MSF POLICY FOR REPRODUCTIVE HEALTH AND SEXUAL VIOLENCE CARE

International Working Group on reproductive health and sexual violence care

Final Version

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INTRODUCTION

As a humanitarian and medical organization, MSF commits to assisting people affected by conflict and crisis, be it the result of epidemics and famine, natural disaster or social exclusion. MSF's assistance aims to reduce mortality, prevent morbidity whenever possible, and to alleviate suffering.

In 2008, MSF adopted a policy for "Sexual and Reproductive Health" and a corresponding "Core package" describing the assistance the organization aspired to deliver. The current revised policy takes into account experience acquired since then, including the competing health needs in the contexts in which MSF works.

Part I of the policy describes the scope of MSF response to specific **REPRODUCTIVE HEALTH NEEDS** and guides action according to potential impact on maternal and newborn mortality and suffering. The policy establishes an order of priority; headed by obstetric, newborn, post partum and abortion care and followed by essential preventive action. The presence of other actors and the specific needs in a population has to be taken into account and will justify adapted approaches. The policy emphasises the inseparable nature of maternal and newborn health and the large burden of mortality and suffering that prevails among very young mothers in particular.

Part II of the policy describes MSF's scope of action regarding **SEXUAL VIOLENCE**. Less directly related to mortality, sexual violence, specifically rape, involves significant suffering and ill health in the short and long term. Care for victims of sexual violence is a priority for MSF and every project should be prepared to offer related assistance – independently of or as a complement to reproductive health care activities. Female genital mutilation is addressed as part of sexual violence.

Contextual considerations, including insecurity, may confine MSF medical action to health facilities, assisting those who manage to attend. However, whenever possible MSF establishes a **dialogue with communities about available assistance and undertakes action to identify and reach the people most in need**, including those hidden by stigma, ignorance, fear and discrimination. Traditional birth attendants (TBAs), like other community members, can form a community link to MSF assistance. They may be integrated as health promoters and supportive staff under the supervision of skilled personnel; they will however only become skilled medical staff by completing formal training.

MSF's primary objective is the provision of medical care. However, the burden of reproductive health problems and sexual violence in many contexts is still largely under-exposed. MSF's experiences in this domain should be routinely documented for the purpose of **monitoring**, **research**, **innovation and**

advocacy. MSF experience should **contribute to awareness** about causes of mortality and suffering, and should highlight cases when structural and political barriers stand in the way of improvement.

I. REPRODUCTIVE HEALTH CARE

MATERNAL AND NEWBORN MORTALITY AND SUFFERING are not direct results of conflict and crisis, but rather of the absence of health care. In many of the contexts in which MSF works, obstetrics and newborn care are in a constant state of emergency. Conflict and crisis further exacerbate this situation: displacement, violence, epidemics and food shortages present additional risks for pregnant women and affect their environment, particularly the access to medical assistance. In some contexts, high maternal mortality in itself is considered a crisis and may justify MSF's intervention and assistance.

MSF cannot be the substitute for deficient or non-existent national health systems. But MSF can alleviate suffering and avert maternal and newborn deaths by offering medical care that addresses the main causes of mortality and suffering.

1. ACTION WITH A DIRECT IMPACT ON MATERNAL MORTALITY

1.1 Obstetric care

- ✓ *In 15% of all pregnancies, the complications are life-threatening*[1]
- ✓ *The major complications that account for 80% of all maternal deaths are: severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), unsafe abortion*[2]
- ✓ *60% of maternal deaths occur just before, during, or just after delivery, often from complications that cannot be predicted. However, almost all complications can be treated with relatively simple means.*
- ✓ *Facility-based delivery handled by skilled birth attendants*[3] *is the single most effective intervention to reduce maternal and perinatal mortality*

MSF ensures the provision of obstetric and newborn care and encourages women to have a facility-based delivery with skilled birth attendants.

Obstetric complications requiring surgical intervention will occur. MSF will ensure surgical capacity for obstetric emergencies whenever relevant and feasible.

The indication for a caesarean section is based first and foremost on a risk assessment for the mother. In the management of emergency obstetrics MSF also takes the foetus' wellbeing into consideration and ensures concrete action to preserve it. Nonetheless, (exclusive) foetal indications for caesarean section are discouraged in contexts where there is limited capacity for newborn care and little likelihood of comprehensive obstetric care being available for the mother's future pregnancies.

MSF's emergency obstetric care includes the management of complications resulting from unsafe abortion and miscarriage, and the management of ante- and postnatal complications, including post partum complications of women who have delivered at home or in another health facility.

1.2 Newborn care

- ✓ *40% of deaths in children under 5 occur during the 28-day neonatal period. Two-thirds of these deaths are preventable without intensive care*
- ✓ *It is estimated that 25–45% of newborn deaths occur during the first day after birth*[4]
- ✓ *Main causes of newborn mortality are prematurity and low birth weight, infections, asphyxia (lack of oxygen at birth) and birth trauma*[5]

Essential care for all newborns is an integral part of all MSF obstetric care. Maternity ward care covers immediate resuscitation, routine assessment and prevention of hypothermia as well as establishment of exclusive breastfeeding, systematic examination of the newborn, routine preventive measures, prevention of

1 UNFPA 2007 http://www.unfpa.org/sowmy/resources/docs/main_report/en_SOWMR_ExecSum.pdf
2 Fact sheet N°348, May 2012 and related studies (Source: WHO)
3 "Skilled attendance" denotes not only the presence of skilled attendants but also the enabling environment they need in order to be able to perform capably. It also implies access to a more comprehensive level of obstetric care in case of complications requiring surgery or blood transfusions. (Source: UNFPA)
4 UNICEF, The State of the World's Children 2009. Maternal and Newborn Care. New York 2009
5 Fact sheet N°333, May 2012 and related studies (Source: WHO)

mother-to-child transmission of HIV (PMTCT) when relevant, and the treatment of manifest or suspected neonatal infection.

In situations where MSF deals with a high incidence of complicated pregnancies and deliveries (e.g. referral hospitals), neonatal care units offering specialised care will be considered according to need. Kangaroo mother care[6] is the approach of choice for premature and low birth weight babies.

Prolonged life support of newborns has to be based on expected long term prognosis; related decisions are taken, whenever possible, in consultation with the mother/parents.

1.3 Postnatal care for mothers and newborns (PNC)

- ✓ *About 45% of post partum maternal deaths occur within 1 day of delivery, more than 65% within 1 week, and more than 80% within 2 weeks*[7]

MSF encourages women to stay in a health facility at least 24 hours following vaginal delivery to detect and manage early post partum complications of the mother and/or baby, and to help initiate breastfeeding.

MSF organises at least one follow-up visit for mothers and babies within the first week after delivery, either in a health structure or as part of outreach activities at community level. Postnatal care reaches out to all women, irrespective of whether their delivery took place in the health facility or at home.

Follow-up visits for mothers and babies until six weeks post-delivery are encouraged to diagnose late complications, to ensure continuation or initiation of prevention of mother-to-child transmission of HIV (PMTCT) when relevant and to support exclusive breastfeeding, vaccination for the baby and contraceptives for the mother.

1.4 Safe abortion care

- ✓ *Unsafe abortion is 1 of the 4 main causes of maternal mortality worldwide*[8]*. Maternal deaths due to unsafe abortion remain close to 13% of all maternal deaths worldwide; higher in specific regions and contexts.*
- ✓ *Unsafe abortion and unwanted pregnancy contribute significantly to the burden of ill health, suffering and maternal mortality in the contexts in which [MSF] works*[9]
- ✓ *Experience suggests that a woman will resort to unsafe abortion methods to terminate an unwanted pregnancy if safe abortion care is not available*

MSF manages complications resulting from unsafe abortion as part of all obstetric care (see above).

MSF will respond to girls' and women's needs for the termination of pregnancy (ToP); it is part of the organization's actions aimed at reducing maternal mortality and preventing unsafe abortion.

Termination of pregnancy in MSF projects is supported until 22 weeks gestational age. MSF will not support requests for sex-selective termination of pregnancy.

When a quality provider is accessible, girls/women requesting a termination of pregnancy can be referred[10].

Safe abortion care includes counselling of the woman/girl and provision of contraceptives.

The legal context, its customary interpretation as well as communities' perception of termination of pregnancy can result in security consequences for women and/or staff; this needs to be taken into consideration.

MSF commits to ensuring the confidentiality of women and girls requesting a termination of pregnancy.

6 Method of care of preterm infants, which involves infants being carried, usually by the mother, with skin-to-skin contact.
7 http://www.who.int/maternal_child_adolescent/epidemiology/maternal/en
8 Maternal mortality trends 1990–2010
9 MSF International Council resolution November 2004 and International Board statement October 2012
10 Referral of patients to another health provider involves MSF to validate the provider, to ensure access (incl. covering related costs) and patient follow-up

2. PREVENTIVE ACTION

2.1 Antenatal care (ANC)

- ✓ *Women are more likely to give birth with a skilled attendant if they have had at least one ANC visit*[11]
- ✓ *Antenatal care is an opportunity to promote the benefits of skilled attendance at birth and to encourage women to seek post partum care for themselves and their newborns*[12]

Skilled antenatal care allows for the diagnosis of a number of obstetric risks and conditions threatening foetal survival; furthermore MSF uses antenatal care as a strategic opportunity to:

- create an "entry" to obstetric services with skilled birth attendants
- encourage a birth plan and the anticipation of emergency transport
- diagnose and treat pregnancy pathologies including hypertensive disorder and anaemia
- diagnose and treat communicable diseases, including malaria, reproductive tract infections (RTIs), HIV and other conditions complicating pregnancy and affecting foetal and neonatal wellbeing
- initiate PMTCT in a timely manner
- identify teenage mothers for close follow-up and adapted care

Antenatal care alone cannot reduce maternal and neonatal mortality and must be implemented as a complement to obstetric and newborn care.

2.2 Provision of contraceptives

- ✓ *Provision of contraceptive services has the potential to reduce maternal mortality by 30% (90% of the abortion-related and 20% of the obstetric-related mortality)*[13]
- ✓ *2 in 5 pregnancies in the developing world are unintended*
- ✓ *Contraceptives can prevent mortality and suffering related to unwanted pregnancy and unsafe abortion*

MSF will provide contraceptives in all relevant projects dealing with girls and women of reproductive age, including HIV care and nutrition programs. Provision of contraceptives to adolescents, men and women is based on need and will include a choice of methods, medical information and counselling on options adapted to the patient's specific situation. Adolescent girls are particularly vulnerable to sexually transmitted diseases (STIs) and unwanted pregnancies; addressing their needs requires an adapted approach.

2.3 Prevention of Mother-to-Child Transmission of HIV/AIDS (PMTCT)[14]

- ✓ *It is estimated that more than 90% of children living with HIV acquired the virus during pregnancy, birth or breastfeeding – forms of HIV transmission that can be prevented*[15]
- ✓ *Effective PMTCT has the potential to improve the mother's own health and to reduce mother-to-child HIV transmission risk to 5% or lower in a breastfeeding population, from a background transmission risk of 35% (in the absence of any interventions and with continued breastfeeding)*[16]

PMTCT implementation will be prioritised in contexts where MSF has a significant involvement in antenatal and/or obstetric care (critical mass of patients) and where the prevalence of HIV is at least 1%.

PMTCT should be offered in these contexts even if HIV care cannot be assured. Priority will be given to testing and enrolment during the antenatal period, but can also be done during labour and post partum.

In contexts where HIV care is available, testing and enrolment in PMTCT will be encouraged in the antenatal and during the entire breastfeeding period. Prevention of mother-to child transmission of HIV (PMTCT) and early infant diagnosis are important points of entry to continuous HIV care for the mother and for the infant.

11 The partnership for maternal, newborn and child health: Opportunities for Africa's newborns (WHO 2006)
12 The access: clinical and community maternal, neonatal and women's health services (USAID 2007)
13 WHO, USAID, Repositioning Family Planning: Guidelines for advocacy and action, 2008
14 PMTCT, Strategic orientation final (Oct 2012 – MSF)
15 UNAIDS, Report on the global AIDS epidemic, 2008, Published: www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008
16 Antiretroviral drugs for treating pregnant women and preventing HIV infections in infants (WHO 2010)

2.4 Prevention, screening and treatment of cervical cancer[17]

- ✓ *Cervical cancer is the second cause of cancer death in women in the developing world*[18]
- ✓ *Because of poor access to high quality screening and treatment services, the majority of cervical cancer deaths (85%) occur in women living in low- and middle-income countries*

Screening and/or treatment of cervical (pre) cancer, as well as preventive action (human papilloma virus (HPV) vaccination), can be implemented as part of ongoing activities, in MSF projects, in which cervical cancer prevalence is particularly high.

MSF will prioritise cervical cancer screening and treatment action as well as HPV vaccination among HIV positive women.

3. OTHER AREAS OF INVOLVEMENT

3.1 Fistula repair

- ✓ *Worldwide, it is estimated that at least 3 million women in poor countries have un-repaired vesico vaginal fistulas, and that 30,000–130,000 new cases develop each year in Africa alone*[19]

A large majority of obstetric fistula is the result of prolonged obstructed labour; a small part results from medical interventions (caesarean section, hysterectomy) or sexual violence.

MSF obstetric care focuses on the timely management of obstructed labour, the provision of skilled surgery for emergency caesarean section and secondary prevention of obstetric fistula through early identification and catheterization.

Obstetric fistula gives rise to physical problems (incontinence), stigma, depression and social isolation.

The implementation of fistula repair activity requires punctually specific medical expertise and should be considered as a complement to established or planned obstetric care programs in contexts where obstetric fistula is frequently seen in MSF patients. Successful fistula repair is an important step in women regaining dignity and confidence in their body.

17 Cervical Cancer: Guidance for operations (January 2013 – MSF)
18 First cancer death cause in women is breast cancer
19 Wall LL, Obstetric vesico vaginal fistula as an international public-health problem, Lancet 2006; 368: 1201–09

II. CARE FOR CONSEQUENCES OF SEXUAL VIOLENCE

Sexual violence, specifically rape

- ✓ *Worldwide there is no common definition of sexual violence, nor comprehensive data showing its prevalence, but sources looking at crime data on rape, data on sexual violence in conflict and on violence against women, reflect widespread existence of sexual violence in all contexts*
- ✓ *Country-specific studies report that as many as 1 in 3 women have been raped before the age of 18 or an estimated yearly incidence of 400,000 cases of rape. Official crime data documents as many as 135 reported rapes per population of 100,000*[20]
- ✓ *Rape is known to be the most underreported crime – in 75–95% of rape cases the police are never notified*
- ✓ *Since 2005, MSF has assisted 10,000–15,000 victims of sexual violence annually, individual cases as well as situations with sudden massive incidence of rape. About 5% of the victims assisted by MSF are boys and men.*

Sexual violence occurs in all societies and in all contexts at any time. Destabilization of contexts often results in increased levels of violence, including sexual violence. Sexual violence is particularly complex and stigmatising and generates long-lasting consequences. Challenges are multiple and need to be considered as part of MSF care efforts: legal considerations, confidentiality, protection, stigma and perception as well as access to, and acceptance of, assistance.

MSF assistance focuses primarily on the medical care for victims of sexual violence, be they women, children or men, and includes:

- treatment of injuries
- prevention of infection (sexually transmitted diseases, HIV, hepatitis B, tetanus)
- management of unwanted pregnancy
- psychological support
- provision of a Medical Certificate

All MSF projects should be prepared to offer medical care to victims of sexual violence – independently of or as a complement to reproductive health care activities.

Depending on the context and feasibility, MSF will contribute to the other forms of support required, namely social and legal support, community awareness and advocacy. As a minimum, measures should be taken to raise awareness about the medical consequences of rape and the existence of assistance.

MSF commits to ensuring the confidentiality of all patients approaching MSF for sexual violence care.

Female genital mutilation (FGM)

- ✓ *FGM poses serious physical and mental health risks for women and young girls, especially for women who have undergone extreme forms of the procedure*
- ✓ *FGM is associated with an increased prevalence of complications in childbirth, like severe pain, haemorrhage, tetanus, infection, infertility, cysts and abscesses, urinary incontinence, dyspareunia, and even maternal deaths, in addition to psychological problems*[21]

FGM can be considered another form of violence inflicted on girls and women with important short- and long-term health consequences.

MSF does not support the practice of female genital mutilation (FGM); and does not provide training, drugs or medical material.

Infibulation can result in life-threatening complications and MSF will treat these as part of emergency medical care. MSF addresses complications of FGM that may arise during labour and delivery. MSF will re-open the FGM closure and leave it open after birth. Re-infibulation, even when requested by the patient, can be considered as supporting the practice of FGM and is not done by MSF.

Teams should spend time explaining the rationale for MSF's position of not re-infibulating to health staff and the local population.

20 Data and studies from countries like South Africa, Lesoto, Burundi, Colombia, DRC
21 Female genital mutilation and obstetric outcome … 2001–3, Lancet 2006