminalise and penalise the practices and lifestyles of sex workers.

a) STI and HIV/AIDS

Sex workers are one of the most exposed populations to STIs including HIV and hepatitis B. This exposure is caused by the nature of sex work, but also by acts of violence which they are too often confronted to and that limit their capacity to protect themselves. Exposure to health problems can also be caused by risks taken in unprotected sexual intercourse in their personal life, with the aim of differentiating private and professional sexual practices. The infection of numerous sex workers with STI (gonorrhoea, syphilis, chlamydia and trichomonas notably) contributes to increasing their risk of being infected.

58. It should be noted that we do not use the term 'prostitution', given that it is morally loaded and associated with deviance and promiscuity. Using the term ‘work’ helps distinguish between the economic activity and the individual concerned and helps make prostitution more visible, invisibility being a vehicle for stereotypes and stigmatisation. In addition, many people working in prostitution around the world claim the status of sex worker in order to secure recognition and social rights.

with HIV. Moreover, STI, violence and the multiplication of sexual partners are risk factors for infection with papillomavirus which can cause cervical cancer, and this occurs in contexts where access to screening remains limited.

d) Psychoactive substances (drugs and alcohol)

It is important to note that sex work and drug/alcohol consumption do not necessarily go hand in hand. There is in fact no basis to the myth that everyone working in prostitution is a drug addict and the reality is far more complex. Without generalising, drug and alcohol consumption is a risk and vulnerability among some sex workers, which may be a threat to their health and safety. There is indeed an increased risk of both physical and sexual violence. Overconsumption of drugs and/or alcohol can also lead to a reduction in the effective use of condoms and to a risk of agreeing more readily to unprotected sex - a vehicle for contamination by STIs. Where needles are shared, there is a high risk of contamination by HIV, hepatitis B and C and syphilis (in some rare cases).

c) Psychological disorders

Sex workers may face psychological disorders that can take many forms (posttraumatic stress disorder, depression, addiction, etc.). These disorders are not systematically caused by sex work but can be related to a traumatic migration pathway, a precarious administrative situation, violence and one’s own individual difficulties.

d) GBV

Sex workers are highly exposed to multiple forms of violence including GBV. The frequency of violence, including sexual violence of which sex workers are the victims increase the risk of physical pathology and psychological disorders. Acts of violence increase the risk of exposure to HIV/STI and/or the occurrence of unwanted pregnancies. This can take the form of violence in the workplace but also perpetrated by the intimate partner or members of the family. Moreover, legal systems that criminalise sex work and penalise sex workers increase precarity and favour the clandestinity of the activity. The violence that is encountered can also be caused by judicial systems that legitimate police harassment and force people to hide, thus facilitating acts of violence by a third party60.

e) Unwanted pregnancies and access to contraception

Unprotected sex (or accidental rupturing of condoms) can lead to unwanted pregnancies. As male and female sex workers sometimes do not have access to healthcare services, it is rare for them to have access to services offering contraceptive methods. Numerous barriers impede this access: financial barriers, stigmatisation, lack of information on available services and, in some cases, incompatible opening hours. Moreover, many false beliefs and representations on contraception are conveyed among sex workers as well as by poorly trained health professionals. Similarly, the knowledge and use of the emergency pill remains limited; its availability is not always generalised within projects. In many contexts, unwanted pregnancies lead to unsafe abortion practices that can have serious consequences on health.

f) Inadequate antenatal and postnatal monitoring and care

The lack of monitoring during pregnancy and postpartum has also been identified as an issue by sex workers themselves. There again, they are confronted to multiple barriers impeding their access to quality services. The lack of regular check-ups will then delay the diagnosis of certain complications and expose the mother and the child to serious health risks.
3. SPECIFIC HEALTHCARE PROVISION

MdM has defined a framework for interventions for harm reduction programmes relating to sex work. Based on an empowerment approach, a community approach and the development of partnerships, it is presented in the shape of a red umbrella.

This framework is based on a holistic approach, in which SRH is fully integrated, as shown in the second branch of the umbrella. This way, MdM encourages the implementation within programmes of harm reduction activities that reinforce access to SRH services. Similarly, it is essential that SRH projects take account of the specific needs of sex workers to provide adequate care.

Based on that premise, the basic principles to observe are the following:
- Respect for confidentiality and anonymity;
- Non-judgemental approach and acceptance of different lifestyles and practices of people encountered: creating bonds of trust;
- Positive reception;
- Free access to care;
- Comprehensive and enlightened information based on the most recent scientific recommendations on contraceptive methods;
- Free access to health prevention materials;
- Free access to emergency contraception;
- Appropriate opening-hours;
- Work out in the community with outreach activities and mobile clinics;
- As comprehensive provision of care as possible, including psychosocial aspects;
- Empowerment;
- Long-term sustainability (duration of funding should not determine duration of project).

Those working with male and female sex workers must respond to their needs and respect their autonomy and dignity, whatever their age, origins, sexual orientation or serological status. A non-judgemental approach is therefore a key principle. Sex workers themselves have a genuine knowledge of the terrain, realities and needs; their involvement increases the relevance of a project in that it is guided by those at whom the services are directed. Projects must be drawn up for and by the users. The involvement of sex workers, which takes place at different levels, is therefore a key advantage: the traditional way is via ‘peer educators’ who carry out awareness-raising outreach activities aimed at communities and who can ensure the project is sustained and accepted. This can also lead to sharing experiential knowledge. They therefore become essential intermediaries for conveying health prevention messages (they alone have genuine knowledge of the practices) and for establishing relationships of trust. Collaboration with healthcare personnel is also valuable as users and professionals enrich each other’s skills in order to adjust their practices.

To facilitate trust and use of services by sex workers, it is essential to win their trust by ensuring continuity, feasibility and flexibility of services. Mobile clinics offering medical and social services help reduce geographical barriers in accessing healthcare. Other intervention strategies are possible such as the use of new technologies (text-messaging, e-counselling, etc.).

Example of activities conducted as part of harm reduction projects and SRH projects:
- Thematic activities in MdM’s reception facility, with role plays performed by sex workers;
- Discussions around all effective contraceptive methods with demonstrations using anatomical models (2D uterus, vagina, etc.) and discussions around the question of negotiating the use of a condom;
- Workshops aimed at co-constructing IEC tools regarding SRH (including contraception) with sex workers;
- Discussion workshops around perceptions of sex workers about contraception;
- Provision of the emergency pill and advance provision for sex workers who express the need for multiple emergency contraceptives to ensure that they have them if needed and that they will be able to take them as soon as possible after unprotected sex;
- Distribution and promotion of dental dam (a square soft latex tissue, used for protection against diseases and STIs during orogenital sex leading to contact with the vulva or anus of the partner);
- Individual interviews and discussions (notably in the bus going to the sex workers’ workplace) on diverse topics concerning health, STI (e.g. what to do if the condom ruptures for example), contraception, unwanted pregnancies, rights, safety (e.g. what to do when arrested by the police), but also their life and goals...
- Training/awareness-raising of staff.

‘We had noticed that several users of the harm reduction for sex workers project were confronted to unwanted pregnancies. In Russia, there really aren’t any policies around information about the issue of contraception. A large choice of methods exists but access to information regarding these methods is a real problem. This was the trigger point of our reflection on including more messages around SRH and adopt an integrated approach to SRHR and activities aimed at preventing HIV into our harm reduction project. The team developed, in partnership with sex workers, an IEC tool on contraception in the form of a booklet, ‘Alice in contraception-land’. This tool has proved extremely useful when working on prejudice and false beliefs that are widespread regarding contraception. We also provide sex workers with emergency contraception in our mobile clinics. We talk about negotiating the use of a condom and questions around GBV. We also inform sex workers on certain frequent practices such as vaginal showers’.

Svetlanna Tsukanova, Project Coordinator, Russia
working on SRH harm reduction projects (continuum of care, unwanted pregnancies, contraception, cervical cancer, etc.);

- Training/awareness-raising of healthcare professionals to the specific needs of sex workers;
- Screening of cervical cancer, using the self-sampling HR HPV test, and referral for treatment of precancerous lesions;
- Feminist self-defence classes dispensed by peers;
- Setting up a system of warning and information regarding violence, including GBV, for sex workers via an online platform to share information.

My job is to inform sex workers of their sexual health and rights, specifically in case of violence. Firstly, I give them information about the French health system, where any woman is entitled to regular gynaecological check-ups and testing, and I tell them what to do if they are infected with STI.

With certain people, communication is complicated because they cannot/ will not waste time to go and see a doctor. This attitude makes my task harder, but I try and overcome this obstacle by attempting to create a trusted bond by talking about shared life experiences, such as family. I have found a particularly appropriate moment to communicate with them and inform them of their health and rights: this is during menstruation when they are more available since they are not working. I seize this opportunity to show them the hospital, so that they know where they are going in the case of an emergency. My work comes with certain difficulties, but this is what makes my role important.'

Julan Huang, Prevention Facilitator on the Lotus Bus Programme, France

Involvement of Chinese sex workers in the INCA project (prevention of cervical cancer) was interesting. The particular thing that we noticed was an increased participation during the months with self-sampling (for precancerous lesions screening) and a decrease during the months with direct referral to a gynaecological check-up. Without us intervening, women spread the word. Like with TROD, the popularity of self-sampling shows the importance of screening techniques that enable the outreach to the populations that have least access to care or those who face the most important barriers to accessing healthcare within the legal framework'.

Nora Martin-Janko, Lotus Bus Programme Coordinator, France

1. DEFINITION

Currently, there are around 70.8 million displaced persons in the world, among which 25.9 million crossed international borders in search of protection. Migration is a social fact. MdM views it as such and is committed to the people who have been exiled for a long time, in France like in other countries in Europe or other continents: Latin American, Africa, Middle East, Asia. Migration (voluntary departure) and exile (forced departure) are movements of population that take place in the general context of a refugee system crisis in many destination or transit countries. While migrations are increasing, access to rights and health by migrant people keeps decreasing in many places around the world. Closing and control of borders and criminalisation of migrant people, with the subsequent effects (custodial practices, detention, expulsion and returning in the country of origin or transit) are the cause of health problems and prevent access to healthcare by exiled people.

2. ELEMENTS OF VULNERABILITY

Throughout their migration pathway, which is hereby viewed as more than a mere displacement (departure from the country, border crossing, country of destination), displaced persons face a tremendous number of difficulties that reduce respect of their SRHR. While there are no specific pre-existing pathologies at departure, migrants encounter events, barriers and specific obstacles during their journey and their access to healthcare

62. UNHCR, Figures at a glance, 2019
63. WHO, 10 things to know about the health of refugees and migrants, January 2019
the lack of facilities, notably in transit centres and shelters. Thus, their vulnerability increases along the way as they are more frequently confronted to GBV, limited access to contraception and unsafe abortion. In addition, in the destination countries, they are most often excluded from the health system on the basis of their residential status, exacerbating the inequalities throughout Europe64.

a) Barriers in accessing healthcare

The multiple obstacles faced by migrants are complexified by the experiences of displacement and are an addition to other barriers to healthcare: sociocultural barriers, administrative barriers, financial barriers, language barriers, stigmatisation, fear of inspection, etc. Despite the human rights conventions protecting migrants, many do not have access to social and medical services.

Little data exists on the health of migrants but, nevertheless, it is clear that they make less use of health services than the general population. In general, primary healthcare is underused and services are accessed late and in emergency situations. It is noted that maternal mortality of migrant women is 2.5 times higher than the mortality of women born in France, rising up to 3.5 times higher for women originating from sub-Saharan Africa65. There is also a report on the health of migrant refugees published by the WHO Europe that states a higher risk of cervical cancer in migrant people than in the population of the host country66.

In France, 28% of hospitalisations of women receiving State Medical Aid (AME - Aide Médicale d’Etat) are linked to complications resulting from delays in pregnancy monitoring and follow-up care (40% of women in our programmes have delay in antenatal care). Another perinatal care study in France showed an increased risk of maternal mortality among women foreign nationals, in part explained by their low uptake of health services. Undocumented status and recent arrival in France are factors behind inadequate pregnancy monitoring67.

In populations living in slums in France in 2007, only 8.3% of women were monitored during pregnancy, and the contraceptive prevalence rate was of 10%. Over 60% of women welcomed in the healthcare advice and referral centre (Caso) of Saint-Denis68 had never used contraception.

b) GBV

In the different steps of the migration journey, people can be more exposed to GBV. The conditions of migration and the conditions of shelter are factors that can increase the vulnerability of people to that type of violence. Situations where migrants live on the street in precarious accommodation as well as some public facilities providing shelter exposes migrants to rapes and sexual abuse, exploitation and trafficking, all the more for women travelling alone69. According to a study by Amnesty International70, 60 to 80% of women transiting from Central America to the United States through Mexico were victims of sexual violence. More recently, numerous testimonies of migrants who had transited through Libya revealed the extent of the violation of human rights and sexual violence71. The MdM survey on violence suffered by people who have transited through Libya, Italy and France during their migration, conducted at the CASO of Saint Denis in 2018 reveals that sexual abuse concerns 50% of women and 18% of men during the migration process. Violence has dramatic consequences on health and life for survivors, male or female: injuries, chronic pain, handicaps, unwanted pregnancies, STIs including HIV, psychological consequences, social consequences... However, the risk of violence remains high upon arrival in the host country. The survey conducted by ANRS PARCOURS72 and the DSAFIR study73 have shown that, for example, women migrants from Sub-Saharan Africa in France were 6 times more at risk of forced sexual intercourse after their arrival in France. The study shows that the sexual violence undergone by those women on the French territory multiplies by a their risk of being infected with HIV. Due to lack of facilities and appropriate measures, girls and women are rarely in capacity of reporting the violence of which they are the victims.

c) Barriers to accessing sexual and reproductive health services

Migrant women are at higher risk of pregnancy complications. Throughout the programme led by MdM in France in 2014 directed at vulnerable populations, only 42% of pregnant women had benefited from one antenatal consultation.

On arrival in the destination country, various barriers rise against free access to women migrants to SRHR:

- Restrictive national policies regarding access to care, with the exception of emergency care;
- Complex administrative procedures impeding access to these services (proof of residence);
- Transition to another system on the basis of their residential status and recent arrival in France are factors behind inadequate pregnancy monitoring.
CHAPTER 5: CROSS-CUTTING PROVISION OF CARE

WHO Europe defined migrants as a priority SRH population and so it is essential to offer quality sexual and reproductive health services to reduce the vulnerability of these populations. Key points for migrant healthcare:

- Improving the quality of healthcare services through transcultural consultations (reducing language barriers, using health mediators, awareness-raising and training of healthcare personnel on issues of health for migrants and migrants’ rights and non-discrimination);
- Organising health mediation between migrant populations and national health service facilities;
- Developing community-based projects that ‘reach out’ to those who are most excluded from care and from the statutory healthcare system;
- Providing health information and education to migrant populations about their health and SRH rights in their language and using culturally appropriate IEC materials. Health promotion must include an outreach strategy to increase coverage;
- Reducing the financial barriers to accessing SRH care by limiting direct payment for care and by encouraging free provision of care for the most vulnerable people (pregnant migrant women and migrant children);
- Reducing the risks associated with the physical environment;
- Monitoring and analysing the use of healthcare services by migrant people and highlighting the barriers to accessing healthcare. A lack of data impedes the development of more appropriate support for migrants;
- Creating a network of partners and raising awareness of medico-social facilities about how to care for migrants;
- Supporting policy changes in favour of protecting migrants and guaranteeing equal access to healthcare services.

In 2019, the Italy mission initiated a programme specifically targeting management of survivors of GBV in three regions of the country. Since 2015, according to the HCR, over 470 000 people have reached Italy from the Mediterranean: among them were 50 000 women and 80 000 minors. On the migration pathway, most people have faced extremely violent situations: physical violence, torture, rape and sexual abuse, etc. Upon arrival, individuals are neither aware of their rights nor of the possibility to access healthcare and protection. They do not know where to seek help, or who to trust. Moreover, actors and services caring for migrants on arrival are not always in capacity of providing an appropriate response, which causes many people to miss out on accessing care. To improve the response to survivors’ needs, MdM therefore decided to develop different activities: stakeholder mapping and analysis of the quality of services, reinforcing the capacities of actors involved in immediate care, setting up awareness-raising sessions for migrants on their rights and available services, and supporting coordination systems between various stakeholders and the services providing immediate care.

Jean-Pierre Foschia, Medical Coordinator, Italy

In Europe, 40% of migrants are women.

Sarah Belkacem, Field Coordinator, Oran, Algeria

WHO Regional Office for Europe How Health Systems Can Address Health Inequities Linked to Migration and Ethnicity, 2018

Health mediation is a part of social mediation as defined by the following: ‘process of creating and repairing social bonds and solving conflicts in everyday life, via the intervention of an impartial and independent third party who attempts, through the organization of discussions between people or institutions, to improve a relationship or solve a conflict’
IX. PROVIDING CARE TO LGBTQ+ PEOPLE

1. DEFINITIONS

a) Gender identity, gender expression and emotional and sexual orientation

The term ‘gender identity’ refers to the way one identifies, feels, thinks, recognises oneself as a woman, man or transgender. This identification can be in accordance or not with the sex with which the person was born. Hence, a person can be born with a female sex and identify as a male gender identity or the opposite.

The term ‘gender expression’ refers to the way that one expresses one’s gender identity through the way one dresses, talks or moves. This gender expression can be masculine, feminine or androgynous and can correspond or not to the gender identity or to the sex.

Regarding the emotional and sexual orientation, there is reference to heterosexuality, homosexuality or bisexuality. This refers to the sexual or emotional attraction that one can feel for someone of one’s own sex, for someone of the opposite sex or for both. It is always the choice of the person regardless of the gender expression and gender identity.

b) LGBTQ+ People

The acronym LGBTQ+ refers to the following definitions:

- **L = Lesbian**: a person who identifies as a woman and who is sexually and romantically attracted to other people who identify as a woman
- **G = Gay**: a person who identifies as a man and who is sexually and romantically attracted to other people who identify as a man. More generally, the term ‘gay’ is used for any person attracted to people with the same sexual identity
- **B = Bisexual**: a person who is romantically and sexually attracted by people who identify as men and by people who identify as women
- **T = Transgender**: a person whose gender identity does not correspond to his/her sex
- **Q = Queer**: this inclusive term designates a person who does not want to be defined by his/her sex or sexual orientation

There is not consensus on the + which represents various other categories.

2. ELEMENTS OF VULNERABILITY

There is little data regarding the important issue of access to appropriate SRH services to answer the needs of LGBTQ+ people. This remains a challenge in many contexts, including in developed countries. While most medical needs of LGBTQ+ people are similar to the usual standards of medical care, some specificities need to be considered.

Thus, research shows that LGBTQ+ people suffer more from some problems in physical, mental and sexual health. They are often faced with barriers to accessing care, notably by fear of stigmatisation and discrimination.

In a large majority of countries, healthcare services remain heterosexually centered, i.e. based on the premise of heterosexuality, thus neglecting the specific needs of people from sexual minorities. The majority of healthcare practitioners are not/little trained on those needs, yet the little data available shows a link between the LGBTQ+ experience and health vulnerabilities. By fear of discrimination, LGBTQ+ people rarely disclose their sexual orientation and/or gender identity to healthcare professionals.

### a) STIs and HIV/AIDS

Regarding STI, gay and transgender people represent the population that was historically most impacted by STIs including HIV. In particular, men who have sex with men are at increased risk of being infected with HIV and other STIs in comparison to men who are exclusive heterosexuals. In 2017, an estimated 12% of new infections in the African region and 57% of new infections in Europe and North America occurred within a population of men having sex with men.

Sexual relationships between women carry a low risk of HIV transmission, but the risk is proven for other STIs including HPV. In addition, some lesbians continue having sexual relationships with men without accessing any prevention service.

### b) GBV, notably GBV based on emotional and sexual orientation and gender identity

While yet again, data is limited, there is evidence to show that LGBTQ+ people face many types of violence in relation to their gender identity and/or their sexual orientation. This includes psychological, physical and sexual violence. In some contexts, studies have even described homophobic ‘remedial’ rapes on lesbian people.

### c) Inadequate access to SRH

Few healthcare professionals are aware

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76. European Evaluation Society and the Latin America and Caribbean Evaluation Network (RELAC) Guide to including a gender perspective in VOPEs, innovating to improve institutional capacities, 2015

77. WHO, 52nd Directing council. Addressing the causes of disparities in health services access and utilization for lesbian, gay, bisexual and trans (LGBT) persons, 2013
of the specific needs of LGBTQ+ in SRH. In addition, people often have limited access to quality information regarding SRH and prevention services. Thus, lesbians, bisexual women or transgenders often have inadequate SRH monitoring. Due to the perception by healthcare staff that their sexuality does not involve penetration, they are less inclined to abide to cervical cancer screening.

Similarly, access to contraceptive methods for LGBTQ+ is often inadequate due to false beliefs, including beliefs held by health professionals. Transgender people with testosterone treatment can still experience unwanted pregnancy in the case of unprotected sex. The question of contraception is not sufficiently addressed for lesbian people, while some of them still continue to have sexual intercourse with men, thus exposing them to unwanted pregnancies in the case of unprotected sex.

d) Addictive behaviours

Some studies have shown that LGBTQ+ people can present with an increased risk of developing addictive behaviours (tobacco, alcohol and drugs), in comparison with the general population. The use of alcohol and psychoactive substances can increase the practice of unsafe sexual behaviours.

3. SPECIFIC HEALTHCARE PROVISION

Taking into consideration the different barriers to accessing quality healthcare, notably SRH, for LGBTQ+ people, it is important that MdM encourages the support of healthcare professionals towards a better, more appropriate care within the organisation’s projects.

Within a framework of adequate services, the basic principles to abide to are:

- Respect for confidentiality and anonymity;
- Non-judgemental attitudes and acceptance of different lifestyles, gender identities, emotional and sexual orientations of the people received;
- Creating bonds of trust;
- Positive reception;
- Free access to care;
- Comprehensive and enlightened information based on the most recent scientific recommendations regarding contraceptive methods;
- Free access to health prevention materials;
- Free access to emergency contraception;
- Work in the community via outreach activities and mobile clinics;
- A holistic provision of care, including psychosocial aspects;
- Empowerment.

Those working with LGBTQ+ people must respond to their needs and respect their autonomy and dignity, regardless of their age, origins, sexual orientation or serological status. A non-judgemental approach and a non-discrimination approach are therefore two key principles.

LGBTQ+ people themselves have a genuine knowledge of the terrain, realities and needs; their involvement increases the relevance of a project in that it is guided by the users. Projects must be drawn up for and by the users. The involvement of LGBTQ+ people, which takes place at different levels, is therefore a key advantage: this is commonly achieved via ‘peer educators’ who carry out awareness-raising outreach activities aimed at communities and who can ensure the project is sustained and accepted. This can also lead to sharing experiential knowledge. They therefore become essential intermediaries for conveying health prevention messages (they alone have genuine knowledge of the practices) and for establishing relationships of trust. Collaboration with healthcare personnel is all the more valuable that users and professionals enrich each other’s skills in order to adjust their practices.

To facilitate trust and uptake of services by LGBTQ+ people, it is essential to gain their trust by ensuring continuity, feasibility and flexibility of services.

Example of activities conducted within projects for better consideration of the specific needs of LGBTQ+:

- Encouraging healthcare professionals to explore their own beliefs and views on LGBTQ+ during workshops, help them realise the impact of these representations on professional practices;
- Training healthcare professionals on the specific needs of LGBTQ+ people in terms of SRH and specifically prevention of STI, effective contraceptive methods adapted to needs and profiles (for example copper IUD or other non-hormonal contraceptive methods for people with testosterone treatment);
- Encouraging healthcare professionals to use a neutral language; for example, using the term partner instead of ‘boyfriend’ or using the same terms as a person to designate him/her (name and gender of his/her choice);
- Co-constructed IEC tools on SRH elaborated with LGBTQ+ during workshops;
- Depending on context, developing communication tools to convey the message that the healthcare professionals of a given facility are aware of the specific needs of LGBTQ+ people (e.g. poster);
- Discussions around all effective contraceptive methods using anatomical models for demonstrations (vagina, 2D uterus, etc.) and discussions around negotiating the use of a condom;
- Individual interviews and discussions on diverse topics around health, STI (e.g. what to do when a condom ruptures), contraception, unwanted pregnancies, rights, safety but also their life and goals;
- Activities aimed at screening for cervical cancer specifically directed at lesbian, transgender and queer people, notably the self-sampling HR HPV test and referral for treatment of precancerous lesions.

CHAPTER 6

INTERVENTIONS IN THE CONTEXT OF A CRISIS
I. DEFINITIONS

A situation is defined as an emergency when a sudden and unforeseen event occurs that requires immediate measures to minimize its adverse consequences.

A humanitarian crisis is an event which constitutes a serious threat to the health, the security or the well-being of a community or another group of people. Armed conflicts, epidemics, natural disasters and other major emergency situations can all be accompanied by a humanitarian crisis or can lead to one.

A disaster is a serious disruption of the functioning of society, causing widespread human, material or environmental losses which exceed the ability of affected society to cope using only its own resources. Disasters are often classified according to their cause (natural or manmade).

In humanitarian crisis contexts, girls and women are particularly exposed to increased risks of unwanted pregnancy, maternal death, GBV or sexually transmitted infection. As a consequence, the needs in SRH services and care increase too. Yet, access to SRH services is rarely a priority for humanitarian actors whose responses are generally focused on basic care, access to nutrition, water and shelter. Given the scale and the duration of conflicts, and the number of people requiring humanitarian assistance, the international community...
gradually took interest in the specific difficulties caused by a lack of SRH care for individuals, in particular for women and girls.

However, in the field, the needs remain largely unmet and the complications caused by the lack of SRH care lead to an important increase of mortality and morbidity in the population and continue to put the health and life of thousands of people in danger, especially girls and women. Ensuring the availability and access to information on SRH and SRH services is therefore crucial to achieve an effective humanitarian response, respectful of the fundamental human rights and empowerment of girls and women.

Today, over 32 million women and girls of reproductive age are in need of humanitarian aid. It is crucial to focus on SRHR in a crisis context. This is firstly because, when social and judicial systems collapse, girls and women are exposed to a higher risk of GBV and notably of sexual violence, maternal mortality and morbidity and also to complications of pregnancy, birth or unsafe abortion. Secondly, the needs in SRH do not suddenly vanish with the appearance of a conflict but, on the contrary, multiply, consenting relationships continuing while means of support crumble and sexual violence rises.

In the event of a crisis, MdM aims at re-establishing access to care for populations by focusing on primary health care (PHC). Since 2014, MdM integrates SRH as an absolute and systematic priority in emergency interventions. So as to better frame this integrated response, MdM developed and implemented Guidance notes on SRH & GBV in crisis settings directed at the whole MdM workforce on the field (to be consulted for further information).

MdM’s interventions are based on:
- Setting up a minimum emergency package in SRH which consists in a set of coordinated activities to be implemented from the onset of an emergency response;
- Elaborating multidisciplinary response strategies regarding GBV to enable to identification of survivors and their access to cross-sectional care services.

3. IAWG AND THE INTER-AGENCY FIELD MANUAL

In 1995, a consortium of NGOs, funders, governments and United Nations agencies created the Inter-Agency Working Group in SRH in humanitarian crises (IAWG – Interagency Working Group). Ever since then, the coalition has played a crucial role in advocacy, research and technical support to improve access to SRH services in the cases of conflicts or natural disasters.

The IAWG aims at:
- Identifying gaps, progress and lessons learned;
- Evaluating the SRH situation in the field;
- Defining technical norms for the provision of SRH services;
- Developing sound evidence to be shared with decision-makers, managers and practitioners;
- Advocating the inclusion of people impacted by crises in global development programmes and humanitarian actions.

The most important contribution of IAWG was to develop guidelines to delivering SRH care in emergency situations, published in the form of the Inter-Agency Field Manual (IAFM). The manual defines a minimum package of activities to implement at the onset of an emergency: the Minimum Initial Service Package (MISP). Since 2004, the MISP has become an international standard and has been added to Sphere standards.

The IAFM was revised in 2018, the new version taking into account the most recent data concerning clinical practice and programme implementation. This chapter builds on that version of the manual.

MdM is a member of IAWG and particularly contributes to the working groups regarding GBV, abortion, contraception and advocacy.

4. IAWG, The needs of crises-affected women and girls must be mainstreamed across family planning summit commitments
5. UNFPA, Maternal mortality in humanitarian crises and in fragile settings, November 2015. “The number of maternal deaths in the 35 countries currently affected by a humanitarian crisis or fragile conditions is estimated at 185 000 in 2015, which is 41 per cent of the global estimate of maternal deaths (303 000).”
7. IAWG, Inter-Agency Field Manual on Reproductive Health in Humanitarian settings, 2018
8. IAWG, MISP Cheatsheet, 2019: https://iawg.net/resources/misp-reference
II. MINIMUM INITIAL SERVICE PACKAGE

1. OBJECTIVES

Crisis situations often lead to an interruption of the population’s access to many - if not all - SRH services. While the re-establishment of comprehensive care provision is the overall aim, it is often necessary to begin with prioritising.

Thus, The Minimum Initial Service Package defines the most important SRH services to focus on in order to prevent the inevitable rise of mortality and morbidity, while preserving the right to live in dignity.

The MISP comprises six objectives:

➡ Ensuring an organisation is designated by the health sector as responsible for directing the implementation of the MISP (lead agency for SRH)
➡ Preventing excess maternal and neonatal mortality and morbidity
➡ Preventing transmission and reducing mortality and morbidity caused by HIV and other STI
➡ Preventing sexual violence and responding to the needs of survivors
➡ Preventing unwanted pregnancies (including guaranteeing access to safe abortion care)
➡ Planning comprehensive SRH services integrated within primary health care centres, as soon as possible

“In Nigeria, MdM works at implementing the MISP in SRH through the creation of four SRH clinics within refugee camps. In each of them, care is provided by 2 experienced midwives. Awareness-raising sessions are usually the first activity of the day. These sessions revolve around the importance of accessing antenatal care, danger signs during pregnancy, the importance of giving birth assisted by skilled personnel, nutrition of the newborn and child, family planning, etc. We also provide antenatal and postnatal consultations and family planning services. Regarding emergency obstetric care, it is not available within the clinic, but we have developed effective coordination mechanisms with other actors and a referral system to other facilities open 24/7. Finally, our midwives are also trained on identifying and managing the care of survivors of GBV and sexual violence.”

Dr Zainab Jibril Adam, Technical Advisor in SRH/GBV, Nigeria

9. IAWG, Inter-agency Field Manual on Reproductive Health in Humanitarian settings, 2018
2. PRIORITY ACTIVITIES OF THE MISP

a) Coordinating the implementation of the MISP

In the event of a crisis, an organisation must be designated as lead agency in SRH/MISP to ensure the coordination between actors providing health services. This organisation will be in charge of assessing the available SRH services and determining who does what (4W). It will also be in charge of conducting regular meetings with different stakeholders, of coordinating equipment supplies and of sharing information regarding health policies and national protocols in SRH. MdM is usually not the lead organisation in charge of this coordination but takes an active part in coordination meetings. It is usually the UNFPA who fulfils that role.

b) Preventing excess maternal and neonatal mortality and morbidity

Maternal mortality is a major cause of death for women of reproductive age in crisis situations. Deteriorated sanitary conditions increase mortality and morbidity related to obstetric complications. It is estimated that the proportion of pregnant women within a population at a given time is 4%. It can be expected that 15% of them will present with complications during pregnancy or birth. The most frequent causes of maternal death are haemorrhage, postpartum sepsis, pre-eclampsia and eclampsia, complications of abortion, as well as prolonged labour with dystocia. Such complications are often unpredictable. It is therefore crucial to take account of the specific needs of pregnant women, parturients and newborns at the onset of the crisis to prevent a rise in neonatal and maternal mortality and morbidity. Let us be reminded that the WHO recommends that all births be assisted by skilled personnel and take place in a health facility with the necessary equipment and staff to manage complications. The key interventions to prevent a rise in maternal and neonatal mortality and morbidity are therefore the following:

OBJECTIVE OF THE MISP: PREVENTING EXCESS MATERNAL AND NEONATAL MORBIDITY AND MORTALITY:

- Ensuring provision of and access to hygienic and safe obstetric services, basic neonatal care, and emergency neonatal and obstetric care including:
  - At referral hospital level: qualified personnel and necessary equipment to provide CEmONC
  - At health facility level: skilled birth attendants and equipment required for non-complicated vaginal births and for BEmONC provision
  - At community level: informing the community of the availability of hygienic obstetric services and EmONC services and of the importance of benefiting from care administered by healthcare facilities. Birthing kits for hygienic deliveries must be provided to pregnant women and birth attendants to promote hygienic deliveries at home when access to a facility is not possible
  - Setting up a referral system to other facilities, available 24/7, to facilitate transportation and communication between the community, the health centre, and the hospital
  - Ensuring the availability of vital post-abortion care in health centres and hospitals
  - Ensuring the availability of drugs and equipment for hygienic deliveries and immediate neonatal care in cases where access to a healthcare facility is not possible or not reliable

For further information on BEmONC and CEmONC, refer to chapter 4. IV. Obstetric care and immediate neonatal care.
c) Preventing transmission and reducing morbidity and mortality linked to HIV and other STI

Crisis situations are the source of an increase in the vulnerability to STI including HIV. Multiple factors contribute to this increase and this is particularly noticeable in environments where people are displaced:

- Poor state of health infrastructures and shortage of protection equipment making it difficult to apply universal standard precautions;
- Congestion in health facilities and poor attention given to measures aiming at standard precautions;
- Difficult/intermittent access to antiretroviral treatment (ARV);
- Limited access to quality condoms
- Increase in GBV: sexual exploitation, sexual violence used as a war weapon, opportunistic violence, etc.;
- Increase in unsafe behaviours: sex work, early onset of sexual activity in some adolescents, unsafe behaviours, early marriages often with a big age difference between spouses, etc.

In addition, among the people affected by a crisis, a significant proportion lives with HIV. Impeded access to health facilities and antiretroviral treatment may result in an increase in morbidity and mortality. It is then necessary to set up essential activities to reduce HIV transmission but also to limit the effect of the crisis of the health of people who are already infected with HIV. The main activities are:

- Enabling rational and safe blood transfusion
- Ensuring the application of standard precautions
- Guaranteeing the availability of free lubricated condoms and, in case this is not possible, providing feminine condoms (if they are already used by the population)
- Supporting the provision of antiretrovirals to continue treatment for people who have been recruited in ART programmes before the crisis, notably women who were recruited as part of PMTCT programmes
- Delivering post-exposure prophylaxis to survivors of sexual violence and professionals exposed
- Supporting the provision of cotrimoxazole prophylactic treatment for opportunistic infections in patients who turn out to be seropositive or for which HIV has been diagnosed
- Monitoring the availability of syndromic diagnosis and treatment of STI

d) Preventing sexual violence and addressing survivors’ needs

GBV are a major public health issue and a serious violation of human rights. They can occur in any social or economic background and are solidly rooted in cultures around the world.

In crisis situations, whether resulting from an armed conflict of a natural disaster, episodes of GBV rise and especially sexual violence. So as to prevent sexual violence and respond to the needs of survivors from the onset of the crisis, the following activities must be envisaged:

- Working in collaboration with other departments, specifically with the working sub-group on GBV, to introduce preventative measures at community, local and district level, notably in health facilities to protect the most affected populations, such as women and girls, from sexual violence
- Making care, clinical references and other support services available to survivors of sexual violence
- Creating confidential and secure spaces within health facilities to receive survivors of sexual violence and provide them with appropriate care and clinical references

The elements relating to MdM’s intervention strategies in terms of managing GBV in crisis contexts are explained in more detail in section III. of this chapter: Focus on prevention and management of GBV.
e) Preventing unwanted pregnancies
In the event of a crisis, access to effective contraception can be limited due to destroyed health facilities, shortage of supplies, congested health facilities, lack of competent human resources, financial barriers, etc. Nonetheless, the need in contraceptive methods persists, and some people using contraception before the crisis can no longer access it. In addition, the crisis situation may increase the number of people in need of a contraceptive method (precarious life conditions, safety risks, disruption of social patterns, etc.) and it can also increase unsafe behaviours (sexual services in exchange for shelter, food or protection for example). In such contexts where access to services may be limited, availability of long-term contraception and emergency contraception is a priority goal to prevent unwanted pregnancies and potential unsafe abortions. The key activities to develop are therefore:

f) Planning the integration of comprehensive SRH services in primary care units

The MISP is the starting point of response and the basis of planning in SRH. It defines priority activities which are complemented, as soon as possible, by the implementation of comprehensive SRH services. To plan this transition, it will be necessary to undertake the following:

- Collecting essential data required to develop comprehensive services (maternal and neonatal mortality, prevalence of STI including HIV, contraceptive prevalence, attitudes and behaviours of the population impacted in terms of SRH);
- Determining an adequate location to deliver future comprehensive SRH services through the mapping and analysis of the existing facilities and/or determining appropriate locations to set up new facilities (permanent or semi-permanent via mobile clinics for example);
- Carrying out an estimation of needs in equipment and essential generic drugs;
- Assessing the capacities of healthcare personnel with regards to SRH (sufficient number of resources, adequate level of competence and knowledge);
- Coordinating with referral facilities and other actors to deliver specialised care; MdM alone can rarely guarantee the provision of all levels of care.

<table>
<thead>
<tr>
<th>OBJECTIVE OF THE MISP: PREVENTING UNWANTED PREGNANCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ensuring the availability of a set of reversible contraceptive methods, long-acting and short acting (including masculine and feminine condoms and emergency contraception) in primary healthcare facilities to address the needs</td>
</tr>
<tr>
<td>- Providing information, notably tools for information, education and communication (IEC) and counselling in contraception that emphasises informed choice and consent, efficiency, respect for intimacy and confidentiality of clients, equity and non-discrimination</td>
</tr>
<tr>
<td>- Make the community aware of the availability of contraception for women, adolescents</td>
</tr>
</tbody>
</table>

It is also essential that women can access services providing comprehensive abortion care. This activity is stated as part of the additional activities to the MISP that are recommended by the IAWG.

<table>
<thead>
<tr>
<th>OBJECTIVE OF THE MISP: PLANNING COMPREHENSIVE SRH SERVICES INTEGRATED IN PRIMARY HEALTH CARE, AS SOON AS POSSIBLE. WORKING WITH PARTNERS IN THE DEPARTMENT/UNIT TO ADDRESS THE SIX COMPONENTS OF THE HEALTH SYSTEM, INCLUDING:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Service provision</td>
</tr>
<tr>
<td>- Healthcare personnel</td>
</tr>
<tr>
<td>- Health information system</td>
</tr>
<tr>
<td>- Medical products</td>
</tr>
<tr>
<td>- Financial considerations</td>
</tr>
<tr>
<td>- Governance</td>
</tr>
</tbody>
</table>
CHAPTER 6: INTERVENTIONS IN THE CONTEXT OF A CRISIS

3. ANOTHER PRIORITY IN TERMS OF SRH: COMPREHENSIVE ABORTION CARE

Once the priority activities of the MISP detailed above are implemented, they must be complemented by other activities, notably access to comprehensive abortion care. Ideally, IAWG recommends that care linked to safe abortion within legal boundaries are effective within 3 months after the beginning of the crisis. It is essential to include these services during the transition to comprehensive services. Let us remember that in many contexts, the legal authorisations of comprehensive abortion care are minimal, limited to certain reasons and certain conditions, notably when the woman’s health is at stake or in the case of rape.

In countries where the law is restrictive, depending on MdM’s intervention strategy in the area and after a comprehensive analysis of context including the legal framework, activities in relation to abortion may nonetheless be undertaken (see chapter 4. VI. Provision of care for unwanted pregnancies and comprehensive abortion care, and MdM practical sheets: Management of unwanted pregnancies and comprehensive abortion care).

4. NECESSARY MEDICAL EQUIPMENT AND DRUGS

In most crisis contexts, inter-agency SRH kits will be available. These kits will be available from the UNFPA which should be contacted at the start of the intervention. If no kits are available from the UNFPA or the WHO or if delays in provision are too important, the SRH materials will have to be integrated into international orders, in the form of kits or in bulk (for further information, please refer to the list of materials suggested Appendix 2). The emergency stock at MdM also includes an SRH kit. The following table presents the different inter-agency SRH kits available from UNFPA. The detailed list of what is in each kit is available from IAFM11, which helps evaluate the necessary amounts of materials with regards to the population whose needs are to be covered.

<table>
<thead>
<tr>
<th>Kit number</th>
<th>Kit name</th>
<th>Color code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kit 1A</td>
<td>Male Condoms</td>
<td>Red</td>
</tr>
<tr>
<td>Kit 2</td>
<td>Clean Delivery (A and B)</td>
<td>Dark blue</td>
</tr>
<tr>
<td>Kit 3</td>
<td>Post-Rape Treatment</td>
<td>Pink</td>
</tr>
<tr>
<td>Kit 4</td>
<td>Oral and Injectable Contraception</td>
<td>White</td>
</tr>
<tr>
<td>Kit 5</td>
<td>Treatment of Sexually Transmitted Infections</td>
<td>Turquoise</td>
</tr>
</tbody>
</table>

Primary Health Care Facility Level (BEmONC): Primary Health Care Facility Level (BEmONC) kits contain both disposable and reusable material, for use by trained healthcare providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a 3-month period. It is possible to order theses kits for a population of less than 30,000 persons, this just means that the supplies will last longer.

<table>
<thead>
<tr>
<th>Kit number</th>
<th>Kit name</th>
<th>Color code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kit 6</td>
<td>Clinical Delivery Assistance – Midwifery Supplies (A and B)</td>
<td>Brown</td>
</tr>
<tr>
<td>Kit 8</td>
<td>Management of Complications of Miscarriage or Abortion</td>
<td>Yellow</td>
</tr>
<tr>
<td>Kit 9</td>
<td>Repair of Cervical and Vaginal Tears</td>
<td>Purple</td>
</tr>
<tr>
<td>Kit 10</td>
<td>Assisted Delivery with Vacuum Extraction</td>
<td>Grey</td>
</tr>
</tbody>
</table>

Referral Hospital Level (CEmONC): Referral Hospital Level (CEmONC) kits contain both disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. In acute humanitarian settings patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional case load. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a 3-month period.

<table>
<thead>
<tr>
<th>Kit number</th>
<th>Kit name</th>
<th>Color code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kit 11</td>
<td>Obstetric Surgery and Severe Obstetric Complications Kit (A and B)</td>
<td>Fluorescent Green</td>
</tr>
<tr>
<td>Kit 12</td>
<td>Blood Transfusion</td>
<td>Dark Green</td>
</tr>
</tbody>
</table>

NOTE: The Inter-agency Emergency Reproductive Health (IARH) Kits are categorized into three levels targeting the three health service delivery levels: The kits are designed for use for a 3-month period for a specific target population size. Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. As these kits are not context-specific or comprehensive, organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP to comprehensive SRH.

In Uganda, MdM implements the whole package of priority activities mentioned in the MISP. To integrate comprehensive abortion care we organised, in collaboration with the NGO IPAS, workshops on value clarification and attitude transformation directed at the whole staff and teams of the hospital supported by MdM. This was an opportunity to introduce MdM’s work in countries where the law is restrictive, depending onMdM’s institutional position on the question of unwanted pregnancies and abortion, and also to clarify the legal framework in Uganda. These activities were a success. Several healthcare practitioners who were reluctant at first then volunteered to be trained on medical abortion and MVA. These workshops can be considered a crucial determinant of the success of the project. The presentation of the positioning also largely contributed to convey a sense of safety within the teams towards the implemented activities.’

Blandine Britis Betbeder, Medical Coordinator, Uganda

CHAPTER 6: INTERVENTIONS IN THE CONTEXT OF A CRISIS

III. FOCUS ON PREVENTION AND MANAGEMENT OF GBV

1. DEFINITION

Gender-based violence (GBV) can be defined as ‘any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (gender) differences between men and women.’

GBV is a consequence of inequalities in society and of the vulnerability of certain people, notably women. The term is most commonly used to refer to violence against women. The term is most commonly used to refer to violence against women. The term is most commonly used to refer to violence against women. The term is most commonly used to refer to violence against women.

Regarding types of violence, MdM suggests the following classification which combines the definition by UNFPA with the classification developed by the inter-agency working group on SRH in crisis situations: 

- **Sexual violence**, including rape, sexual abuse, sexual exploitation, sexual harassment and forced sex trade
- **Physical violence** (beating, burning, biting, attempted murder, feminicide, etc.)
- **Psychological violence** (insults, blackmailing, harassment, rejection, etc.)
- **Early or forced marriage and harmful traditional practices**
- **Human trafficking** including sex trafficking and child trafficking
- **Denial of resources** and lack of perspectives based on gender, sexual orientation and/or gender identity
- **Harmful acts on the basis of sexual orientation and gender identity** (which can be physical, psychological, economic, social, etc.)

For monitoring purposes, and in accordance with the GBVIMS developed by the UNFPA, MdM utilises six categories of violence in the case of interventions in the context of a crisis:

- **Rape**
- **Sexual assault**
- **Physical violence**
- **Forced marriage**
- **Denial of resources and opportunities**
- **Psychological violence**

THE GBVIMS® is an information management system set up by UNFPA, ICR and HCR. It enables actors providing services to survivors of GBV to securely collect, store, analyse and share data in relation to reported situations of violence. The system also enables to compile data between different actors and therefore produce global results for a given context.

2. UNDERSTANDING THE ISSUE

Gender-based inequalities and discriminations along with misrepresentations and power abuse can be found in all societies. The occurrence of a crisis exacerbates the pre-existing patterns and norms and adds new risk factors by multiplying the sources of economic vulnerability, promiscuity, crowded environments, isolation (in particular for women, children and adolescents), displacement and insecurity. An environment then develops that is prone to GBV, notably sexual, psychological or physical violence. This violence may be perpetrated by intimate partners, family members, neighbours or members of the community, participants to the conflict, state or non-state actors. Sexual violence may also be used as a tactic of warfare or a means of repression.

In emergency situations, assessing the prevalence of GBV is extremely difficult. First, access to health data in general is limited. A majority of survivors of GBV do not access care.

In post-conflict situations, when access to health services progressively comes back to normal, girls and women continue to undergo important levels of GBV. Moreover, girls and women who were exposed to violence during the crisis, notably sexual violence, face many obstacles in reintegrating society due to social stigma.

3. MdM’S INTERVENTION STRATEGY

In crisis contexts, MdM seeks to develop multidisciplinary response strategies in order to enable to identify survivors and help them access medical services, mental health services, psychosocial support, legal assistance, protection and social and economic reintegration services. MdM alone cannot guarantee all aspects of care, therefore it is essential that the response be coordinated with other actors of humanitarian aid, helped by effective referral mechanisms and based on a partnership approach. This must be undertaken while preserving a survivor-centred approach. The different elements of MdM’s SRH strategy in a crisis context, specifically including management of GBV, are developed in Guidance notes on SRH & GBV in crisis settings.

The fear of retaliation (by the author(s) or by the family), shame, helplessness, stigmatisation, insecurity, lack of knowledge of available services or lack of trust of humanitarian actors of public services are some of the barriers to care. This explains the need for MdM to be proactive in identifying survivors.

12. IAWG, Inter-agency Field Manual on Reproductive Health in Humanitarian settings, 2018
13. UNFPA, Managing gender-based violence programmes in emergencies - E-learning companion guide
14. IAWG, Inter-agency Field Manual on Reproductive Health in Humanitarian settings, 2018
For MdM, responding to GBV implies setting up a core set of activities from the onset of the response to the crisis. This core set of activities will help guarantee access, within the facilities supported by MdM and/or mobile clinics, to medical care, mental health care and psychosocial support. The question of establishing a medical certificate must also be considered at this stage and survivors who wish to must be able to obtain it.

Complementary projects will then be added to this core set of activities that will extend the response provided. These activities will be implemented depending on the constraints and opportunities in a given context, comparable to the pieces of a jigsaw puzzle that are added one by one. These activities should not be considered to be optional, only in the context of a crisis they may take more time to be implemented. The following figure represents the core set of activities and the complementary activities.

4. ELEMENTS OF CARE RELATED TO THE CORE SET OF ACTIVITIES

a) Medical care

So as to prevent individual consequences on health, survivors of rape (sexual violence with penetration) must have access to medical care as soon as possible and ideally within 72 hours of the assault. Indeed, to be efficient, the prevention of HIV transmission must take place within 72 hours of the assault. Emergency contraception to avoid pregnancy must be administered as soon as possible for maximum efficiency and 5 days at the latest after the assault (diminished efficiency). Medical care is based on strict ethical principles. It consists in a succession of crucial steps guiding healthcare professionals that guarantee quality care. This implies the following items to be included in the programmes:

- Ensuring the availability of necessary materials for medical care in the facilities supported by the projects, or the mobile clinics;

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Lucille Terré, GBV Coordinator, Central African Republic

‘The project in Central African Republic began by focusing on opening medical care services for GBV (sexual and physical), by means of training, accompanying and equipping SRH services within health centres. Then, new partnerships established with ‘Association des femmes juristes de Centrafrique’ (Women’s legal experts in Central African Republic) and the IAC enable to set up, within the same health centres, services providing legal and psychosocial support. This enhanced access of survivors to holistic care and enabled to identify cases of GBV by multiplying the possible points of entry for survivors. The presence of the three services in a single location also contributed to strengthening the coordination of service providers and to raising awareness on the stakes of access to cross-sectional care. This was achieved, for example, by raising awareness of health staff on the importance of establishing medical certificates’.

Lucille Terré, GBV Coordinator, Central African Republic
In Nigeria, in the state of Borno, MdM provides health services to populations impacted by the crisis caused by the Boko Haram armed group. The service package includes the MISP, and notably the management of survivors of GBV, including sexual violence. These services provide medical care and psychosocial support. Despite community awareness-raising activities, the services remain underused, and the survivors only access the health facility several weeks to months after the assault. This long delay impedes the provision of a post-exposure HIV prophylactic treatment which must be initiated within 72 hours, or the prevention of a potential pregnancy by the prescription of an emergency contraception within 120 hours after the rape.

To better understand the different factors influencing access to rapid medical care, MdM undertook a social and anthropological research, in partnership with the Population Council organisation. Using qualitative methods, this research will analyse social norms surrounding GBV, behaviours in terms of care and barriers faced by survivors in accessing care. While there is very little data on GBV in crisis situations, this study will enable MdM and the overall field of humanitarian aid to be better equipped to respond to the needs of survivors.

Aurélie Leroyer, Programme manager for GBV and crisis

b) Intervention in mental health and psychosocial support

Crisis situations cause multiple psychological and social changes that affect not only individuals but also their families and community ties, which leads to situations of vulnerability and to an incapacity to respond to the most basic needs. In addition, violence reinforces the risk of psychological distress and compromises the psychological and social balance of populations. Mental health and psychosocial support (MHPSS) are core elements of caring for survivors of GBV. The interventions set up must seek to implement global care, responding to

medical, psychological and social needs, and must be, as integrated as possible to primary healthcare services and/or other services such as sexual and reproductive health services, existing community support mechanisms, etc.

For effective prevention and care of mental health disorders, the activities implemented must be set up at individual and community level. Interventions directed at the community seek to strengthen survivors’ well-being by improving their environment.

At individual level, the aim is to enhance capacities survivors’ capacities for resilience as well as their coping strategies. The capacity for resilience depends on risk factors that individuals might be exposed to, but also of protective factors that enable individuals and communities to respond to situations of difficulty and distress. Activities towards psychosocial support aim at creating or restoring the social functioning of the impacted population and the emotional and psychological balance of individuals within their social environment.

It is essentially about responding to people’s basic needs, including ensuring access for survivors to medical care.

In terms of MHPSS, this includes the following activities:
- Mapping the available services to orient survivors to actors who can respond to their various needs (shelter, food, protection, MHPSS, etc.);
- Providing training, from the onset of the response, to the health personnel in charge of psychological first aid care and raising their awareness on the necessary skills for clinical interviews (empathy, active listening and confidentiality);
- Encouraging taking account of needs in MHPSS in different areas of intervention: protection, health, nutrition, food safety, camp management, water and sanitation, etc.;
- Promoting measures of protection of survivors and secured spaces.

c) Confidentiality issues

Respect for confidentiality is an essential premise before setting up any intervention in relation to the management of GBV. To achieve it, it is essential that the whole staff be made aware of this issue and formally commits to guaranteeing confidentiality (MdM has developed a written document to sign regarding committing to confidentiality for the management of sensitive data: see Guidance notes on SRH & GBV in crisis settings. Guidance note 2.10: Data management). It is also necessary that the facilities have good visual insulation and are soundproof, and that the organisation of the space enables confidentiality to be preserved. The patient pathway must be conceived to enable discretion and avoid stigma. Moreover, the data regarding GBV is very sensitive due to the relationship to health, sexual life and geographical origin of survivors which enables a person to be identified, recognised or traced. Managing this data implies to apply strict security measures in line with the directing principles defined by the WHO regarding personal data protection and protection of privacy, notably the principle of confidentiality, the principle of ‘doing no harm’, fundamental rights and freedom and more specifically respect for consent. Given the nature of the data and the risk presented by its management, it is mandatory to set up security measures guaranteeing the confidentiality of information, i.e. preventing the data from being distorted, damaged or accessed by unauthorised persons. Securing this information is to be considered at every stage of the person’s care, from the first point of contact and throughout the continuum. It concerns collection, storage, analysis and destruction of data. Any actor intervening directly or not in the management and follow-up of a survivor of GBV’s data must apply the same measures of precaution. That person may be held responsible for any rupture of confidentiality, given the severe consequences that it can have for the person’s survival, health and integrity, and also for other members of the health staff.

d) Coordination mechanisms

A response to GBV requires a cross-sectional approach. No facility, agency, organisation or group of actors alone can have a mandate, the capacity or the resources to provide a comprehensive response. Coordination is therefore essential.

To achieve it, it is necessary to address the following:
- Identifying the organisation in charge of coordinating the response to GBV (lead of the GBV sub-cluster, if it is in place);
- Identifying actors involved in medical and psychosocial care of GBV;
- Actively participating to coordination mechanisms.

Coordination takes place at different levels:
- On a national level with the actors of humanitarian aid: when clusters are activated, the coordination takes place within the GBV sub-cluster;
- On a bilateral level: this is about coordinating the care of survivors (case management);
- Within a partnership approach: depending on context, partnerships are formalised notably with local actors than will enlarge the services provision while supporting the sustainability of the actions undertaken, their acceptance by the population and the complementarity of the activities developed.

e) Referral system

It is essential that survivors of GBV have rapid and reliable access to medical care, and to mental health care and psychosocial support, but also to protection services and, when possible, legal support. Setting up a referral system in addition to MdM’s care is crucial. This requires networking activities together with actors involved in management of GBV. Establishing referral pathways must detail the locations of care and modalities of access. A referral system must be set up rapidly based on a mapping of actors and
assessment of the quality of existing services provided by various actors (via visiting facilities and maintaining regular contact.

So as to enhance cross-sectional management of survivors of GBV, one reference service should ideally be identified for each area of intervention and for the following elements of care:

- Medical care when it is not available within MdM projects;
- Mental health care and psychosocial support when it is not available within MdM projects;
- Secondary healthcare facilities;
- Legal assistance;
- Protection and temporary shelters.
CHAPTER 7

EMPOWERING INDIVIDUALS AND COMMUNITIES TO TAKE ACTION
CHAPTER 7: EMPOWERING INDIVIDUALS AND COMMUNITIES TO TAKE ACTION

I. DÉFINITIONS / CONCEPTS

1. EMPOWERMENT

Empowerment is both an objective and a process through which individuals and groups of people develop their ability to take action and transform their environment and living context. When applied to the field of health, it is the process through which an individual or group develops their capacity to take control of the factors that affect their health. This process is based on the development of an individual and collective critical conscience, the identification and questioning of relationships of power and domination, which are the roots of inequality, towards the goal of equity and social justice.

Empowerment is a process individuals and groups engage in as actors and beneficiaries. The process begins before the intervention of MdM and will continue afterwards. The question that is asked here is, at the crossing point where we meet with populations, how do we contribute to that empowerment process?

Inequalities, exclusion, poverty, bad health are often attributed to the inner characteristics of the rejected individuals (‘the poor man is poor because he makes no effort’, ‘the sick woman is sick because she does not take care of her health’, etc.) This attitude trivialises and perpetuates inequalities and it ignores the relationships of power and domination that underpin them. It also contributes to stigmatisation and self-blame of the excluded people who may experience the feeling that they are, as individuals, entirely responsible for their exclusion.

Developing critical consciousness is a fundamental element of the process of empowerment and consists in the acquisition of different levels of consciousness:

- **Collective consciousness**: ‘the individual is not the only one confronted with their problems’;
- **Social consciousness**: ‘individual or collective problems are influenced by structural, social and cultural factors’;
- **Political consciousness**: ‘finding solutions to structural problems’.

2. CRITICAL CONSCIENCE

1. See: What is empowerment for Médecins du Monde?, MdM, 2019
requires social change.’ Developing critical consciousness means inviting and encouraging individuals and communities to question and analyse their everyday life and the determinants of their SRH, to help construct the consciousness that change is possible, and support the collective action to operate that change.

3. POWER

‘Power’ is the key word lying within empowerment. SRH is closely linked to power relationships that take place in many settings (intimate, family, work, political or religious settings). The exercise of power can be visible (in legislation, institution, physical power), hidden (corruption, nepotism and favouritism), or invisible (through cultural and social traditions and norms, socialisation, stereotypes, moral judgement, etc.). In our projects promoting SRHR we must have a subtle understanding of the issues of power at stake and analyse how we can contribute to transforming them. The following 4 forms of power can be useful in conducting this analysis:

a) The ‘power within’

The ‘power within’ refers to dignity, self-esteem and the ability to free oneself from the effects of interiorised oppression. People who are systematically excluded from spheres of influence and decision internalise and trivialise the messages they receive regarding how they are expected to behave. This has an important effect on their ability to make choices, exercise their rights or access services. To cite an example, women and girls are traditionally socialised in such a way that their sexuality serves their partners desire. For that reason, they have less knowledge on their body, their sexuality, their desire and their needs. Diverse actions may participate in strengthening the ‘power within’ in terms of SRH: creating value with and mobilising people’s strengths and skills, creating spaces and opportunities for active participation, developing activities to enhance knowledge, self-esteem, autonomy in managing SRH, training activities and awareness-raising activities on health and rights, peer-support, value clarification and attitude transformation activities for professionals...

b) The ‘power to’

The ‘power to’ is the process through which an individual or group reaches the ability to make decisions and choices. This includes the capacity to decide, show authority, solve problems. It is based on a sense of self-efficiency, i.e. the belief that our actions can have effects. Professionals can impede self-efficiency by considering people as unable to make their own choices or by making decisions instead of them, which is often the case, for example, for adolescents and young people. The activities that may contribute to developing the ‘power to’ are the following: psychosocial activities and workshops regarding life skills¹, training on negotiation, training on self-defence, counselling, information and participation of individuals in therapeutic choices (curative or preventive), providing multiple choices, recognition, valorisation and strengthening of competencies and capacity of analysing one’s own situation. It also implies working on access to resources and services as well as professionals’ attitudes.

c) The ‘power with’

The ‘power with’ is the ability to act collectively through solidarity and

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² The term ‘life skills’ refers to individuals’ competencies and capacities to adapt to the challenges and requirements of daily life. ‘Life skills’ are categorised in 4 groups: 1. Cognitive capacities or critical thinking enabling the adequate analysis and use of information 2. Competencies in relation to problem solving or conflict solving 3. Personal abilities that strengthen one’s capacity to listen, make decisions for oneself and self-regulate oneself 4. Interpersonal capacities in communicating and effectively interacting with others.
CHAPTER 7: EMPOWERING INDIVIDUALS AND COMMUNITIES TO TAKE ACTION

4. PARTICIPATION

‘Transforming societies requires participation, including communities working together with health services to reach common health goals’.

Ensuring participation of the people who are directly impacted by our projects and supporting their participation in the development of the health policies that affect them is one of the core principles of MdM.

Participation is defined at both an individual and collective and community level. Each individual has the right to participate in the decisions affecting his/her own health, including therapeutic choices regarding his/her SRH. This requires, among other elements, the right to access reliable evidence-based information that is understandable and applicable to the individual’s life context. It is also based on a shared power and knowledge, and co-decision by health personnel and their patients. At community level, participation requires our active support towards the participation of the people affected throughout all stages of our projects cycles: identifying priorities, planning, implementing and evaluation. Finally, we must support communities to assert their rights to participation before institutions and other health actors so that they are sustainably associated to the development of the health services and policies that affect them.

5. EMPOWERMENT AND RIGHTS-BASED APPROACH

SRH rights originate from various rights mentioned in treaties and other regional and international legal tools (such as the SDG framework) which the States are legally or morally bound to. A rights-based approach implies acknowledging these rights via advocacy actions for the implementation of different reference texts on human rights and the effective respect of these rights at national, regional and international level. These rights are all too often merely theoretical and are regularly questioned. For them to become a reality, each individual and community must have the capacity to assert them. This requires to be aware of these rights, to be able to measure the difference between legal dispositions and the reality of implementation or non-implementation in daily life, and to use all available levers (advocacy, legal action, collective action, civil disobedience, etc.) to assert them. By contributing to developing the empowerment of individuals and communities in our projects, our aim is to enable each and every human, as rights holders, to claim and exercise the entirety of their rights.

6. GENDER-APPROACH AND EMPOWERMENT

The terms ‘empowerment’ and ‘empoderamiento’ have been used by southern feminist activist movements in the 80’ to suggest an alternative to the stories of development policies that presented women in the South as being victims only.

They developed an approach that does not homogenise women from the South but rather takes account, in context analysis, of the multiple causes leading to situations of oppression of women from the South (patriarchal...
societies, colonial and neo-colonial dependencies). Appropriate responses include accompanying women and men in the development of a stronger power within (self-esteem, psychological and physical well-being) and better access to and control of natural, social, financial, educational and political resources. It is also about developing consciousness of reality and of the issues that individuals experience and developing their individual capacity to make decisions to change that reality. Finally, it is the question of developing decision making to act and exercise more control over one's own decisions.

Developing an empowerment strategy is a core element in the continuum of the gender approach and in the response to gender inequalities. It was also cited in the Beijing Declaration of 1995:

‘Women’s empowerment and their full participation on the basis of equality in all spheres of society, including participation in the decision-making process and access to power, are fundamental for the achievement of equality, development, and peace’

The needs in empowerment of women are described in three areas:

- Sexual and reproductive rights (control over sexuality and body but also in terms of childbirth, reduction and elimination of all forms of violence over women, etc.)
- Economic rights (fighting to reduce vulnerability and economic dependency of women, enhancing well-being of women and families)
- Political and legal rights (better access and control over community management and institution transformation, laws, etc.)

MdM targets four priority areas to enhance empowerment in our actions:

1. INVOLVEMENT IN THE PROJECT CYCLE

‘When given the opportunity, communities can develop effective strategies to address their needs and reduce mortality and morbidity. These strategies are often highly innovative, practical, and culturally acceptable.

Julan Huang, Prevention Worker on the Lotus Bus Programme, France
What is scaled-up is not solutions but a process to support communities to develop their own solutions.6

We must adapt the methodologies of participative projects to enable individuals and communities that are directly affected to become true actors of our projects from the development to the evaluation and transfer. It is also about encouraging the participation of people, communities and community organisations that are directly affected in managing and governing the project, and systematically involving them in the project evaluation stage. This approach requires flexibility and respect for individuals and communities’ pace.

a) Diagnosis and development

The use of participative methodologies in diagnosis and prioritisation by involving the most affected people and communities provides with the best possible knowledge and understanding of the intervention context. It also helps people become an active part of the project from the beginning, ensuring higher ownership and involvement in the future, and contributes to strengthening the individuals’ capacity to analyse and understand their own situation. In addition to the identification of health issues, it is also important to identify the strength and resources of individuals and communities that can be used to reach the project aims.

b) Planning and implementation

During that phase, we must ensure continuous participation of the people involved in the project - through all aspects of accountability. It is also about creating opportunities for beneficiaries to be involved in the monitoring and management of our projects by integrating representatives in management and/or governance boards. Moreover, we must, as far as possible, foster opportunities for active participation in the implementation of our actions through proactive recruitment and support policies to enhance the use of the communities’ resources and competencies. Finally, we must delegate resource management as much as we can to communities.

c) Evaluation and capitalisation

Assessing the effective impact of our actions (and the quality of that assessment) is directly linked to the level of participation of the beneficiary population in the evaluation of a project. Participation in evaluation does not merely consist in a simple consultation. It must integrate beneficiaries in defining what elements must be evaluated and in determining how to assess the elements. It is about integrating people in the analysis of the information collected, collect suggestions for change and adjustments of actions.

EXAMPLE OF A PARTICIPATORY PROJECT AROUND SRH IN NEPAL

‘A large-scale study was conducted in rural Nepal in 1998, which showed that education sessions directed at new mothers had had little or no impact on neonatal mortality’. Five years later, the same research team conducted a large-scale study on the impact of participatory health programmes which demonstrated a significant impact on maternal health and a decrease of neonatal mortality by 30% in comparison to zones with no participatory approach. In each participating community, around ten meetings were organised with women’s groups who were led to identify health problems in relation to maternity and propose solutions. Financial aid and support were provided to help them achieve their projects. It is interesting to notice that, despite the fact that only a minority of women participated in the groups, the project had a larger impact on the overall community. Moreover, the impact was sustainable, given that a year after the end of the research 95% of groups will still active without external support.’


2. HEALTH EDUCATION AND PROFESSIONAL VALUES AND ATTITUDE EDUCATION

In the context of an empowerment approach, health education refers to the practices that reinforce the power and freedom of individuals and communities to adopt healthy behaviours and lifestyles. It does not only concern information about health. It is more than just that, as it seeks to give people knowledge, attitudes and skills to be able, if they wish to, to change their behaviour. It necessarily goes with a consideration given to individuals and communities’ contexts, sociocultural determinants of health and power dynamics, all of which impede their capacity to take on health-enhancing behaviours. A health education approach acknowledges individuals as the experts of their own health and builds on their knowledge, their assets and their experiences.

In practice, this involves awareness-raising and training of professionals so that they adopt the attitude of a facilitator centred around the choice and rights of the beneficiaries. Training on counselling, aid relationship, receiving and listening skills and patients’ rights are some of the activities that can participate in achieving this goal.

We must also ensure the participation of community members in the development of strategies and health information, education and communication tools. This participation can take many forms: participatory research to explore knowledge, attitudes and practices of the community in relation to SRH, focus groups and workshops to develop key messages and identify appropriate channels of communication, forming ‘pilot groups’ to evaluate and adjust communication tools, participation of
community members in the creation or production of communication tools (videos, theatre plays, radio broadcasting, podcasts, visual tools, etc.), sharing of information between peers. When forming the groups, particular attention must be given to their representativeness (in terms of level of education, languages, literacy, etc.)

Individuals’ participation helps ensure that the messages make sense with regards to the local culture and to acknowledge and bring to light individuals’ expertise and competencies. In many cases, the people involved in the development of tools will play an active role in sharing the associated contents with their community.

The mechanisms involved must enhance sharing and mutual learning between the community and the external professionals and may lead to negotiation on what can be said or done with regards to the local context. Professionals ensure that the contents developed are technically correct and that they do not contribute to reinforcing stereotypes. For populations, it helps break away from the negative view on health education, often perceived as a form of control and imposition of knowledge. Finally, community members can participate to developing communication tools for their community as well as training and communication tools for professionals. It can participate in a better consideration by health professionals of the views and experiences of their patients. One of the best ways to promote individual’s participation in health education is through peer involvement, whereby members of the community act as intermediaries in their communities by becoming educators and healthcare workers. Community workers must benefit from adequate and sufficient support (in terms of training, supervision and recognition, etc.) to enable them to fulfil their essential role without putting their health, safety or well-being at risk.

To facilitate the implementation of awareness-raising activities directed at young people and adolescents, we wanted to develop a picture box on the theme of SRH. To develop this tool, we collaborated directly with care givers and young people and adolescents themselves. To achieve this, we worked with school societies to identify the adequate pictures to use and how to formulate the messages. The box was then validated during a workshop with representatives of school societies and care givers. We received positive feedback on the use of the box. The involvement of young people helps ensure a genuine adequacy between the tool and the targeted audience.

Florence Koni Kouadio, Field Coordinator, Republic of Ivory Coast

3. SUPPORT TO INDIVIDUALS’ AND COMMUNITIES’ ADVOCACY ACTIONS

It is about supporting individuals and communities in the formulation and expression of their own policies and encouraging the development and structuring of their own advocacy strategies. This implies, among other things, training, networking and provision of necessary resources. To enable people to construct and lead their advocacy action, we must make sure to foster a supportive environment: promoting the development of collective communal spaces where people can exchange and share information, informing people of their rights, training them to the tools to assert these rights, and putting them in contact, when possible, with locally competent people who can offer assistance in supporting the community in asserting their rights (legal experts, organisations, lawyers, etc.). Other activities may contribute to structuring and implementing the advocacy project such as public speaking, argument formulation, lever and target identification, media training, etc. We must support communities to develop a network of partners and collaborators and enhance coalitions. Alongside this support to communities in leading their own advocacy actions, we must ensure participation of the population in MdM’s advocacy in SRHR. Decision makers are more or less inclined to hearing the voice of the population. Some prefer to engage with an NGO that acts as a ‘filter’. However, accepting that role sometimes justifies the political and social exclusion of communities. While sharing our expertise we must also defend the right to speak and self-representation of marginalised populations and report when decision-makers fail to take their voice into account. Faithful to the principle ‘nothing about us, without us’ we must make sure never to talk in the name of the people directly affected as this presents a risk to deprive them of an opportunity to develop their empowerment and make themselves heard.

4. SUPPORT THE CREATION AND DEVELOPMENT OF COMMUNITY ORGANISATIONS

This is about supporting the creation and structuring of community organisations and about strengthening the capacity of these organisations. In the diagnosis stage and during the implementation of our projects, we must identify all the informal groups and organisations that already exist and are likely to contribute to individuals’ empowerment and involve them, as far as possible. They can be groups of the civil society (self-support, young people or women’s groups, users’ organisations or community organisations) or institutions and bodies acting as representatives of the population (neighbourhood committee, health boards, local representatives).

When such groups do not exist, we can participate in their creation by facilitating the creation of communal
collective spaces for discussion and help bring to light a common issue and failure to protect human rights. By making our own resources available, seeking the support of other actors and, on the basis of a shared diagnosis, we can strengthen the capacities of these organisations through administrative support, training (on SHRH, project planning, advocacy, etc.) and logistic support. We can also contribute to reinforcing networks of actors of the civil society (inter-agency platforms, advocacy coalitions) on a local, national, regional and international level around common values and objectives. Based on an intersectional approach, we must also promote coalitions of actors from different horizons. Finally, to ensure the sustainability and the autonomy of organisations of the civil society, we must support them in developing their financial strategies and improving funding research. Alongside this, we must identify and raise-awareness of potential funders to encourage them to provide financial support to actors of the civil society and support their actions towards empowerment.

EXAMPLE OF THE YOUNG AMBASSADORS OF WESTERN AFRICA

In Western Africa, young people face many obstacles to becoming actors of their sexual and reproductive life. Half the woman give birth to their first child during adolescence, and in the whole sub-region, 225 women die each day of complications linked to birth. The contraceptive prevalence is also very low - 11% only for young people and adolescents. Up to now, health policies regarding access to contraception were primarily developed by older men who are not representative of the population. Young people’s and young women’s voices, in particular, are not heard.

Numerous actors of the civil society have advocated for a higher participation of young people in developing policies through the creation of the network of Young Ambassadors. These young people, aged 15 to 30 years old, mostly come from organisations of the civil society. They are volunteers and activists. They defend the interests and rights of young people in the development of policies regarding access to contraception, ensure these policies receive adequate funding and represent young people in various decision-making boards (commissions, steering committees, etc.). MdM and other organisations support them via training and strengthening competencies so that they can make young people’s voice heard.*

*For further information, see Empowerment en Pratique #2: Les jeunes ambassadeurs : Quand les jeunes sont acteurs du changement social (Empowerment in Practice 2: Young Ambassadors: when young people are actors of social change). ([lien URL])
III. SPECIFIC ELEMENTS OF IMPLEMENTATION OF AN EMPOWERMENT APPROACH TO SRH PROJECTS

While there are many good reasons for us to be committed to the principle of empowerment in our projects, there are as many (bad) reasons for it to be considered secondary in the heat of the action: financial constraints, time issues, emergency management, pressures from authorities, feeling that it is too complex...

We should never be discouraged! We are all capable of including empowerment in our actions. Here are some key elements for guidance:

FOR EAR

“We were born with two ears and a mouth. This is because we must listen twice as much as we speak.”

Listening means to put yourself in someone’s shoes, to understand the world from his/her point of view. It is the foundation of an empowerment approach and it must be at the heart of all individual relationships as well as in the organisation and structuring of our projects.

FOR MOBILISATION

Mobilisation in the field of health is the process of reinforcing capacities through which individuals, groups and organisations plan, implement and evaluate activities in a continuous and participative manner. The ultimate goal of community mobilisation is not only the resolution of the problem, but it is also about strengthening of communities’ capacity to act as a whole to respond to their needs and influence their environment.

FOR PARTICIPATION

Empowerment cannot be reduced to participation, i.e. the shift from silent assistance to participation to debate and decisions. Nonetheless participation is an important lever of empowerment. To achieve effective participation, it is necessary that individuals have the right to participate in the decisions that directly affect them, including the development, implementation and monitoring of health interventions.

FOR OPPORTUNITIES

Accompanying the empowerment process of marginalised populations implies the acceptance of an extent of helplessness, as we are not in charge of their destiny. It is then difficult to measure our contribution in the light of where the process takes us, as we do not decide the destination. What can be measured however is the opportunities that we created and seized to help people move forward on their pathway to empowerment. This requires extreme flexibility and some extent of opportunism to achieve.

FOR VALUES AND VOICE

Such an approach is based on certain core values that we must embody, promote and defend such as the notion of social justice, solidarity and democracy and the right for all individuals to participate in decisions impacting them. Empowerment can also serve as a reflector so that the voices of excluded and marginalised populations may be expressed and heard.

FOR EQUALITY

Health unveils profound inequalities that exist in our societies. Empowering marginalised populations must contribute to effective equality in health and effective equality in rights.

FOR RECIPIROCITY

An empowerment approach implies questioning relationships of power between caregivers and beneficiaries as well as between MdM and local partners. It requires the recognition of everyone’s ability to contribute to collective construction and to be a provider, nobody being exclusively limited to the role of the receiver. Creating and acknowledging these reciprocal links forms an essential component of participation which, in turn, contributes to empowerment.

FOR MILITANCY

Promoting empowerment is not easy. Sometimes, it may seem easier or quicker to act or decide instead of other people. If we engage in that approach, it is not to make things easier but out of militancy, as we are convinced that it is the key for social change.

FOR EQUITY

Equity in health means that everyone has the same opportunities to achieve their full potential in health and nobody is disadvantaged. Ensuring equity through empowerment requires inclusive and voluntary consultation mechanisms, always seeking to involve the most marginalised people. When developing the power to take action of some people we must ensure that it is not at the expense of other even more marginalised people.

FOR NEGOTIATION

Our priority and methods are not necessarily those of the populations involved. We must be open to negotiation with people and communities but also among professionals of a team; with oneself: where do I stand, what are my true motivations, what can I accept and what must I refuse? We must sometimes know to ‘let go’ and accept the compromise caused by the negotiation. This condition and the capacity to permanently redefine, re-evaluate and readjust our actions are important elements of quality and are determinants of any empowerment approach.

FOR TIME

We must respect the timescale of people and communities and adapt, rather than try to impose our pace. We must recognise and accept that the process of empowerment may be slow and learn to be patient and adjust our projects accordingly. This must not be considered an obstacle to effectiveness but rather the necessary time towards sustainable social change.

7. Proverb attributed to the Greek philosopher Epictetus (1st century of our era)
**ABBREVIATIONS AND ACRONYMS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AFOA</td>
<td>Association for the treatment of obstetric fistulas in Africa</td>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy programme</td>
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<tr>
<td>BCG</td>
<td>Bacille Calmette-Guérin (tuberculosis vaccine)</td>
</tr>
<tr>
<td>BEmONC</td>
<td>Basic Emergency Obstetric and Neonatal Care</td>
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<tr>
<td>CAC</td>
<td>Comprehensive Abortion Care</td>
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<tr>
<td>CAOA</td>
<td>Centre d’Accueil, d’Orientation et d’Accompagnement [Reception, referral and support centre]</td>
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<tr>
<td>CASO</td>
<td>Centre d’Accueil, de Soins et d’Orientation [Healthcare, advice and referral centre]</td>
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<tr>
<td>CC</td>
<td>Cervical cancer</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
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<tr>
<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Neonatal Care</td>
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<td>CHW</td>
<td>Community health worker</td>
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<td>CSE</td>
<td>Comprehensive sexuality education</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DPT</td>
<td>Diphtheria, pertussis (whooping cough) and tetanus</td>
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<tr>
<td>EC</td>
<td>Emergency Contraception</td>
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<tr>
<td>EVA</td>
<td>Electric vacuum aspiration</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>FP2020</td>
<td>Family Planning 2020</td>
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<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
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<td>GBVIMS</td>
<td>Gender-Based Violence Information Management System</td>
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<tr>
<td>HAS</td>
<td>Haute Autorité de Santé (France) [French Health Authority]</td>
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<tr>
<td>HEADSSS</td>
<td>Home, Education/ Employment, Activities, Drugs, Sexuality, Self-image and Safety</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>HR HPV</td>
<td>High-risk Human Papilloma Virus</td>
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<tr>
<td>IAC</td>
<td>Inter-African Committee</td>
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<td>IAMF</td>
<td>Inter-Agency Field Manual</td>
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<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>ICRC</td>
<td>International Committee of the Red Cross</td>
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<td>IEC</td>
<td>Information, education, communication</td>
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<td>IUD</td>
<td>Intrauterine device</td>
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<td>IM</td>
<td>Intramuscular</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
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<td>IRC</td>
<td>International Rescue Committee</td>
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<td>ITMN</td>
<td>Insecticide treated mosquito nets</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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<td>IV</td>
<td>Intravenous</td>
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<tr>
<td>KAP</td>
<td>Knowledge, attitude and practice</td>
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<td>LAM</td>
<td>Lactational amenorrhoea method</td>
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<tr>
<td>LGBTQ</td>
<td>Lesbian, gay, bi-sexual, transgender, queer</td>
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<td>LNG</td>
<td>Levonorgestrel</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MdM</td>
<td>Médecins du Monde</td>
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<td>MHPSS</td>
<td>Mental Health and Psychological and Social Support</td>
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<td>MISP</td>
<td>Minimum Initial Service Package</td>
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<tr>
<td>MNT</td>
<td>Maternal and Neonatal Tetanus</td>
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<td>MSF</td>
<td>Médecins sans Frontières [Doctors without borders]</td>
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<tr>
<td>MVA</td>
<td>Manual vacuum aspiration</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NHIS</td>
<td>National Health Information System</td>
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<tr>
<td>OPV</td>
<td>Oral polio vaccine</td>
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<tr>
<td>PEP</td>
<td>Post-exposure Prophylaxis</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
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<tr>
<td>SDI</td>
<td>Sociocultural Determinants</td>
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<td>SDG</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>SRHAY</td>
<td>Sexual and Reproductive Health of Adolescents and Youth</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TBA</td>
<td>Traditional birth attendants</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Emergency Fund</td>
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<tr>
<td>VCAT</td>
<td>Value clarification and attitude transformation</td>
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<tr>
<td>VIA</td>
<td>Visual inspection with acetic acid</td>
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<tr>
<td>WA</td>
<td>Weeks of Amenorrhoea</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</tbody>
</table>
Let us repeat that universal precautions and waste management protocol must be in place in every health facility. Regarding infection control and prevention and sterilisation, it is useful to refer to Worksheets 3.14 and 3.15 in the Reference Framework for Primary Healthcare in Emergency and Crisis Settings.

Regarding general information on essential pharmaceutical materials and drugs, it is useful to refer to Worksheet 3.17 in the MdM Reference Framework for Primary Healthcare in Emergency and Crisis Settings. Equipment and drugs must be purchased based on the validated MdM quality criteria and come from validated suppliers (see MdM Technical Sheets: Quality, Safety, Efficacy - Management of Pharmaceutical Products - Actions throughout the Cycle).

The following tables present the essential general drugs and the recommended basic equipment and necessary materials and are classified according to the type of ward/nature of health issue managed, the attached lists are provided as examples and must be adjusted to context and available resources. The necessary amounts must be determined based on the target population.

1. The list of necessary drugs, consumables and medical materials is based on the following publications:

- IAWG, Inter-Agency Field Manual on Reproductive Health in Humanitarian settings, 2018
- MSF, Essential Obstetric and Newborn Care, 2015 Edition
- WHO, WHO recommendations on antenatal care for a positive pregnancy experience, 2017
- WHO, Selected practice recommendations for contraceptive use, 2017
- WHO, Family planning: a global handbook for providers, 2018
- WHO, Intrapartum care for a positive childbirth experience, 2018
## CATEGORY OF CONSUMABLES / MATERIALS

<table>
<thead>
<tr>
<th>BASIC SRH CONSUMABLES</th>
<th>COMPOSITION</th>
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<tbody>
<tr>
<td>Sterile and no-sterile gloves (several sizes)</td>
<td>Syringes and needles (IM et IV)</td>
</tr>
<tr>
<td>Surgical compress or gauze</td>
<td>Catheters 20G et 22G</td>
</tr>
<tr>
<td>Sticking plaster</td>
<td>Tubing</td>
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<tr>
<td>Intermittent urinary catheter 12, indwelling urinary catheter 12 and 14</td>
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<table>
<thead>
<tr>
<th>CONSUMABLES RELATED TO UNIVERSAL PRECAUTIONS AND HYGIENE</th>
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</thead>
<tbody>
<tr>
<td>Soap</td>
<td>Medical waste bucket</td>
</tr>
<tr>
<td>Safety box</td>
<td>Bleach</td>
</tr>
<tr>
<td>Single-use gloves</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ESSENTIAL SRH EQUIPMENT AND MATERIAL</th>
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</thead>
<tbody>
<tr>
<td>IEC material</td>
<td>Stethoscope, sphygmomanometer and thermometer</td>
</tr>
<tr>
<td>Faetal stethoscope</td>
<td>Tourniquet</td>
</tr>
<tr>
<td>Tape measure</td>
<td>Adult and newborn scales</td>
</tr>
<tr>
<td>Height chart for adults and infants</td>
<td>Examination table</td>
</tr>
<tr>
<td>Examination table</td>
<td>Speculums</td>
</tr>
<tr>
<td>Gestogram</td>
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</tbody>
</table>

## TYPE OF SERVICES / CARE: FAMILY PLANNING / SERVICES OFFERING CONTRACEPTIVE METHODS

### DRUGS
- Iron + folic acid (oral);
- Contraceptives:
  - Combined oestrogen and progesterone pills (oral)
  - Progestogen-only pills (oral)
  - Emergency pill: levonorgestrel, ulipristal acetate
  - Injectable progesterone (IM: Depo-Provera® / Sub-cutaneous: Sayana Press®)
  - Injectable oestrogens and progesterone (IM)
  - Copper IUD (e.g., CU380A) or progesterone IUD (e.g., Mirena®)
  - Contraceptive sub-cutaneous implants (e.g., Jadelle® 2 implants, Implanon® 1 implant)
  - Vaginal ring with progesterone
  - Local methods (spermicides...)
  - Internal and external condoms (male/female)
  - Local anaesthetic: lidocaine (injectable or dermal spray);
  - Antiseptic solutions: polyvidone iodine (dermal and vaginal solution), chlorhexidine (dermal solution);
  - Treatment of STI (to be adjusted to national protocols): Benzathine-penicillin (IM), Erythromycin (IV), Azithromycin (per os), Cefixime (per os), Metronidazole (per os), Ceftriaxone (IV), Acyclovir (per os), Clotrimazole (tablet of vaginal cream);
  - HIV treatment: in line with national protocols (depending on epidemiological contexts).

### CONSUMABLES
- Basic consumables (see first table);
- Consumables in relation to universal precautions and hygiene (see 1st table);
- Resorbable suturing threads (vicroyl 3,0), surgical blades;
- Clean surgical drapes;
- For monitoring purposes: health cards, registers.

### MEDICAL EQUIPMENT
- Basics (See first table);
- Insertion/removal of IUD: 1 stainless steel box, 1 cup, 1 Rochester-Pean forceps 24cm, 1 Pozzi forceps 24cm, 1 straight dressing forceps 24cm, 1 uterine sound, 1 speculum 30mm, 1 speculum 35mm, 1 pair of Sims Scissors 20cm, IUD reminder card;
- Implant insertion/removal: scalpel, 1 dissecting forceps, 1 mosquito forceps, Implant reminder card;
- Mini-laparotomy instruments for tying Fallopian tubes (only in CEmONC centres): 1 stainless steel box 1 scalpel, 1 uterine elevator, 1 needle holder, 1 pair of blunt scissors, 1 dissecting forceps;
- Materials for vasectomy (CEmONC centres only): 1 Babcock forceps, 1 dissecting forceps, 1 pair of Sims scissors.

### MEDICAL TESTING
- rapid HIV test (depending on epidemiological contexts);
- pregnancy test;
- materials useful for carrying out a cervical cancer screening (see cervical cancer line).
### DRUGS
- antipyretics: paracetamol (per os);
- anaemia: iron + folic acid (per os);
- solutes: ringer lactate 500 ml and sodium chloride 0.9 % 500 ml;
- antibiotics: amoxicillin (per os), ampicillin (IV, IM) and gentamicin (IV, IM);
- treatments for pre-eclampsia and eclampsia: magnesium sulphate (IV, IM) and its antidote calcium gluconate (IV);
- anticonvulsants: diazepam (IV, IM, intrarectal);
- local anaesthetic: lidocaine (injectable or dermal spray);
- deworming treatment: albendazole or mebendazole (per os);
- malaria treatment: sulfadoxine/pyrimethamine (per os) for preventative treatment and artemether/lumefantrine (per os) for curative treatment;
- antihypertensive treatment: hydralazine (IV) and methyldopa (according to MSF) or nifedipine (according to the WHO) (per os);
- HIV treatment: in line with national protocols (depending on epidemiological contexts);
- Uterotonics: oxytocin (IV, IM) and misoprostol (per os, intravaginal or intrarectal);
- Antiseptic solutions: polyvidone iodine (dermal or vaginal solution), chlorhexidine (dermal solution);
- Vitamins: vitamin K for the newborn (per os or IM), vitamin A pour breastfeeding woman (per os);
- STI treatment (to be adjusted to national protocols): benzathine-penicillin (IM), erythromycin (IV), azithromycin (per os), cefixime (per os), ceftriaxone (IV), metronidazole (per os), acyclovir (per os), clotrimazole (tablet or vaginal cream);
- Eye-care for the newborn: tetracycline 1% eye ointment or polyvidone iodine 2.5%;
- PMTCT: following national protocols.

### CONSUMABLES
- Basic consumables (see first table);
- Consumables in relation to universal precautions and hygiene (see first table);
- For monitoring purposes: antenatal registers, maternal; immunisation card, referral sheets, maternal medical record.

### MEDICAL EQUIPMENT
- Basic equipment: (see first table)
- Other supplies: stretcher, source of light, insecticide treated mosquito nets (depending on epidemiological context);
- Refrigerator;
- Steriliser

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2 As much as possible, both molecules must be available given that their indications are different however, since this is not always possible (e.g. absence of cold chain or of registration of Misoprostol), the availability of at least one of them must be guaranteed.

<table>
<thead>
<tr>
<th>MEDICAL TESTING</th>
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<tbody>
<tr>
<td>HIV rapid test (depending on epidemiological context);</td>
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<tr>
<td>Syphilis rapid test;</td>
</tr>
<tr>
<td>Malaria rapid test or thick smear blade and microscope (depending on epidemiological contexts);</td>
</tr>
<tr>
<td>Urine test strip with detection of glycosuria and proteinuria;</td>
</tr>
<tr>
<td>Necessary equipment to carry out cervical cancer screening (see CC).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VACCINE</th>
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</thead>
<tbody>
<tr>
<td>Antitetanic vaccine.</td>
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</tbody>
</table>

### TYPE OF SERVICES / CARE:
- BEMONC

- antipyretics: paracetamol (per os);
- anaemia: iron + folic acid (per os);
- solutes: ringer lactate 500 ml and sodium chloride 0.9 % 500 ml;
- antibiotics: amoxicillin (per os), ampicillin (IV, IM) and gentamicin (IV, IM);
- treatments for pre-eclampsia and eclampsia: magnesium sulphate (IV, IM) and its antidote calcium gluconate (IV);
- anticonvulsants: diazepam (IV, IM, intrarectal);
- local anaesthetic: lidocaine (injectable or dermal spray);
- deworming treatment: albendazole or mebendazole (per os);
- malaria treatment: sulfadoxine/pyrimethamine (per os) for preventative treatment and artemether/lumefantrine (per os) for curative treatment;
- antihypertensive treatment: hydralazine (IV) and methyldopa (according to MSF) or nifedipine (according to the WHO) (per os);
- HIV treatment: in line with national protocols (depending on epidemiological contexts);
- Uterotonics: oxytocin (IV, IM) and misoprostol (per os, intravaginal or intrarectal);
- Antiseptic solutions: polyvidone iodine (dermal or vaginal solution), chlorhexidine (dermal solution);
- Vitamins: vitamin K for the newborn (per os or IM), vitamin A pour breastfeeding woman (per os);
- STI treatment (to be adjusted to national protocols): benzathine-penicillin (IM), erythromycin (IV), azithromycin (per os), cefixime (per os), ceftriaxone (IV), metronidazole (per os), acyclovir (per os), clotrimazole (tablet or vaginal cream);
- Eye-care for the newborn: tetracycline 1% eye ointment or polyvidone iodine 2.5%;
- PMTCT: following national protocols.
### TYPE OF SERVICES / CARE: BEMONC

#### CONSUMABLES
- Basic consumables (see first table);
- Consumables in relation to universal precautions and hygiene (see first table);
- Cord clamp or string to tie the umbilical cord;
- Clean surgical drapes to put under the mother;
- Suturing threads: vicryl 3.0, 2.0 and 0;
- For monitoring purposes: child health cards, birth registers, immunisation cards and referral sheets.

#### MEDICAL EQUIPMENT
- Basic equipment (see first table);
- Other supplies: stretcher, hospital beds, resuscitation table for the newborn, source of light, ITNs (depending on epidemiological context);
- Gynaecological examination table and delivery table;
- Delivery kit: 1 stainless steel box, 2 pairs of Mayo scissors, 2 Kocher forceps;
- Suture kit: 1 stainless steel box, 1 needle holder, 1 pair of blunt scissors, 1 dissection tweezers;
- Defibulation kit: 1 stainless steel box, 1 pair of Mayo scissors, 1 dissection tweezers, 1 needle holder;
- 1 amnihook;
- Instruments for MVA: vacuum+ lubricant + set of suction cannulas + gradual mechanical dilator;
- Obstetric vacuum device (Kiwi if available);
- Equipment for neonatal resuscitation: facial mask and ambu bag adapted to newborns, mucus extractor;
- Protection of medical staff: protective apron and protective eyewear;
- Refrigerator;
- Steriliser;
- (Oxygen cylinder or oxygen concentrator).

#### MEDICAL TESTING
- HIV rapid test (depending on epidemiological context);
- Syphilis rapid test;
- Malaria rapid test or thick smear blade and microscope (depending on epidemiological contexts);
- Urine test strip with detection of proteinuria.

#### VACCINES
- BCG;
- Anti-hepatitis B vaccine;
- Anti-polio vaccine;
- Anti-tetanus vaccine.

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### TYPE OF SERVICES / CARE: CEMONC

#### FOR A CAESAREAN SECTION
- Operating table;
- Surgical light;
- Surgical gowns, caps, masks and shoes;
- Sterilisable surgical drapes and linen which can be sterilised;
- Antiseptic soap and scrubs;
- Sterile compresses and sterile abdominal compresses;
- Operative drapes, sterile or sterilisable;
- Rolls of adhesive plaster;
- Surgical instruments: 1 stainless steel box, 1 instrument basket, 4 Backhaus towel clamps, 2 Bengolea haemostatic forceps, 2 Kelly haemostatic forceps, 2 Kocher forceps, 1 dressing forceps, 4 Duval tissue forceps, 1 standard surgical forceps, 1 100ml cup, 1 Mayo-Hegar needle holder, 1 pair of Farabeuf retractor, 1 scalpel handle n°4, 1 pair of Metzemberg scissors, 1 pair of curved Mayo scissors;
- Radiant warmer for newborns;
- Suction device;
- Oxygen cylinder or oxygen concentrator.

#### FOR ANAESTHESIA
- Medical equipment: oxygen extractor, laryngoscope, Magill forceps, manual insufflator with safety valve, stethoscope, sphygmomanometer, maternal monitoring (pulse, blood pressure, saturation);
- Consumables: oxygen nasal cannula or mask, oxygen, silicon tube, endotracheal tube, gastric tube, spinal needle;
- Drugs: plasma substitute, atropine, bupivacaine, ephedrine, adrenalin, naloxone, furosemide;
- Regulated drugs: diazepam, ketamine, fentanyl, morphine, thiopental.

#### FOR TRANSFUSION
- Consumables: Monitoring chart at patient’s bed, Infusion needles 21G, Anticoagulant EDTA anticoagulant tubes, Blood bags 150, 250 and 450 ml;
- Necessary tests: photometer, Haemoglobin test (Hemocue) with lancets and cuvettes, HIV tests (2 tests), hepatitis B test, hepatitis C test, Malaria test, Syphilis test, Blood group tests anti A, anti B anti AB, anti D (rhesus);
- Equipment: refrigerator, electronic scale, timer.
**TYPE OF SERVICES / CARE: COMPREHENSIVE ABORTION CARE**

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Anaemia: iron + folic acid (per os);</th>
<th>Local anaesthetic: lidocaine (injectable);</th>
<th>Analgesics: anti-inflammatory;</th>
<th>Misoprostol + mifepristone depending on availability;</th>
<th>Antiseptic solutions: polyvidone iodine (dermal and vaginal solution), chlorhexidine (dermal solution);</th>
<th>Contraceptives;</th>
<th>Treatment of STI;</th>
<th>Antibiotics.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSUMABLES</td>
<td>Basic consumables (see first table);</td>
<td>Consumables in relation to universal precautions and hygiene (see first table);</td>
<td>Clean surgical drapes;</td>
<td>For monitoring purposes: health cards, registers.</td>
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</tr>
<tr>
<td>MEDICAL EQUIPMENT</td>
<td>Basic equipment (see first table);</td>
<td>Equipment for EVA, MVA and dilation and evacuation: 1 instrument box, 1 Cheron dressing forceps, 1 Collin speculum 35mm, 1 Collin speculum 25mm, 1 Martin malleable uterine hysterometer, 1 cup 100ml, 1 Pozzi forceps, 1 Muzeux forceps, 1 set of gradual mechanical dilators (Hegar dilator 3 to 14mm in diameter or Pratt or Denniston dilators), 1 dressing forceps, 1 Foerster forceps, Aspiration equipment; For MVA: one licensed vacuum device (e.g. IPAS AMIU Plus®) and a set of adapted aspiration tubes 4 to 12mm of diameter, lubricant; For EVA: metal connector, flexible tube, silent electric aspirator with adjustable vacuum up to 800mbars or an aspiration syringe adjustable up to 600 mbar; a colander;</td>
<td>Materials required to set up contraceptive methods;</td>
<td>Ultrasound scanner (optional).</td>
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</tbody>
</table>

**TYPE OF SERVICES / CARE: POSTNATAL CONSULTATION**

| DRUGS          | Antipyretics: paracetamol (per os); | Anaemia: iron + folic acid (per os); | Soluties: ringer lactate 500 ml and sodium chloride 0.9 % 500 ml; | Antibiotics: amoxicillin (per os), ampicillin (IV, IM) and gentamicin (IV, IM); | Treatments for pre-eclampsia and eclampsia: magnesium sulphate (IV, IM) and its antidote calcium gluconate (IV); | Anticonvulsants: diazepam (IV, IM, intrarectal); | Local anaesthetic: lidocaine (injectable or dermal spray); | Deworming treatment: albendazole or mebendazole (per os); | Malaria treatment: sulfadoxine/pyrimethamine (per os) for preventative treatment and artemether/lumefantrine (per os) for curative treatment; | Antihypertensive treatment: hydralazine (IV) and methyldopa (according to MSF) or nifedipine (according to the WHO) (per os); | HIV treatment: in line with national protocols (depending on epidemiological contexts); | Uterotonics: oxytocin (IV, IM) and misoprostol (per os, intravaginal or intrarectal); | Antiseptic solutions: polyvidone iodine (dermal or vaginal solution), chlorhexidine (dermal solution); | Vitamins: vitamin K for the newborn (per os or IM), vitamin A for breastfeeding woman (per os); | Contraceptives; | STI treatment (to be adjusted to national protocols): benzathine-penicillin (IM), erythromycin (IV), azithromycin (per os), cefixime (per os), ceftriaxone (IV), metronidazole (per os), acyclovir (per os), clotrimazole (tablet or vaginal cream). |
|----------------|--------------------------------------|-------------------------------------------|-------------------------------|---------------------------------------------------|------------------------------------------|----------------|----------------|----------------|
| CONSUMABLES    | Basic consumables (see first table); | Consumables in relation to universal precautions and hygiene (see first table); | Clean surgical drapes; | For monitoring purposes: child and mother health cards, immunisation cards for mother and children and referral sheets. |
| MEDICAL EQUIPMENT | Basic equipment: (see first table); | Additional equipment: stretcher, hospital beds, source of light, insecticide treated mosquito nets (depending on epidemiological context); | Suturing kits; | Refrigerator; | Steriliser; | Protection of healthcare practitioners: protective apron, protective eyewear. |
### TYPE OF SERVICES / CARE: POSTNATAL CONSULTATION

<table>
<thead>
<tr>
<th>MEDICAL TESTING</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>HIV rapid test (depending on epidemiological context);</td>
<td>Syphilis rapid test;</td>
</tr>
<tr>
<td>Malaria rapid test or thick smear blade and microscope (depending on epidemiological contexts);</td>
<td>Urine test strip with detection of proteinuria;</td>
</tr>
<tr>
<td>Necessary equipment for cervical cancer screening (see line on cervical cancer).</td>
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</tbody>
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| VACCINES | Anti-tetanus vaccine. |
### APPENDIX 3:
**MAIN INTERNATIONAL LEGAL INSTRUMENTS RELATING TO ABORTION**

*International conventions* on protection of human rights do not always specifically refer to sexual and reproductive rights, however these SRHR are rooted in universal and imperative human rights.

The World's Abortion Laws Map (Center for Reproductive Rights) is the definitive record of the legal status of abortion in countries across the globe.

Regular updates are available at: [https://reproductiverights.org/worldabortionlaws](https://reproductiverights.org/worldabortionlaws)

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<tr>
<td>Art. 3</td>
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<td>Art. 9.1</td>
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</tbody>
</table>

Sexual rights emerged gradually from global conferences on human rights and development, with the aim of protecting women. Human rights must be respected, protected and achieved. Human rights are universal, inalienable, indivisible and interdependent.

The right to life, as stated in the main international treaties on human rights, does not apply before birth and international law relating to human rights does not recognise an ‘antenatal right to life’.
The following elements are based on *Practical sheets: Management of unwanted pregnancies and comprehensive abortion care by MdM*.

MdM’s response regarding abortion focuses on managing unwanted pregnancies during the first trimester of pregnancy (14 weeks of amenorrhea). This care is integrated in comprehensive SRH services. When opportunities to provide abortion services within healthcare facilities are limited or absent, a harm reduction strategy linked to unsafe practices may be carried out so as to reduce mortality and morbidity linked to least safe abortions.

The activities regarding management of unwanted pregnancies in MdM projects are underpinned by 4 main intervention strategies:

- **Support to the health system** to strengthen access and quality of care around abortion, within the legal framework
- **Direct intervention during which MdM directly sets up comprehensive abortion care** integrated as part of an SRH response and/or as part of a primary health care response, including outside the legal framework
- **Referral** to other services and actors providing comprehensive abortion care, which is the minimum response in contexts where MdM will not or cannot develop activities in relation to management of unwanted pregnancies and comprehensive abortion care
- **A harm reduction approach related to the risks of abortions carried out in bad conditions**, through community access to comprehensive information on medical abortion methods and self-administration of misoprostol.

These intervention strategies are detailed in the following tables:
1. Defining and Positioning Interventions and Developing Related Strategies

**Methods:**
There are four principal methods to put in place to reduce mortality and morbidity associated with unsafe abortion.

- Comprehensive SRH care
- Where the opportunities to treat UWP during the first trimester of pregnancy (14 weeks of amenorrhea) is provisioned as part of overall SRH care
- MdM’s response focuses on treating UWP and providing CAC

**Principles:**
- Willingness of the health authorities to strengthen available CAC services within the framework of the law
- Introduce awareness-raising activities at community level and provision of information on methods of abortion and self-administering misoprostol
- Put in place/support referral mechanisms for treating complications
- Supply or support procurement of good quality inputs and equipment for setting up CAC
- Train health professionals in CAC (including PAC) in the facilities supported and in line with legislation
- Conduct a full diagnosis including an analysis of the legal framework as a minimum
- If working outside the legal framework, institutional approval is secured by submitting the request to the Executive and Communication Committee and field teams are subsequently fully informed of this approval

**Operational Aspects:**

- Intervening directly with MdM directly setting up CAC provision in line with legislation
- Referring to services and providers delivering abortion eligibility criteria set out in legislation
- Integrate a component that is often neglected in crisis settings
- Significantly complements the MdM approach to treating GBV survivors and possibility of including this strategy as an add-on to care provision
- Development of extensive expertise that can feed into institutional advocacy
- Where civil society medical organisations directly provide care, CAC element can be consolidated

**Strengths:**
- Better coverage of needs and improved treatment and care for all abortion requests during the first trimester beyond the legal criteria, where the legislation is restrictive
- Strong influence on the quality of services put in place
- More immediate impact on reducing abortion-related mortality and morbidity
- Possibility of implementing in contexts where health services are not fully functioning

**Weaknesses:**
- No strengthening of public health services
- Short-term impact with only limited sustainability possible
- Need for extensive human resources
- Cost often higher than other intervention methods

**Opportunities:**
- Possibility of complementing the harm-reduction intervention methods
- CAC delivered under the terms of the law
- Limited legal and security risks
- Strengthening of the healthcare system and possible sustainability

**Risks:**
- Potential lack of involvement of healthcare professionals if CAC not prioritised by health authorities
- Reluctance on the part of women and adolescents to access healthcare facilities
- Difficulty with securing supplies of mifepristone and misoprostol, especially where these drugs do not appear on the country’s list of essential generic medicines
- Potential reluctance on the part of some health professionals as regards free provision of care, when abortions are occasionally performed outside the legal framework by health professionals themselves, often in return for high fees

**Preconditions for Implementation:**
- In-depth analysis of the legal framework
- Analysis of the legal, security and other types of risk and the development of a strategy to mitigate these
- If working outside the legal framework, institutional approval is secured by submitting the request to the Executive and Communication Committee and field teams are subsequently fully informed of this approval

**Advantages:**
- More significant and variable legal, security and other types of risk depending on context
- Difficulty of importing mifepristone and misoprostol
3. ADOPTING A HARM REDUCTION APPROACH TO ABORTION PERFORMED IN POOR CONDITIONS BY ENHANCING COMMUNITY ACCESS TO FULL INFORMATION ON MEDICAL METHODS OF ABORTION AND SELF-ADMINISTERING MISOPROSTOL

**PRINCIPAL ACTIVITIES**
- Set up a network of partners to share full evidence-based information on the risks of dangerous abortion practices
- Set up a network of partners to share full evidence-based information on medical abortion and self-administered misoprostol
- Set up activities on Value Clarification and Attitude Transformation with the MdM teams and project partners
- Strengthen healthcare facilities to provide post-abortion care and to treat complications and set up a referral system
- Identify a retail outlet/source of supply for good quality misoprostol

**PRECONDITIONS**
- Analysis of the legal framework
- Analysis of security and other types of risk
- Sociocultural survey of the determinants of UWP and community-based abortion practices
- Analysis of the availability and quality of misoprostol (pharmacies and healthcare facilities)
- Strengthening partner healthcare facilities for Post-abortion Care
- Securing institutional approval by submitting the project to the Executive Committee and fully informing field teams of this approval

**Strengths**
- Involvement of civil society and community partners
- Greater coverage of needs not met within the health system
- Building of women’s and adolescent girls’ capacity to act as regards their SRH and treating UWP

**Weaknesses**
- Limited strengthening of public health services
- Limited medical support for self-administration of misoprostol

**Opportunities**
- Civil society potentially strengthened on the issue of treating UWP
- Possibility of developing operational research activities to influence practice at a global level and to inform institutional advocacy

**Risks**
- Potential legal, security and other types of risk depending on context
- Difficulties with rapidly accessing treatment for potential complications

See: Management of UWP and Comprehensive Abortion Care - Factsheet 5. Unsafe Abortion Harm-reduction Strategy

4. REFERRING TO SERVICES AND PROVIDERS OFFERING COMPREHENSIVE ABORTION CARE

**PRINCIPAL ACTIVITIES**
Define a referral route to good quality services
Secure a budget line (from own funds if possible, to limit problems of eligibility of costs) to deliver CAC via services which are offering CAC and charging for this provision
Organise workshops to clarify values and transform attitudes within MdM teams and other partners involved in the project

**PRECONDITIONS**
- Diagnostic complet incluant une analyse à minima du cadre légal
- Cartographie des acteurs et des services fournis des SCA
- Analyse de la qualité de services fournis
- Coordinación avec les différentes structures de référence et définition des modalités de référencement

**Strengths**
- Limited legal and security risk for MdM
- Minimum response in contexts where MdM cannot or does not wish to develop activities to treat UWP and provide CAC

**Weaknesses**
- Potential non-implementation if no CAC providers in the intervention area
- Where MdM is intervening to support the health system, conducting referrals potentially depends on public health service professionals. It might prove complex in a restrictive legal context to organise referrals without exposing partners, patients and the health professionals themselves

**Opportunities**
- Possibility of setting up within projects with no specific focus on treating UWP (crises and conflicts, migration and Harm Reduction)
- Possibility of complementing intervention approach designed to reduce the harm of dangerous abortion practices

**Risks**
- Potential non-implementation if no CAC providers in the intervention area
- Where MdM is intervening to support the health system, conducting referrals potentially depends on public health service professionals. It might prove complex in a restrictive legal context to organise referrals without exposing partners, patients and the health professionals themselves
APPENDIX 5:
SEXUAL AND REPRODUCTIVE HEALTH EVALUATION SHEET

<table>
<thead>
<tr>
<th>Target population</th>
<th>Coverage area (Km)</th>
<th>Number of villages/neighbourhoods covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural/Urban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expected number of pregnant women</th>
<th>Number of children under 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic groups</th>
<th>Displaced population</th>
<th>Yes/No; if yes, number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Refugee population</td>
<td>Yes/No; if yes, number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transport and communication</th>
<th>Method of communication</th>
<th>Radio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Fixed/mobile telephone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Internet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IT equipment</th>
<th>Transport available at the facility</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specify type</td>
<td></td>
</tr>
</tbody>
</table>

## I. GENERAL INFORMATION

### Type of healthcare facility

### Opening hours

### Access to the facility

#### Methods of transport

#### Time from base/Referral health centre

Specify any seasonal differences:

### Infrastructure

#### Type of walls and condition

#### Type of roof and condition

#### Cleanliness of facility

Access to water

If yes

Distance

Type of access

Drinking: Yes/No

Hand-washing water: Yes/No

#### Type of power supply

Regular access to power supply

Toilets

Incinerator

Placenta pit

Waste management system

Safety box available in wards

Yes/No

Yes / No; if yes, number

Yes/No

Yes/No

Yes/No

Yes/No

Yes/No

Yes/No

EN 322
**II. HUMAN RESOURCES**

Take time before evaluation to get to know/fill out the national or international recommendations relating to human resources for the level of facility being assessed. Comparing what is expected in the recommendations with what is actually implemented provides a means of evaluating the facility.

<table>
<thead>
<tr>
<th>TYPE OF PERSONNEL</th>
<th>PRESENT IN THE FACILITY</th>
<th>NUMBER OF PERSONS</th>
<th>PERSONNEL LEVELS RECOMMENDED FOR THE LEVEL OF CARE BEING EVALUATED</th>
<th>COMMENTS (VALID/EQUIVALENT QUALIFICATIONS, FULL-TIME/PART-TIME, ETC.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecologist/Obstetrician</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing assistant</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy technician</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory technician</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetist</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional birth attendant</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Worker</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning personnel</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security personnel</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

...
### III. SEXUAL AND REPRODUCTIVE HEALTH SERVICES

☐ BEmONC Level (Basic Emergency Obstetric and Neonatal Care Level)

☐ CEmONC Level (Comprehensive Emergency Obstetric and Neonatal Care Level)

Take time before the evaluation to get to know/fill out the national or international recommendations relating to human resources for the level of facility being assessed. Comparing what is expected in the recommendations with what is actually implemented provides a means of evaluating the facility.

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>NATIONAL OR INTERNATIONAL RECOMMENDATIONS</th>
<th>COMMENTS</th>
<th>COST OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevention of mother-to-child transmission of HIV/AIDS</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Treatment for eclampsia</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Use of uterotonics</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Parenteral administration of antibiotics</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Eutocic delivery</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Assisted delivery</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Artificial delivery of placenta</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Caesarean section</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Transfusion</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Neonatal care including resuscitation</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Postnatal care</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Post-abortion care including manual vacuum aspiration</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Comprehensive abortion care (MVA and/or medical abortion)</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Services providing at least 3 contraceptive methods</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Management of STI</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health promotion and education</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Screening for CC</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Treatment of precancerous lesions</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Management of GBV</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Services adapted to young people and adolescents (training for healthcare professionals, IEC tools, opening hours, etc.)</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Management of fistulas</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Referral service</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Outreach activities</td>
<td>Yes</td>
<td>No</td>
<td>Specify</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood Bank</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
## Equipment

<table>
<thead>
<tr>
<th>EQUIPMENT</th>
<th>YES</th>
<th>NO</th>
<th>CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam table</td>
<td></td>
<td></td>
<td>Good</td>
</tr>
<tr>
<td>Sphygmomanometer</td>
<td></td>
<td></td>
<td>Average</td>
</tr>
<tr>
<td>Stethoscope</td>
<td></td>
<td></td>
<td>Unusable</td>
</tr>
<tr>
<td>Obstetric stethoscope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doppler (Sonicaid)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thermometer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suturing kit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of oxygen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery kit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partograph</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric ventouse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual vacuum aspiration kit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal speculums</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face mask and self-inflating ball for neonatal resuscitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric scales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid upper arm circumference tape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height chart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunisation record card</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Pharmacy

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a standard list of drugs? (If yes, take a copy of it)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Frequency of drug deliveries and name of supplier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are drugs free?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which drugs are free?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are drugs stored in a clean and orderly location?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are drugs kept under lock and key?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are the storage temperature (around 20°C) and humidity acceptable?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is there a fridge for drugs and vaccines?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are there drug use and stock control tools in place?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do stocks run out?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

## Drugs (See UNFPA Kits)

<table>
<thead>
<tr>
<th>DRUGS, CONSUMABLES AND TESTS</th>
<th>PRESENT AT THE CENTRE</th>
<th>STOCK-OUTS IN THE PREVIOUS 3 MONTHS (TICK TO CONFIRM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron + Folic acid (tab)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paracetamol 500 mg (tab)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albendazole or mebendazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artesunate/ lumefantrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxytocin 10 UI ampoule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misoprostol tab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium sulphate ampoule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium gluconate ampoule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metronidazole vial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ampicillin vial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ringer lactate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suture thread</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetracycline 1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyvidone iodine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least 3 contraceptives methods:</td>
<td>(Give details)</td>
<td></td>
</tr>
<tr>
<td>Emergency contraceptives:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid HIV tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid syphilis tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid malaria tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary sticks (with proteinuria)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary pregnancy test</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Referral

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an identified referral healthcare facility? Which one? How long does it take to get there?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is it open 24/7?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the healthcare facility have transport in case of emergency?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If not, does the referral facility have an ambulance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is medical transport free? If not, how much does it cost?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Comments:
### IV. EPIDEMIOLOGICAL DATA AND SERVICE UPTAKE

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>DATA ON THE GENERAL POPULATION (&gt;24 YEARS)</th>
<th>DATA ON YOUNG PEOPLE AND ADOLESCENTS BROKEN DOWN BY AGE, ACCORDING TO THE NHIS (when possible: 10-14 years old, 15-19 years old, 20-24 years old)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of maternal deaths at the healthcare facility in the previous year</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of neonatal deaths at the healthcare facility in the previous year</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Average number of consultations per day per healthcare worker</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Rate of antenatal consultation 1 (or number per month)</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Rate of antenatal consultation 4 (or number per month)</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Rate of antenatal consultation 8 (or number per month), according to new WHO recommendations</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Immunisation rate for TT2</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of births at healthcare facility</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of c-sections</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Rate of c-sections (last trimester)</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Rate of postnatal consultations (or number per month)</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of manual vacuum aspirations carried out per month</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of contraception consultations for new patients</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of contraception consultations for established patients</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of fistula cases detected per year</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
<tr>
<td>Number of cases of gender-based violence dealt with in the previous year</td>
<td>Month 1: Month 2: Month 3:</td>
<td></td>
</tr>
</tbody>
</table>

| Number of post-abortion care patients                                     | Month 1: Month 2: Month 3:                  |
| Number of abortions carried out within the legal framework (comprehensive abortion care) | Month 1: Month 2: Month 3:                  |
| Number of cervical cancer screenings performed                            | Month 1: Month 2: Month 3:                  |

### NATIONAL HEALTH INFORMATION SYSTEM

- Are consultation and birth records correctly filled out? Yes/No
- Does the healthcare facility have the current NHIS in place? Yes/No
- Are NHIS reports submitted monthly? Promptly: Yes/No Complete: Yes/No
- Is health data monitored and analysed? Yes/No

### V. MONITORING HEALTHCARE FACILITIES

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>PERSONS RESPONSIBLE (e.g.: facility director, district management team, management committee, health committee, etc.) timing of supervisions, checklist used...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal monitoring of facility activities</td>
<td>Yes/No</td>
</tr>
<tr>
<td>External monitoring and supervision of facility activities</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Supervision and monitoring of community health workers</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

### VI. COMMUNITY LINKS

<table>
<thead>
<tr>
<th>TYPE OF COMMUNITY WORKERS</th>
<th>NUMBER</th>
<th>FUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remarks:
To carry out a diagnosis of context with a gender perspective, the Harvard Development Institute developed and published, at the end of the 80’s, a Gender Analysis Framework. It is a tool that incorporates three different elements in the analysis.

- The activity profile: it analyses who does what in a given context, in terms of reproductive, productive and community aspects. This enables to identify the distribution of labour for each gender and the inequalities that may exist in the division.

- The access and control profile: it analyses what type of resources are accessible depending on the gender, and who has more or less control over these resources. This enables to analyse inequalities in terms of distribution and use of various existing resources in a community that are necessary for people’s life and survival.

- Analysis of factors and trends: it analyses the different contextual factors that may have a positive or negative influence on people in terms of gender and gender relationships. This enables to identify contextual factors to address if we wish to transform inequalities and discrimination based on gender in our projects and identify factors of opportunity for that change.

---

**APPENDIX 6:**

**GENDER AND GENDER CONTINUUM ANALYSIS CHECKLIST**

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>MEN</th>
<th>WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Productive activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income generating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal employment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Building sector:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Agriculture:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Sex work:</td>
<td></td>
<td></td>
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<tr>
<td>&gt; ...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal employment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reproductive activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuel related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care for the elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning and repairing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social, political and religious activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration/justice/ registration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ACCESS AND CONTROL GRID

<table>
<thead>
<tr>
<th>Resources:</th>
<th>Access</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEN</td>
<td>WOMEN</td>
<td>MEN</td>
</tr>
<tr>
<td>Land</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education / training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside income</td>
<td></td>
</tr>
<tr>
<td>Asset ownership</td>
<td></td>
</tr>
<tr>
<td>Basic needs (food, clothing, shelter...)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Political power/prestige</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

## INFLUENCING FACTORS GRID

<table>
<thead>
<tr>
<th>Influencing factors</th>
<th>Constraints</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community norms and social hierarchy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographic factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal aspects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The general approach of the project and/or of certain activities reinforces stereotypes of inequality between men and women or reduces people’s autonomy of decision.

Examples:
- Migration: Strengthening the role of women as people who care for children by providing child health services that are not attractive for men, rather than encouraging them to equality in terms of parental responsibilities.
- Drug consumption: Systematically advising women who are drug addicts not to have children.
- Sex work: Advocating laws forbidding sex work and penalising clients.
- SRH: Showing only strong and manly men in advertisements for masculine contraceptives.

Approaches or activities that do not actively question sexist stereotypes and discrimination.

Examples:
- Migration: Legal and psychosocial support services with a neutral view of gender may not acknowledge that women might prefer female counsellors and service providers.
- Drug consumption: Drop-in-centre services that are accommodating, ignore the specific needs of women in relation to SRH.
- Sex work: Mobil health clinics for sex workers that provide primary health care, including SRH, without any information or discussion around GBV.
- SRH: Prevention messages that do not target a specific sex. For example: ‘Being faithful’ does not make a distinction between women’s and men’s needs.

Approaches or activities that acknowledge the various needs and constraints of individuals depending on the sex and/or sexual orientation, and address those. Such activities significantly improve women’s (and men’s) access to prevention, treatment and care. However, they alone do not contribute to modifying the wider contextual programmes that are rooted in sex inequalities. They are insufficient to fundamentally change division of labour and power in terms of gender relationships.

Examples:
- Migration: Efforts aiming at integrating STI treatment in services offering contraceptive methods enable women to access these services without fear of stigmatisation.
- Drug consumption: Setting up drop-in-centre services with spaces, opening times and specific services for women, and having female human resources could help improve drug addicts’ use of services.
- Sex work: Mobile health clinics with professionals trained on addressing female, transgender or male sex workers with specific health needs, with a non-judgemental approach, will facilitate access to services for all.
- SRH: By providing women with feminine contraceptives, as it is acknowledged that male contraceptives are controlled by men and that the imbalance in power makes it difficult for women to negotiate their use. However, it has no impact on the power of negotiation of women towards men.

Approaches or activities that help men, women and non-binary people to examine the expectations of society with regards to all genders, stereotypes, discrimination and their impact on the SRH of each sex.

Examples:
- Migration: Training on daily life skills, the possibility to negotiate which encourages participants on the reason for which individuals believe the way they do. Participants are encouraged to take responsibility for themselves and others in order to promote healthier behaviours.
- Drug consumption: Group sessions to question relationships in drug users couples and roles and relationships with the partner.
Sex Work: Facilitating peer-group meetings and providing them with resources (funds, capacities, material, etc.) to get organised and initiate actions to promote the rights and autonomy of sex workers.

SRH: Projects working with men and women to redefine gender norms and encourage health sexuality for both sexes.

TRANSFORMATIVE
Approaches or activities that actively aim at constructing norms and social structures based on sex equality, beyond participants’ individuals behaviours.

Example:
Projects that question gender-based social relationships and engage discussion to change this within a group, a community or, more widely, in society through advocacy.