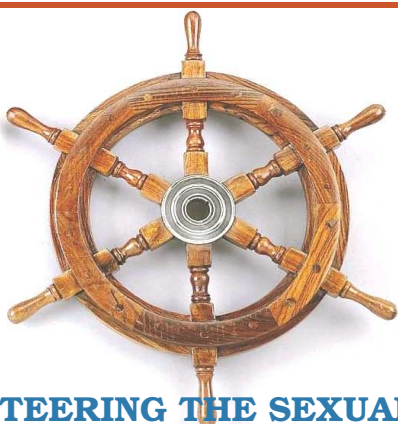


REPUBLIC OF MAURITIUS



**STEERING THE SEXUAL &
REPRODUCTIVE HEALTH
PROGRAMME IN ORDER TO
PROVIDE OPTIMUM SERVICES**

**THE NATIONAL
SEXUAL &
REPRODUCTIVE
HEALTH POLICY**

JULY 2007

MINISTRY OF HEALTH AND QUALITY OF LIFE

TABLE OF CONTENTS

TABLE OF CONTENTS	I
ABBREVIATIONS AND ACRONYMS	III
ACKNOWLEDGEMENTS.	IV
FOREWORD.....	V
CHAPTER 1 - INTRODUCTION	1
1.1 DEMOGRAPHIC AND HEALTH STATUS.....	1
1.2 SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION.....	2
1.3 DEFINITION AND COMPONENTS OF REPRODUCTIVE HEALTH	3
CHAPTER 2 - RATIONALE FOR THE SEXUAL AND REPRODUCTIVE HEALTH POLICY	6
2.1 PREAMBLE.....	6
2.2 CHANGE OF FOCUS	6
2.3 CONTEXT OF THE SEXUAL AND REPRODUCTIVE HEALTH POLICY.....	8
2.4 POLICY GOAL	8
2.5 POLICY OBJECTIVES	8
2.6 GUIDING PRINCIPLES AND VALUES	9
2.6.1 <i>Human Rights</i>	9
2.6.2 <i>Gender Equality and Equity</i>	9
2.6.3 <i>Social Justice</i>	10
2.6.4 <i>Quality Service Provision</i>	10
2.6.5 <i>Universal Access to Comprehensive Sexual and Reproductive Health Services</i>	11
CHAPTER 3 - THE PRIORITY POLICY AREAS, POLICY STATEMENTS AND STRATEGIES 12	
3.1 FAMILY PLANNING AND CONCERNS	12
3.1.1 <i>Pre-marital Conception</i>	13
3.1.2 <i>Teenage Pregnancy</i>	13
3.1.3 <i>Abortion</i>	13
3.1.4 <i>Knowledge of Family Planning Methods</i>	13
3.1.5 <i>Reproductive Health Commodity Security (RHCS)</i>	14
3.1.6 <i>Contraceptive Use</i>	14
3.1.7 <i>Fertility Planning</i>	15
3.1.8 <i>Unmet Need for Family Planning</i>	15
3.1.9 <i>Policy Statement</i>	15
3.1.10 <i>Strategies</i>	15
3.2 INFERTILITY AND CONCERNS	17
3.2.1 <i>Policy Statement</i>	18
3.2.2 <i>Strategies</i>	18
3.3 SAFE MOTHERHOOD AND CONCERNS	18
3.3.1 <i>Breast Feeding</i>	20
3.3.2 <i>Policy Statement</i>	21
3.3.3 <i>Strategies</i>	21
3.4 ABORTION.....	22
3.4.1 <i>Policy Statement</i>	23
3.4.2 <i>Strategies</i>	23
3.5 INFANT AND CHILD HEALTH	24
3.5.1 <i>Policy Statement</i>	25
3.5.2 <i>Strategies</i>	26

3.6	ADOLESCENT, YOUTH SEXUAL AND REPRODUCTIVE HEALTH	26
3.6.1	<i>Available Services</i>	28
3.6.2	<i>Family Life Education Programme (FLE)</i>	28
3.6.3	<i>Policy Statement</i>	29
3.6.4	<i>Strategies</i>	29
3.7	STI/HIV/AIDS.....	31
3.7.1	<i>Policy Statement</i>	33
3.7.2	<i>Strategies</i>	33
3.8	MALIGNANCIES OF THE REPRODUCTIVE TRACT - CANCER OF CERVIX, BREAST AND PROSTATE AND CONCERNS.....	35
3.8.1	<i>Policy Statement</i>	36
3.8.2	<i>Strategies</i>	36
3.9	GENDER AND SEXUAL AND REPRODUCTIVE HEALTH	38
3.9.1	<i>Provision for Victims of Domestic and Sexual Violence</i>	39
3.9.2	<i>Policy Statement</i>	40
3.9.3	<i>Strategies</i>	40
3.10	MALE INVOLVEMENT AND PARTICIPATION IN SRH	41
3.10.1	<i>Policy Statement</i>	42
3.10.2	<i>Strategies</i>	42
3.11	MALE SEXUAL DYSFUNCTION.....	43
3.11.1	<i>Available Services</i>	44
3.11.2	<i>Policy Statement</i>	44
3.11.3	<i>Strategies</i>	44
	45	
3.12	GERIATRICS.....	45
3.12.1	<i>Menopause and Andropause</i>	46
3.12.2	<i>Available Services</i>	46
3.12.3	<i>Policy Statement</i>	47
3.12.4	<i>Strategies</i>	47
CHAPTER 4 - INSTITUTIONAL FRAMEWORK FOR THE IMPLEMENTATION OF THE POLICY.....		49
4.1	MANAGEMENT OF THE DELIVERY OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES.....	49
4.2	PARTNERSHIP AND COORDINATION.....	49
4.2.1	<i>Establishment of the SRH Coordinating Committee and Technical Coordination Committee</i>	50
4.2.2	<i>SRH Technical Coordination Committee</i>	51
4.2.3	<i>Agreement on Implementation Framework</i>	51
4.2.4	<i>Setting Priorities</i>	51
4.2.5	<i>Resource Mobilization and Allocation</i>	51
4.2.6	<i>Setting a Time Frame</i>	51
4.3	MONITORING AND EVALUATION OF IMPLEMENTATION OF THE POLICY	52
REFERENCES:.....		53
ANNEX 1 - THE FORMULATION PROCESS OF THE NATIONAL SEXUAL AND REPRODUCTIVE HEALTH POLICY.....		54
ANNEX 2 - PERSONS CONTACTED.....		55

ABBREVIATIONS AND ACRONYMS

AF	Action Familiale
AHCs	Area Health Centres
ASRH	Adolescent Sexual Reproductive Health
BCG	Bacillus Calmette-Guerin
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CDU	Child and Development Unit
CH	Community Hospital
CHCs	Community Health Centres
CPS	Contraceptive Prevalence Survey
CRC	Convention of the Rights of the Child
EmOC	Emergency Obstetric care
EPZ	Export Processing Zone
GRR	Gross Reproduction Rate
ICPD	International Conference on Population and Development
IEC/BCC	Information Education and Communication/Behaviour Change Communication
MCH	Maternal and Child Health
MCs	Medi-Clinics
MDGs	Millennium Development Goals
MFPWA	Mauritius Family Planning and Welfare Association
NCDs	Non Communicable Diseases
NEPAD	New Partnership for Africa's Development
PMTCT	Prevention of Mother to Child Transmission of HIV
RHCS	Reproductive Health Commodity Security
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
MOH & QL	Ministry of Health and Quality of Life
MWRCDFWCP	Ministry of Women's Rights, Child Development, Family Welfare and Consumer Protection.
MSSNSSCW	Ministry of Social Security, National Solidarity, Senior Citizens' Welfare and Reform Institutions
MYS	Ministry of Youth and Sports
PLWHA	People living with HIV/AIDS

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FOREWORD

Each country of the world has its own challenges and successes in dealing with population growth. In the case of Mauritius, it is renowned for its outstanding achievement in curtailing its population growth rate within a short period of time. The total fertility rate dropped sharply from about six children per woman in the 1960's to about three in the 1970's and to about two in 2000. The population of Mauritius stood about 1.2 million in 2000 instead of 2.7 million as was projected in 1960's.

Undoubtedly, the family planning programme has played a pivotal role in the sharp fertility decline. The reproductive health indicators have improved markedly due to the concerted effort of the government family planning/maternal and child health programme and non-governmental organizations. Access to reproductive health services, including a wide range of contraceptive methods, are available through a network of government health service points. These services are offered free to the population without coercion.

Population issues have always been at the top of the policy agenda of the government of Mauritius in view of their dynamic effects on the socio-economic development of a country. Prior to the Cairo International Conference on Population and Development (ICPD) in 1994, the national policy of the Government of Mauritius was to maintain fertility at replacement level that is when each generation of women replaces the previous one.

Since at the ICPD, the international consensus was that "population is not about numbers but about people", the reproductive health programme of the Government of Mauritius has thus moved from a demographically driven approach to a broader reproductive health orientation. In the absence of an explicit reproductive health policy, Mauritius has fared relatively well in providing comprehensive sexual and reproductive health services to its population.

However, following a Contraceptive Prevalence Survey that was carried out in 2002, some shortcomings in the reproductive health programme have been identified. Hence, the formulation of a comprehensive sexual and reproductive health policy was felt in order to revitalize the sexual and reproductive health programme; more efforts are to be made to ensure its continued success.

The adoption and launching of the national sexual and reproductive health policy demonstrates a renewed interest of the government in providing optimum reproductive health services to its population.

Chapter 1 - INTRODUCTION

1.1 Demographic and Health Status

The estimated mid-year population of Mauritius in 2005 was 1,206,346 with a sex ratio of 97.81 (males to females). The population growth rate is 0.86 percent. The mid year population aged less than 15 years is 24.2 percent, aged 60 years and over was 9.6 percent and female population aged 15-49 years of the total population was 27.7 percent.

The general health status for the population is good and has been improving steadily. The expectation of life at birth has increased from 70.2 years in 1995 (66.4 years for males and 74.0 years for females) to 72.2 years in 2004 (68.9 years for males 75.6 for females).

Maternal mortality ratio was 22 deaths per 100,000 live births in 2005, compared with 61 in 1995. In 2002, the maternal mortality ratio was 5 which is the lowest figure ever recorded in Mauritius.

Infant mortality rate has declined from 19.6 deaths per 1,000 live births in 1995 to 13.2 in 2005.

The Mauritian economy has grown at an average greater than 5.0 percent per annum over the last two decades. EPZ has grown to become the country's main foreign exchange earner and a major employer of women.

Family Planning

In the early 1950's, Mauritius was characterized by a steep decline in mortality, mainly due to the eradication of malaria and improved health services, and by high fertility. Subsequently, policy makers and planners were alarmed by the population explosion as the population was growing at an annual growth rate of 3.12 percent between 1952 and 1962. It was projected that if this population growth rate remained unabated, the population would have grown from about 700,000 in 1962 to about 2.7 million in 2000. However, the population of Mauritius stood at about 1.2 million in 2000.

The total fertility rate dropped sharply from about six children per woman in the 1960's to about three in the 1970's and to about two in 2000. Increase in age at marriage and in use of family planning services are two factors that contributed to this rapid decrease in fertility, especially in the late 1960's and early 1970's. Moreover, this sharp decline in fertility took place in the absence of massive economic development and was coincident with the concerted effort of the Government and the two Non-Governmental Organisations, namely,

Mauritius Family Planning and Welfare Association (MFPWA) and Action Familiale to provide family planning services.

The MFPWA was set up in 1957 by some volunteers who believed that the rampant population growth rate would hinder economic development in Mauritius. The MFPWA promotes modern method of contraception and is involved in many reproductive health related activities.

Since its inception in 1963 by the Vicar General of the Mauritian Catholic Diocese, Action Familiale promotes only natural methods of family planning. Besides promoting sympto-thermal family planning, Action Familiale provides other services, such as, counselling services to couples.

In 1970, women began to have access to family planning services at the Government Maternal/Child Health Services. Family planning and prenatal services are widely accessible through an extensive network of government facilities: 23 Area Health Centres, 112 Community Health Centres, 2 Medi-Clinics, 1 Community Hospital, 8 Hospitals, 4 Family Health Clinics, 2 Family Planning Clinics and 1 Family Planning Supply Centre and 21 Industrial Supply Centres.

1.2 Sexual and Reproductive Health Service Provision

Sexual and reproductive health service delivery is a core function of the Ministry of Health and Quality of Life (MOH & QL) of Mauritius.

The reproductive health and MCH services are integrated into the general health services and are provided free of charge through a network of accessible Health care delivery institutions at the primary, secondary and tertiary levels.

The MOH & QL has established five operational health regions covering the whole island of Mauritius and within each region there are service delivery points that provide state health services including SRH services, free of charge at point of use. There are also well established private sector and Non Governmental Organization Clinics. At the Primary Care level there are 138 facilities composed of 23 Area Health Centres (AHCs), 2 Medi-Clinics (MCs), 1 Community Hospital (CH), and 112 Community Health Centres (CHCs). At the secondary level there are five Regional hospitals and three district hospitals. There are also tertiary facilities with high technology facilities.

The population to doctor ratio in public and private sector in 2005 was 930 inhabitants per doctor and the population to nurse (including midwives) was 431 inhabitants per nurse.

1.3 Definition and Components of Reproductive Health

Reproductive health was defined at the International Conference on population and development in 1994 (ICPD) as “a state of complete physical, mental and social well-being and not the mere absence of disease or infirmity in all matters related to the reproductive system, its functions and processes. Reproductive health therefore implies that people should be able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide freely if, when and how often to do so with no coercion. This includes the right of men, women and young people to be informed and have access to safe, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for fertility regulation which is not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The concept of Sexual and Reproductive Health implies that there is need to address the needs of the population through the Life Cycle from birth until death.

The concept of Sexual and Reproductive Health also includes:

- The right to the highest attainable standard of Health. It means having the right and access to the highest quality of health care
- The right to life and survival. This implies the removal of customs and practices that endanger health and the protection of health.
- The right to non-discrimination on the basis of sex. This implies the equality of women including the elimination of discrimination in areas like education and feeding for children.
- The right to non discrimination on the basis of age. This means the right of adolescents and the elderly to a full coverage of their sexual and reproductive health needs.

Mauritius is a signatory to the 1994 Cairo International Conference on Population and Development Plan of Action in which countries committed themselves to the provision of the highest possible level of reproductive health services for all their citizens.

The components of Reproductive Health from the ICPD Plan of Action have been adopted in Mauritius are as follows:

- Family Planning, including infertility information and services.
- Safe Motherhood: prenatal care including PMTCT, safe delivery, emergency obstetric care (BEmOC & CEmOC), perinatal and neonatal care, postnatal care and breastfeeding.
- Prevention and management of complications of abortion.
- Infant and Child Health.
- Promotion of healthy sexual maturation as from pre-adolescence, responsible and safe sex throughout the lifetime and gender equality.
- Prevention and management of reproductive tract infections, especially sexually transmitted infections (STIs) including HIV/AIDS.
- Prevention and management of sexual dysfunction in both men and women
- Gender and Sexual and Reproductive Health including elimination of domestic and sexual violence against children, women and men.
- Management of non-infectious conditions of the reproductive system such as cervical, breast and prostate cancer,
- Geriatrics and reproductive health problems associated with the menopause and andropause.

The Government of Mauritius has also made various commitments that have enabled Sexual and Reproductive Health to become a priority focus:

- The Millennium Declaration specifying the Millennium Development Goals to be achieved by 2015.
- Vision 2020 and the New Partnership for Africa's Development (NEPAD) which set targets to be achieved by African countries for realistic socio economic development.
- The SADC Sexual and Reproductive Health Strategy 2006-2015, has recommendations for achieving the SRH in the SADC region.
- Mauritius was a signatory to the AU, Maputo plan of Action that calls for strategies to ensure universal access to SRH.
- Mauritius is a member of the Indian Ocean Commission with specific recommendations for SRH.

- The government ratified the Convention of the Rights of the Child (CRC) in July 1990. A children's policy was launched in 2003 with strategies that will ensure implementation towards a " Republic fit for the children"
- Other policies whose strategies have been taken into consideration are the National Youth Policy 2000-2004 and the National Gender Policy 2005.

Through the above mentioned commitments, this National Sexual and Reproductive Health Policy works towards ensuring that all relevant sectors and stakeholders promote Sexual and Reproductive Health through the provision of quality information and services.

The Government of Mauritius receives both technical and financial support from UNFPA and WHO for specific projects linked to strengthening of its SRH programme. As for Action Familiale and MFPWA, they receive grants from the Government for the implementation of SRH activities. In addition, MFPWA receives grants from IPPF.

Chapter 2 - RATIONALE FOR THE SEXUAL AND REPRODUCTIVE HEALTH POLICY

2.1 Preamble

Mauritius has undergone an accelerated social and economic development since the 1960s when the population programme focused exclusively on the attainment of demographic targets. These targets were achieved through a sustained family planning programme. The 1971-1975 National Population Policy set a target to reduce the Gross Reproduction Rate (GRR) from 1.69 in 1969 to 1.2 by 1980. By 1988-1990, when the target was achieved, the emphasis was geared towards improving the quality of life of the present and future generation, to improve health, education, access to employment opportunities, raising the status of women and family welfare. These efforts earned Mauritius the United Nations Population Award in 1990.

The population policy for the period 1992-1994 and onwards was therefore to maintain the Gross Reproduction Rate (GRR) at the replacement level. This was achieved through the intensification of the population and family life education programmes supported by contraceptive services.

The recent demographic history is characterized by low fertility and low mortality, hence a low population growth. The rapid decline in fertility and associated change in age structure of the population has led to a decline in dependency ratio, but there is an increase in the elderly population who live without the traditional family support system.

2.2 Change of Focus

The priority of government is now to formulate a comprehensive national population policy to address emerging reproductive health issues as a result of socio-economic changes in recent years. The family planning programme has shifted its focus from achieving demographic targets to improving the reproductive health of the population in line with the recommendations of the 1994 ICPD/POA. Greater emphasis is being laid on promoting SRH needs of individual women and men as key to improving their quality of life.

The Government also perceives a need to increase the accessibility of high-quality SRH services among adolescents, intravenous drug users, other underserved populations especially those employed in the EPZ, and to address the unmet SRH needs of unmarried women and men. Male involvement and participation in SRH also needs to be strengthened.

Emphasis should also be laid on the issue of Men having Sex with Men (MSM) in the community and also among prison inmates. The huge stigma associated to the MSM and the LGBT (Lesbian, Gay, Bisexual and Transgender) community increases the risk of violence and vulnerability to HIV.

There is evidence to show that whilst services are readily available, they are focused on married women as core target. This blocks out critical SRH targets like adolescents and men. The services are focused mainly on family planning methods/contraceptives aimed at women and are not fully integrated with other SRH service needs for example sexual violence.

The White Paper on Health Sector Development and Reform of the MOH & QL of 2002 recognizes that Mauritius is doing very well but needs new measures to reach levels achieved by countries such as Singapore, New Zealand and other developed countries. The action plan aims to ensure that the country has the vital services that are required and the capacity to deliver them efficiently.

Mauritius is a signatory to the 2006 Maputo Action Plan that has made recommendations for operationalisation of the continental policy framework for ensuring universal access to sexual and reproductive health service including integration of SRH and HIV/AIDS activities.

There are no protocols in place to guide effective and good quality delivery of SRH services.

Despite significant progress, some RH indicators remain alarming, for example high rates of unwanted pregnancies, high rates of abortion, and increasing STIs especially HIV prevalence. Although the contraceptive prevalence rate has increased from 74.7 percent in 1991 to 78.5 percent in 2002 among currently married women aged 15-44 years, there is an increasing trend in the use of less reliable methods.

There is a need to strengthen efforts in order to attain the Millennium Development Goals (MDGs) to which Mauritius has subscribed.

To assist in improving RH indicators, there is a need to identify the shortfalls and develop a strong SRH National Policy including Reproductive Health Commodity Security (RHCS), which will serve as a guiding and organizational framework to promote SRH/RHCS in view of improving access to care and services and maintain the achievements.

2.3 Context of the Sexual and Reproductive Health Policy

The policy is developed as an integral part of the National Development Policy, ‘Vision 2020’ and The White Paper on Health Sector Development and Reform of 2002. It also responds to the recommendations of the National Youth and Gender Policies.

It provides the guiding principles and appropriate strategies for planning, allocation of resources, implementation, monitoring and evaluation of the Sexual and reproductive Health services.

2.4 Policy Goal

To establish an evidence-based framework for the implementation of an integrated Sexual and Reproductive Health programme in order to attain the highest level of health and well-being for all people living in Mauritius.

2.5 Policy Objectives

- I. To guide actions of policy makers, programme managers and service providers of government institutions, NGOs, and private sector for Sexual and Reproductive Health (SRH).
- II. To develop standards and guidelines for Sexual and Reproductive Health services in order to ensure quality and standardization of services.
- III. To mobilize adequate resources to support the implementation of activities.
- IV. To integrate STI/HIV/AIDS in SRH services at all levels of health service delivery.
- V. To ensure that there is privacy during counselling and provision of services.
- VI. To provide youth friendly services in full confidentiality.

2.6 Guiding Principles and Values

The following are guiding principles and values for the implementation of all the components of the RH programme in Mauritius :

2.6.1 Human Rights

The basis and mandate of the National Sexual and Reproductive Health Policy is drawn from the constitution of the Republic of Mauritius, which states that every citizen is entitled to fundamental rights and freedom. One of these rights is the right to good health including sexual and reproductive health. Service providers shall therefore observe and adhere to the Reproductive Health Rights of clients during service delivery as follows:

- The reproductive rights of individuals and couples to decide freely and responsibly the number and spacing of their children and have the information, education and means to do so; attain the highest standard of reproductive health; and make decisions about reproduction free of coercion and violence.
- The sexual rights of people to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health; be free of discrimination, coercion or violence in their sexual lives and in all sexual decisions and expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships.

2.6.2 Gender Equality and Equity

The policy acknowledges that gender is an important concept, which is also contained in the notion of civil and political rights as well as socio-economic and cultural rights enshrined in several international treaties and guaranteed by the constitution of the Republic of Mauritius. Integrating gender in the policy reflects the will of the nation to eliminate all forms of sexual discrimination.

The policy recognizes that any discrimination against young women and men on the basis of sex is a violation of human rights and therefore states that

- I. Gender shall be mainstreamed in all Sexual and Reproductive Health Services.

- II. Information on traditional practices that are harmful for reproductive health such as adolescent marriage shall be provided to individuals and communities.
- III. All forms of exploitation and violence against children and women will be eliminated.
- IV. Women's rights will be promoted as human rights.
- V. Male involvement and participation in SRH issues shall be emphasized at all levels.

2.6.3 Social Justice

The policy recognizes the social rights of all individuals to a decent quality of life including access to proper medical services.

- I. The policy therefore has provision to ensure that Sexual and Reproductive Health are accessible to all people including the adolescents, youth, elderly, disabled and vulnerable groups.
- II. No individual or couple shall be denied access to any SRH commodities due to non affordability if such commodities are necessary to achieve optimal sexual and reproductive health.

2.6.4 Quality Service Provision

In order to establish and maintain good quality Sexual and Reproductive Health services,

- I. Government, NGOs, private medical practitioners, pharmacies and parastatal companies providing SRH services shall be guided by the policies and practices set by the MOH & QL.
- II. SRH policy guidelines, service standards and procedure manuals shall be made available by the MOH & QL in collaboration with stakeholders for use in all institutions (Government and NGOs) at all levels. They should be reviewed periodically.
- III. All Sexual and Reproductive Health strategies, guidelines and practice shall be evidence-based.
- IV. Universal infection prevention and control shall be maintained at all times during the delivery of SRH services.
- V. All Sexual and Reproductive Health services shall be provided in an integrated manner.

- VI. All individuals or couples seeking SRH services shall be counseled and offered voluntary testing for HIV, and referred for appropriate care as the need arises.
- VII. All personnel providing services must demonstrate adherence and commitment to these guidelines, be appropriately supervised, receive regular in-service training to update their knowledge, adopt positive attitudes and maintain skills.
- VIII. Pre service health training institutions shall incorporate Sexual and Reproductive Health in their training curriculum, and ensure regular updates.

2.6.5 Universal Access to Comprehensive Sexual and Reproductive Health Services

The Maputo Plan of Action 2006 calls for countries to operationalize the continental policy framework for ensuring universal access to sexual and reproductive health services and has the following key strategies:

- I. Integrate SRH, STI/HIV/AIDS, malaria programmes and services including reproductive cancers into primary health care to maximize the effectiveness of resource utilization and to attain synergy.
- II. Reposition Family Planning as an essential part of Sexual and Reproductive Health for the attainment of MDGs.
- III. Address the Sexual and Reproductive Health needs of adolescents and youth as a key component of SRH.
- IV. Address the issue of abortion.
- V. Deliver quality and affordable services in order to promote Safe Motherhood, Child Survival, Maternal and Child Health.
- VI. Strengthen African South-South Co-operation for the attainment of the ICPD and the MDGs.

(Note: The issues as spelled above have been addressed in the relevant sections except for number VI on South-South Cooperation.)

Chapter 3 - THE PRIORITY POLICY AREAS, POLICY STATEMENTS AND STRATEGIES

Based on the ICPD Recommendations to address the sexual and reproductive health needs throughout the life cycle, review of existing documents and consultations on the prevailing situation in Mauritius, the following areas were identified as the priority policy areas to be addressed:

- Family Planning
- Infertility
- Safe Motherhood including Breastfeeding
- Abortion
- Infant and Child Health
- Adolescent and Youth Sexual and Reproductive Health
- Sexually Transmitted Infections, HIV and AIDS
- Malignancies of the Reproductive Tract
- Gender
- Male Involvement and participation
- Geriatrics including menopause and andropause

3.1 Family Planning and Concerns

Family planning services are widely accessible in Mauritius through an extensive network of government facilities consisting of 23 Area Health Centres, 112 Community Health Centres, 2 Medi-Clinics, 1 Community Hospital, 4 Family Health Clinics, 2 Family Planning Clinics and 1 Family Planning supply Centre, 8 Hospitals, and 21 Industrial Supply Centres. The MFPWA and Action Familiale are two NGOs that also provide family planning services.

These services have contributed to a decline in the country's total fertility rate (1.79 births per woman in 2005) and the low population growth rate (0.86 per cent in 2005).

However, some challenges remain. In its response to a 2003 United Nations inquiry, the Government indicated that it continues to view adolescent fertility levels, the ageing of its population, and the shrinking size of its working age population as areas of concern.

The Government perceives a need to increase the accessibility of high-quality reproductive health services among adolescents and other

underserved populations, and to address the unmet reproductive health needs of married women.

3.1.1 Pre-marital Conception

The results of the 2002 CPS indicate that premarital conception is on the rise from 8.9 percent in 1991 to 10.5 percent in 2002 among currently or formerly married women aged 15-44 years.

3.1.2 Teenage Pregnancy

Among women aged 15-19 years (teenagers) who were interviewed in the 2002 CPS, 8.7 percent were already mothers and 2.2 percent were pregnant with their first child.

3.1.3 Abortion

The 2002 CPS report indicates that the proportion of women aged 15-44 years who reported having had at least one abortion (spontaneous or induced) has increased from 9.3 percent in 1991 to 14.4 percent in 2002. It is also noted that the proportion of women aged 15-44 years who reported having had at least one induced abortion has increased from 1.8 percent in 1991 to 3.2 percent in 2002.

3.1.4 Knowledge of Family Planning Methods

According to the CPSs, knowledge of at least one method of contraceptive among currently married women 15-44 years is almost universal at 99.7 percent in 1991 and 99.9 percent in 2002. A slight increase in knowledge of tubal ligation, vasectomy, diaphragm, foaming tablets and implants has been noted during the same period.

However, there has been a slight decline in knowledge about the pill, the injectable, IUD and the male condom. Knowledge of the female condom was only 17.7 percent in 2002, which is not surprising, since this method was not available at that time.

The greatest increase in knowledge is noted for most of the natural family planning methods, such as, sympto-thermal method and mucus method. Knowledge of withdrawal method has increased from 74.8 percent in 1991 to 86.3 percent in 2002.

3.1.5 Reproductive Health Commodity Security (RHCS)

RH Commodity Supply Chain

One of the objectives of this policy is to support the goal of the national RH programme. Currently, Mauritius has an integrated supply chain for all essential drugs including RH commodities and contraceptives. For a better and more consistent commodity management, Mauritius needs an integrated logistics management information system (LMIS) in order to gather consumption data and stock levels from facilities on a regular basis.

According to WHO, “essential medicines are those that satisfy the priority health care needs of the population”. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individuals and the community can afford. Mauritius subscribes fully to the WHO Essential Drugs concept, which was implemented as far back as 1979.

3.1.6 Contraceptive Use

According to the 2002 CPS report, contraceptive use in Mauritius is very high (75.9 percent) among currently married women aged 15-49 years.

- The most popular method is withdrawal at 27.1 percent among currently married women aged 15-49 years followed by the pill (15.8 percent) and the male condom (9.1 percent).
- The use of supplied contraceptives, such as, pill, injectable, IUD, vasectomy, male condom and foaming tablets, among currently married women aged 15-44 years, has declined between 1991 and 2002. The use of tubal ligation has remained constant.
- It is important to note that the use of supplied methods is lowest among currently married women with formal education beyond primary level than among those who have not completed primary education (36.4 percent versus 46.3 percent). It should also be noted that 13.7 percent of women with formal education beyond primary level use a natural family planning method, such as sympto-thermal method, mucus method, calendar method, and temperature method and 27.3 percent use withdrawal method.

3.1.7 Fertility Planning

The 2002 CPS asked respondents whether their last pregnancy in the five years prior to the survey was planned (wanted then), mistimed (wanted later), or unwanted. The report revealed that 72 percent of the most recent pregnancies among currently married women aged 15-49 years were wanted, 13.5 percent were mistimed and 8.5 percent were unwanted.

3.1.8 Unmet Need for Family Planning

Unmet need for family planning is on the rise. The CPS results reveal that, among currently or formerly married women aged 15-44 years, 37.8 percent were in need of more effective family planning services in 2002, compared with 26.7 percent in 1991.

This may partially explain the increased number of unplanned pregnancies and calls for more intensive efforts to promote responsible parenthood, more effective contraceptive methods, correct and consistent use of effective methods and to reach women in need of family planning services.

3.1.9 Policy Statement

To improve the availability, accessibility and acceptability of high quality family planning information and services for all the youth, women and men who need them.

3.1.10 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Develop and disseminate IEC/BCC materials on Family Planning and safe sex to clients through all available channels of communication.
- II. Provide family planning information and services to all young people of reproductive age who are sexually active, women and men regardless of their parity and marital status.
- III. Provide contraceptive methods to youth, women and men without parental or spousal consent.

- IV. Design programmes to identify individuals with unmet FP needs and target them for information and services; cater for the family planning needs of the youth, single mothers, PLWHA, commercial sex workers, intravenous drug users, women and men at the workplace.
- V. Adequately counsel all young people, women and men on all available contraceptive methods, including the natural family planning methods such as the sympto-thermal method but let the clients have the fundamental right to decide on the method to use based on informed consent.
- VI. Adequately counsel all clients on the risks associated with the use of all methods including methods like withdrawal.
- VII. Target individuals planning to get married and newly married couples to counsel them on responsible parenthood and encourage men to take more responsibility for SRH and HIV testing before marriage.
- VIII. Provide accurate information on risks associated with pregnancies that are too early, too frequent and too late and encourage individuals and families to delay the first pregnancy until the age of twenty years and to avoid pregnancy after 35 years.
- IX. Encourage satisfied clients to give testimony on their experiences with use of specific methods like long term and permanent methods.
- X. Intensify the follow up of the drop out clients; conduct motivation sessions for non users of family planning methods by reviving home visits and visits to all work places by Community Health Staff.
- XI. Make information and services readily available for Emergency Contraception to all clients on request and especially for those who are victims of sexual violence.

Health Services Delivery

- I. Ensure that all family planning service providers are trained in counselling and service provision using the standard national curriculum for the provision of all methods, especially emergency contraception, IUD insertion, implants and surgical methods in order to offer a wide choice of methods for clients.

- II. Ensure that Family planning information and services are accessible, available and acceptable to all persons. The hours for clinic operation should cater for the needs of working women and men, and youth.
- III. Counsel and offer voluntary testing to all individuals or couples seeking family planning services for HIV and refer for appropriate care as the need may be.
- IV. Promote dual protection for individuals and couples to protect them from STIs, HIV and avoid unwanted pregnancy.
- V. Make condoms of good quality readily available and accessible in supermarkets, grocery shops, and all public places like bars, lodges, hotels.

Research

- I. Conduct operation research to find out the reasons for non utilization of family planning methods; reasons for a shift from use of supplied family planning methods to NFP methods and less reliable methods and use the results to inform policy makers and service providers.

3.2 Infertility and Concerns

There is very little information on infertility. The results of the 2002 CPS reveal that 3.6 percent of currently married women aged 45-49 years are childless. Therefore, based on the assumption that the desire to remain childless within marriage is extremely rare, it is estimated that roughly 3.6 percent of currently married Mauritian women have primary infertility.

The major preventable causes of infertility are infections of the genital tract as a result of STIs, postpartum or post-abortion infections for women. Other factors include abnormalities of the genital tract and male related problems. Considering that abortion is a major public health problem, it may also be a major factor for infertility in Mauritius. Other causes of infertility could be psychological or lack of knowledge about the most fertile days for couples who are only sub-fertile.

Infertility is a major factor for unhappy marriages that often lead to domestic violence and divorce. However, in many countries infertility services are usually given low priority.

Considering that it is possible to prevent infertility caused by infections of the genital tract, correct information should be available to young people, women and men in order to avoid such infections.

3.2.1 Policy Statement

All individuals and couples will be supported to exercise their rights to reproduce as and when they want to.

3.2.2 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

- I. Create awareness and provide information on possible causes and prevention of infertility, to young people through family life education so as to reduce high risk behaviour that can lead to STIs including HIV/AIDS, unwanted pregnancy and abortion.
- II. Counsel and test all individuals or couples seeking infertility services for HIV and refer for appropriate care as the need may be.
- III. Provide information on available services and options for resolving the problem, for example adoption, to the public and infertile couples
- IV. Make available and accessible highly skilled providers and well equipped Infertility Centres for diagnosis and treatment of cases of infertility to those who need these services.
- V. Conduct research to determine the magnitude, major causes of infertility and possible management options and disseminate the results to all stakeholders.

3.3 Safe Motherhood and Concerns

The maternal mortality ratio for Mauritius has been declining very rapidly. In 2005 it stood at 22 per 100,000 live births (2005 Health Statistics Annual, MOH & QL), the lowest in the Africa region.

The maternal and child health services have been strengthened at both peripheral and secondary levels with specialized care being available in some health centres in every region.

Ante-natal care (ANC) is provided at the AHCs and CHCs, while all deliveries are referred to the regional hospitals where echography and foetal monitoring services are available.

Of concern is the fact that women report late for the first ANC visit in the PHC facilities. In 2005, while 3,165 pregnant women reported for first ANC visit in the first trimester (3 months or less), 9,044 reported in the 2nd trimester (between 3-6 months) while 1,526 reported in the 3rd trimester (after 6 months and over). WHO recommendation is for women to report as soon as they know they are pregnant, preferably in the first trimester in order to benefit fully from the ANC services.

- One of the reasons why women report to Health Centres in the 2nd trimester may be because they first consult private Gynaecologists as soon as they know that they are pregnant and later report to the PHC facilities in order to ensure that they can deliver at the Regional Hospitals.
- It is also possible that since most women are employed, it may be difficult for them to take time off to report for ANC until it is quite late.

All pregnant women have their haemoglobin level checked. Anaemia during pregnancy exists among few women. In 2005, for first determination of Hb. levels, 492 cases (4.1%) had Hb. below 9.0 and 1,135 (9.4%) had Hb. of 9.0-9.9.

All pregnant women are offered voluntary counselling and testing for HIV in the public sector only. All HIV positive cases receive HIV preventive treatment with antiretroviral drugs after 25th week of pregnancy and for first 6 weeks for babies after birth. They are also delivered by Caesarian Section (C/S) and babies are fed with formula milk to reduce MTCT of HIV.

Routine testing for syphilis and other STIs is done for all pregnant women (VDRL, KR, and WR) and treatment given as appropriate.

Pregnant women also receive Tetanus Toxoid. In 2005 a total of 26,455 women received the Tetanus Toxoid compared to 25,593 in 2004.

The results of the 2002 CPS reveal that of all births in the five years before the survey, among currently married women aged 15-44 years, 99.6 percent occurred in government and private hospitals while 0.4 percent of women delivered at home. This is an improvement from the 1991 CPS where 7.1 percent of women delivered at home. This must be a major contributory factor for the reduction of maternal and infant mortality in Mauritius.

Post natal care (PNC) is available in both public and private health facilities. Further government services also provide domiciliary visits by Midwives/Nurses. In 2005 while there were 17,924 live births, there were 8,173 PNC first attendances with doctors at government health facilities. Midwives/Nurses carried out 8262 domiciliary visits for post natal in 2005.

There are no reported cases of Vesico-Vaginal Fistula (VVF) in Mauritius.

The percentage of low birth weight (babies weighing less than 2,500 grams) among live births in the public sector facilities increased from 13.9 percent in 1995 to 14.3 percent in 2000 and 17.3 percent in 2005. This calls for more education on proper nutrition, regular ANC attendance, avoiding cigarette smoking and alcohol consumption, change in behaviour and life style during pregnancy.

The number of stillbirths and perinatal deaths has been on the decline since 1975 and was 9.6 and 16.4 per 1000 total births respectively in 2005 (2005 Health Statistics Annual, MOH & QL).

Major causes of early neonatal mortality (deaths under one week) are slow foetal growth, foetal malnutrition and immaturity (31.7 percent); congenital abnormalities (24.4 percent) and infections specific to the perinatal period (6.5 percent).

3.3.1 Breastfeeding

Breastfeeding is beneficial for the health and welfare of infants as the maternal antibodies protect infants from infections and promotes bonding.

The concerns related to breastfeeding are

- The 2002 CPS report indicates that a large majority of infants had been breastfed (91.2 percent) for at least short periods of time. This may be a result of a massive campaign that was carried out a few years before the 2002 CPS. Of those who were ever breastfed, only 21.4 percent initiated the breastfeeding during the first hour after birth while 56.4 percent started between one hour and the end of the first day.
- The mean duration of breastfeeding was found to be 13.6 months in 2002, which is the same as in 1991. It is recommended that breastfeeding should continue until the age of two years or beyond, mothers therefore need more support to continue breastfeeding for longer periods.

- The mean duration of exclusive breastfeeding in 2002 was 2 months among last-born children born in the last five years before the 2002 CPS. This is still short although it was an improvement from 1.1 months in 1991. WHO recommends that infants should be exclusively breastfed for the first six months of life. There is a great need to strengthen the campaign with emphasis on initiation of breastfeeding within the first half hour, exclusive breastfeeding for six months and ensuring to breastfeed for 2 years or more.

3.3.2 Policy Statement

To reduce maternal and perinatal morbidity and mortality and ensure healthy development of the newborn.

3.3.3 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Disseminate IEC/BCC messages on safe motherhood through all available media with emphasis on early attendance for ANC, regular follow ups, proper nutrition, adequate rest, no cigarettes or alcohol consumption during pregnancy.
- II. Train service providers to counsel pregnant women and couples on the importance of prevention and management of STIs/HIV/AIDS during pregnancy, delivery and after delivery to reduce the transmission of HIV to the newborn.
- III. Advocate for all private practitioners to include HIV testing among the routine tests for pregnant women.
- IV. Advocate for all employers to give pregnant women time-off to attend ANC early in the first trimester and for subsequent follow-up appointments.
- V. Develop IEC/BCC on Safe Motherhood and breastfeeding and disseminate them through all possible channels of communication.
- VI. Continue with the campaign for breast feeding to ensure that initiation of breastfeeding is done within half an hour after delivery and that exclusive breastfeeding is practised for 6 months.

- VII. Continue the ongoing training of health service providers on breastfeeding counselling.
- VIII. Advocate for legal measures for government institutions to provide time off facilities to all mothers who work in the public sector. At present, this is available only in the private sector.

Health Service Delivery

- I. Strengthen the institutional capacity to coordinate and manage the RH and MCH programme at all levels.
- II. Build the capacity of Managers and service providers and continuously provide updates for RH and MCH activities.
- III. Develop/update service guidelines to integrate STI/HIV/AIDS prevention and management into the safe motherhood activities and ensure that they are available and accessible to the managers and service providers.
- IV. Strengthen the prevention of MTCT of HIV activities at all levels.
- V. Continue to promote prompt PNC in health facilities and during home visits.
- VI. Ensure Reproductive Health Commodity Security.
- VII. Conduct operational research on the reasons for maternal and newborn morbidity and mortality and take corrective measures.

3.4 Abortion

In Mauritius, abortion for social or personal reasons is illegal as stipulated in the law of 1838 except in cases where the mother's life is in danger. In order for the woman to procure the abortion, it has to be approved by the Supreme Court. The process is so long that there is no reported case where this has ever been accomplished. This law has never been reviewed, but there are reports that abortion is an issue in Mauritius. All cases of spontaneous and induced abortion are referred to the Regional Hospitals for management.

The issues are:

- The 2002 CPS report indicates that the proportion of women aged 15-44 years who reported having had at least one abortion (spontaneous or induced) has increased from 9.3 percent in 1991 to 14.4 percent in 2002. It is also noted that the proportion of women aged 15-44 years who reported having had at least one induced abortion has increased from 1.8 percent in 1991 to 3.2 percent in 2002. However, since

abortion is illegal, the survey results may be biased due to underreporting of induced abortion.

- Reports from government hospitals recorded 1,340 cases with post abortion complications in 2003 and 1,612 such cases in 2004 and 1,389 cases in 2005. These figures do not differentiate between spontaneous and induced abortions.
- It is however well known that many young women resort to abortion in cases of unwanted pregnancy.
- Maternal mortality is low in Mauritius. Between 2001 and 2005, 16 maternal deaths were recorded, and about 6% of the maternal deaths were due to complications of unsafe abortion during the same period.
- The issue of abortion is very sensitive in Mauritius. While a lot of discussions related to abortion are being reported in the mass media, there is hesitation to give it a national focus, as it could receive a lot of pro-life sentiments from the religious sector and other people.

3.4.1 Policy Statement

To prevent abortion, reduce the prevalence and minimize the short and long term complications of abortion.

3.4.2 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Establish programmes to educate adolescents, youth and especially girls on the possibility and advantages of delaying onset of sexual activity and on responsibility to their fertility. This education programme should also include the dangers of early sexuality, unsafe sex, STIs/HIV/AIDS and unwanted pregnancy. The dangers and after effects of abortion should also be highlighted.
- II. Establish programmes to educate parents and communities on the prevention of unwanted pregnancy, and dangers of abortion so that they may effectively communicate with their children.
- III. Advocate for the review of the existing law on abortion.

- IV. Create awareness about the existing law on abortion.
- V. Educate men to be more responsible towards contraception in order to avoid unwanted pregnancy and to support women who end up with unplanned pregnancy.

Health Service Delivery

- I. Train health providers and disseminate national guidelines on the effective management of complications of abortion.
- II. Develop/update management protocols/guidelines to incorporate prevention of STI/HIV/AIDS and ensure that they are accessible to managers and providers.
- III. Provide post abortion counselling and effective family planning methods to avoid repeated abortions at all levels of health care.
- IV. Create new institutions and support existing ones to support pregnant women who experience problems.
- V. Promote contraception in order to avoid unplanned pregnancies.
- VI. Support operations of crèches and institutions that cater for orphans and children that cannot be catered for by their mothers/parents.
- VII. Amend the law to facilitate the adoption of children.
- VIII. Discuss the option for adoption with the women who do not want to keep their babies and train service providers and social workers to counsel about this option.
- IX. Conduct research on the prevalence, consequence, prevention and management of abortion to inform policy makers and service delivery providers.

3.5 Infant and Child Health

The future reproductive health and performance of women and men depends on good health during infancy and childhood. The two most important interventions in early life are good nutrition and prevention of communicable diseases. Apart from being well nourished and free from infections, children also need intellectual stimulation and emotional support during development and good parenting is essential for later psychosocial development.

Children should also be protected from physical and sexual abuse, so Children's Rights should be enhanced through enforcement of the Child Protection Laws and other appropriate Acts.

The socio economic achievements of Mauritius include a persistent decline in the infant mortality rates that in 2005 stood 13.2 deaths per 1000 live births. The major causes of death are congenital abnormalities (25.7 percent), slow foetal growth, foetal malnutrition and disorders related to short gestation and low birth weight (22.4 percent) and infections specific to the perinatal period (9.3 per cent).

The achievement of the Expanded Programme on Immunization in Mauritius is very remarkable and has resulted in the eradication of polio, diphtheria, whooping cough, and tetanus and in the control of measles, hepatitis B and TB. Current vaccination levels are sufficient to ensure widespread immunity. The new Haemophilus Influenza Vaccine (Hib) was added to the EPI package in 2006. In 2005, the immunization coverage for BCG was 90.1 percent, DPT (3rd dose) 87.4 percent, polio (3rd dose) 87.9 percent, MMR (measles/ mumps/ rubella) 87.9 percent and TT coverage for pregnant women (2nd dose or higher) 80.2 percent. Immunization performed in the private sector, not included in the given figures, are estimated to be around 8 per cent

The achievement has been attributed to good management, trained and competent staff, sustained funding to supply vaccines and a well educated and supportive community.

The MOH & QL intends to eradicate or contain all infectious diseases at their present level, so the good performance of the EPI programme needs to be sustained.

The preventable causes of neonatal morbidity and mortality should also be addressed.

3.5.1 Policy Statement

To ensure, optimal physical and psychological development of children free from all types of preventable diseases and abuse.

3.5.2 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

- I. Develop IEC/BCC messages for education of communities on the value of good childhood nutrition; about the relationship between childhood growth and later reproductive health and performance, especially for girls;
- II. Promote good parenting, both for optimal psycho-social development and for the prevention of physical, sexual and psychological abuse.
- III. Continue to provide adequate resources and support to the EPI programme in order to achieve and maintain universal childhood immunization.
- IV. Continue the implementation of the School Health programme for health education and screening.
- V. Improve the detection of physical, sexual and psychological abuse and provide support for the victims and their families.
- VI. Support Institutions to provide shelter, medical care, including PEP, psychological support for victims of physical and sexual abuse.
- VII. Implement programmes to monitor the intellectual development of children with physical and mental disability.
- VIII. Establish/support institutions to cater for handicapped children and assist their parents.
- IX. Conduct appropriate research on the main causes of infant death and on the major problems of childhood, such as, physical and sexual abuse and their impact on future reproductive health and life in general.

3.6 Adolescent and Youth Sexual and Reproductive Health

The major issues are:

- Young people (10-24 years) are becoming sexually active at an increasingly earlier age with high rates of unwanted teenage pregnancy and sexually transmitted infections including HIV/AIDS.
- Teenage pregnancy is reported to be on the increase as well as abortion and its complications. There is a high unmet need for

information, education and SRH services for adolescents and youth. It is therefore very critical that catering for their needs should be a priority on all fronts.

- There are challenges and gaps in relation to sexual and reproductive health needs of adolescents and young people. The biggest challenge is the lack of accurate information and life skills based education provided to adolescents through respective institutions like the family, the educational system and the community in general. This is a result of the breakdown of the family support system with a communication gap between parents and children.
- Available data show that there were 1,554 live births among women 15-19 years old in 2005, representing 8.8 percent of the total live births in Mauritius. This is a major concern since more complications are associated with birth below 20 years.
- According to the 2002 CPS report, 10.9 percent of adolescents (women aged 15-19 years) have already started childbearing. About 13 percent urban adolescents had already started childbearing as opposed to 9.8 percent of the rural adolescents.
- The 2002 CPS reports that knowledge of at least one method of contraceptives by adolescents (women aged 15 to 19 years) is very high at 95.7 percent. Pill (90.6 percent) is the most widely known method followed by male condom (84.5 percent), tubal ligation (63.2 percent), injectable (49.8 percent), count method (38.3 percent), withdrawal method (38.3 percent), temperature method (37.5 percent), IUD (29.2 percent), vasectomy (26.0 percent), female condom (24.9 percent) among adolescents.
- The contraceptive prevalence rate among currently married women aged 15-19 years is 47.3 percent – 26.3 percent are using withdrawal method, 18.4 percent are using supplied methods and 2.6 are using NFP methods. This cohort is less likely to use contraception since most probably they would like to get pregnant.
- Exposure to mass media, changing behaviour patterns as well as negative peer pressure has created serious health risks which are of major concern to government.
- There are also inadequate youth friendly services to cater for the needs of adolescents and young people.

3.6.1 Available Services

The staff of the MOH & QL conducts school health programmes, which include screening, health education and provision of dental care at primary and secondary schools. Immunizations are done at primary schools. For secondary schools and universities there is health education on prevention of Non Communicable Diseases (NCDs) and healthy life styles. Presentations and discussions on SRH, STI/HIV/AIDS are only made on request.

Young people also receive information, counselling and services when they report to health facilities, together with the other clients. Currently there are only two youth friendly clinics situated in Port Louis and at the University of Mauritius. Attendance is reported to be low.

The National Gender policy has made recommendation to address the gender needs of adolescents and young people.

The National Youth Policy 2000-2004 was developed to empower the youth in the new millennium. The policy has a section for Population and Family Life Education whose objectives are to

- Improve life skills of young people so they can be empowered to make informed choices for SRH; provide information on SRH to youth, parents, service providers and community members;
- Consolidate counselling service for SRH at secondary and tertiary level institutions;
- Build capacity of youth and promote networking with agencies involved in ASRH activities and set up structures for youth activities.

3.6.2 Family Life Education Programme (FLE)

The Ministry of Youth and Sports has a Population and Family Life Education programme for young people aged 14-29 years, supported by UNFPA that aims to set up twin programmes of education and counselling to enable young people to plan their lives in a more realistic and responsible way.

The programme includes Life Skills development, training of peer educators and counselors, peer counselling and support, dissemination of information on reproductive health and HIV/AIDS. The activities are implemented through 22 Youth Centres distributed nationally and at tertiary institutions of learning. There is however no provision for health or contraceptive

services by the programme and those in need are referred to health facilities and family planning distribution points.

The Mauritius Family Planning and Welfare Association, Action Familiale and Mauritius Alliance of Women NGOs also conduct, on request, outreach programmes to schools to provide information on sexual and reproductive health, HIV/AIDS and healthy life styles.

The coordination of the information that is provided by different institutions and coverage of schools was a problem. A standard manual was developed in 1999 in order to harmonize training on sexual and reproductive health. This manual is being used by most institutions for training in FLE since 2001.

The Ministry of Education is in the process of integrating SRH and HIV/AIDS in the school curriculum at all levels to emphasize sexual and reproductive health promotion.

New curricula have been developed for primary and secondary schools where the content of SRH is included in biology under human reproduction. A policy for the new curricula is also being developed. The content will be examinable with specific teachers being well prepared to deliver the content areas.

3.6.3 Policy Statement

To provide the community, parents, teachers and young people with accurate information, skills, counselling and user friendly services in order to attain quality sexual and reproductive health for young people.

3.6.4 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Equip parents, guardians, teachers and community leaders with information and skills on adolescents and youth SRH/STI/HIV/AIDS needs, so that they can effectively communicate and guide the adolescents and youth.
- II. Promote communication between adolescents/youth and parents, guardians, teachers and community leaders on SRH/STI/HIV/AIDS through all possible channels.

- III. Ensure that components of Family Life Education begins at the family level continues in primary schools and at all levels of education. Special efforts should be made to address the needs of out of school children and youth as well as those with special needs.
- IV. Ensure that all adolescents and youth have access to accurate information on SRH/STI/HIV/AIDS through school programmes, mass media, health facilities and youth centres in order to promote safe and healthy life styles.
- V. Make readily accessible and available Relevant IEC/BCC materials on SRH/STI/HIV/AIDS for use by adolescents and youth.
- VI. Advocate for the establishment of counselling services in all existing youth centres.

Health Service Delivery

- I. Train health workers in the provision of information, counselling and service delivery for adolescents and young people so that they establish youth friendly health services in all health facilities.
- II. Ensure that youth friendly services are accessible to married and unmarried young people and establish hours of operation that are convenient to all young people.
- III. Ensure the participation of adolescents and young people in the design and implementation of the SRH/STI/HIV/AIDS youth friendly services.
- IV. Develop and make available guidelines for the development of youth friendly services, counselling and service provision in the youth friendly facilities.

Legal Provision

- I. Enact laws to enable young people below the age of 18 years to access health service points unaccompanied by adults for Sexual and Reproductive Services.
- II. Enact and strengthen policies and laws to protect providers of services to young people below 18 years.
- III. Strengthen the implementation of laws that prohibit child prostitution and trafficking.

Research

- I. Conduct regular operational research on ASRH and youth SRH to inform policy and service delivery.

3.7 STI/HIV/AIDS

Sexually transmitted infections (STIs) are a growing public health concern, with both immediate and long-term health, social and economic consequences for women, men and infants. Moreover, STIs amplify the risk of HIV transmission.

In 2005, the MOH & QL reported 93 new cases of gonorrhoea and 62 new cases of syphilis. All complicated STI cases (including HIV/AIDS) are referred to a specialized unit at Bouloux AHC in Port Louis.

The first HIV case was reported in 1987 in Mauritius. By end of 2006, there has been 2,716 cumulative HIV cases reported in Mauritius, of which 2,587 are Mauritians (including 11 children under 15 years). Of the 2,587 cumulative HIV reported cases, 2139 are Mauritian males (82.6 percent) and 448 (17.3 percent) are Mauritian females. Of these 2587 Mauritians, 183 have died (138 men, 42 women and 3 children).

In the last five years, the number of new HIV reported cases has increased by almost six-fold, from 98 in 2002 to 542 in 2006 (see table I).

Table I: Number of new HIV reported cases among Mauritians

Year	New cases	Year	New cases
2001	55	2004	525
2002	98	2005	921
2003	225	2006	542

Modes of transmission among the Mauritians

Yearly data on new HIV reported cases shows that there has been a shift in the main mode of transmission from heterosexual (64 percent in 2001 and 10.2 percent in 2006) to injecting drug use (7 percent in 2001 and 85.6 percent in 2006).

Among the 2,587 cumulative HIV reported cases, it is noted that mother to child transmission is 0.5 percent and unknown mode of transmission is 1.6 percent (see table II).

Table II: Mode of Transmission Among the 2,587 HIV/AIDS Infected Mauritian

Groups	Infection Rate (%)	Groups	Infection Rate (%)
Injecting Drug Use (IDUs)	74.4	Homosexual/ Bisexual	0.9
Heterosexual	16.3	Mother to Child	0.5
Heterosexual and IDUs (Unsafe Sex + Sex Workers)	6.4	Unknown	1.6

Pregnant women who follow antenatal care at government clinics are screened for HIV. The HIV positivity rate among pregnant women has increased from 0.05 percent in 2001 to 0.28 percent in 2006 since, out of the 17,240 tests carried out in 2001, 9 were found to be HIV positive and out of the 16951 tests carried out in 2006, 48 were found to be HIV positive.

Knowledge about transmission and prevention of HIV/AIDS

Respondents of the 2002 CPS were asked questions about HIV/AIDS in order to assess knowledge about the transmission and prevention of HIV/AIDS.

Although 96 percent of the respondents (women aged 15-49 years) reported having heard about AIDS, 72.4 percent of them either knew very little or nothing at all about HIV/AIDS. When asked whether a person could do something to avoid getting HIV/AIDS, 20.0 of them said that they did not know about any way to avoid getting HIV/AIDS, 6.7 percent said that there is no way to avoid getting HIV/AIDS and 73.3 percent said that there are ways to avoid getting HIV/AIDS. When asked about ways to prevent from getting HIV/AIDS, some respondents spontaneously cited use of condoms (49.2 percent), keep one sexual partner (46.5 percent), limiting sexual partners (23.2 percent), avoid blood transfusions (12.3 percent) and avoid mosquito bites (0.7 percent).

In general, the 2002 CPS results reveal that Mauritian women have some misconceptions and limited knowledge about HIV/AIDS, its methods of transmission and prevention. There is a need to intensify the sensitization campaign about HIV/AIDS.

National Response

The national AIDS Control Programme was established in 1987. It focused mainly on primary prevention (information, education and communication, blood transfusion safety and voluntary counseling and testing). From 1999, care and access to antiretroviral treatment was integrated into the programme including prevention of mother to child

transmission (PMTCT) and Post Exposure Prophylaxis (PEP) to all accidental injuries and rape victims.

Under the PMTCT programme, HIV infected pregnant women are offered a protocol of treatment – antiretroviral drugs in the third trimester and caesarian section delivery. The newborn receives antiretroviral drugs for six weeks and artificial milk free of user cost for two years. This protocol reduces the risk of transmission from mother to child from 30 percent to 1 percent.

Since the PMTCT programme was initiated, no contamination has been recorded among the 65 HIV positive mothers who adhered to prophylactic treatment.

Multisectoral activities to promote prevention and to increase access to antiretroviral drugs have been addressed in the National HIV/AIDS Strategic Plan 2001-2005. A National AIDS Committee was also set up to give policy guidance on HIV/AIDS.

At present the major concern is the transmission of HIV among injecting drug users (IDUs) through needle/syringe sharing. In the fight against spreading of HIV/AIDS among IDUs, an Action Plan was elaborated. A 3-pronged strategic approach was recommended, namely, methadone substitution therapy, needle exchange programme and the provision of an HIV/AIDS Act to address issues, such as, testing, confidentiality and stigmatization.

3.7.1 Policy Statement

To contribute to the national goal to reduce STI/HIV infections and continue caring and supporting people affected by STI/HIV/AIDS in order to reduce morbidity and mortality associated with HIV infection and minimize the psychological impact on individuals and population in general.

3.7.2 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Raise awareness among the general public, youth, men and especially women of reproductive age about STIs/HIV/AIDS including their health and economic consequences during SRH service delivery.

- II. Provide information to reduce the risk of STI/HIV infection for women, men and young people through all available media and promote responsible sexual behaviour and refer for HIV counselling and testing when necessary.

Health Service Delivery

- I. Maintain the high standards of provision and use of safe blood and blood products through out the delivery of SRH services.
- II. Maintain the high standards of infection prevention and control during SRH Service delivery.
- III. Include routine hepatitis and HIV screening in ANC care package.
- IV. Decentralize the management of STIs.
- V. To reinforce the training of health service providers in counselling and contact tracing for STIs/HIV.
- VI. Integrate VCT at all level of SRH service delivery
- VII. Maintain and improve the PMTCT activities.
- VIII. Promote the use and increase accessibility of female condoms.

Legal

- I. Enact or strengthen regulations to enforce entertainment and public places (bars, night clubs, hotels, lodges) to stock and distribute female and male condoms.
- II. Amend Civil Status Act to include premarital counselling and compulsory testing for HIV to safeguard the interest of both couple and children

Research

- I. Conduct essential research in the prevention and treatment of STIs including HIV/AIDS.

3.8 Malignancies of the Reproductive Tract (Cancers of cervix, uterus and prostate), Cancer of breast and concerns

There is compelling evidence that cancer is a major health problem in Mauritius. The cancer burden is definitely on the increase with some 1,330 new cases registered annually. Cancer is also the third cause of deaths responsible for some 11 % of all deaths.

According to the latest National Cancer Registry figures for the four-year period 2001-2004, 5327 cancer cases were registered. Malignancies of reproductive tract are also on the increase for both males and females. Of all female cancers cases, female reproductive tract cancers has increased from 22.2 percent in 1999-2000 to 25.0 percent in 2003-2004. Breast and cervical cancers are the leading cancers among women in Mauritius, representing 34.5 percent and 12 percent of all female cancer cases respectively. Overall, male reproductive tract cancers accounted for 13 percent of all male cancer cases. Moreover, cancer of the prostate, which is the commonest male reproductive tract cancer, accounted for 10 percent of all male cancer cases.

Cancer mortality data indicate that 10.5 percent of cancer deaths in males are due to the cancer of the prostate and 35 percent of cancer deaths in females are due to breast, cervix, and uterus cancers.

A wide range of radiology and laboratory services for diagnosing and monitoring cancer patients are available at all regional hospitals. There is a unique Radiotherapy center (~ 50 beds) to cater for treatment of cancer by various modalities including radiotherapy, chemotherapy, and hormonotherapy following surgery.

Moreover, the MOH & QL has established a screening programme for breast and cervical cancers at AHCs and work sites in Mauritius and Rodrigues. The cancer screening programme includes clinical breast examination to detect breast lumps in women and Pap smear cytology for detection of cervical cancer. Mammography service is available in government hospitals and private clinics. Population-based mammographic screening at non-palpable stage is not currently available at government hospitals. Private clinics and MFPWA clinic offer these services, but at a cost.

Cancer of the cervix is associated with several subtypes of the human papilloma virus (HPV), which is sexually transmitted. A vaccine against HPV has recently been marketed and has a major potential to reduce cervical cancer burden in the future.

Women younger than 20 years are biologically more vulnerable and sexual activity with many sexual partners may result in cervical cancer later on. It is theoretically preventable through delayed onset of sexual activity, safe sexual behaviour and/or regular Pap smear, and vaccination against HPV.

The MWRCDFWCP operates through a network of 14 Women Centres, which aims at raising the social, legal, economic and political status of women in the community through advocacy, training and IEC programmes. The MWRCDFWCP in collaboration with the MFPWA had initiated Well-Women Clinics on a pilot basis in 4 Women Centres. These Well-Women Clinics provided counselling and health services that included screening for female reproductive tract cancers.

To reduce morbidity and mortality from the common reproductive tract organ cancers immediate interventions are required. However, in many cases, women and men still present late when unfortunately treatment becomes less effective.

It is therefore imperative to define main priorities, set strategies and implement coordinated activities within the various components of the National Cancer Control Program (NCCP), which are cancer prevention, early diagnosis, effective therapy and palliative care.

In line with WHO recommendations, the MOH & QL has set up a Cancer Task Force to develop a 5-year Action Plan in which issues regarding reproductive tract cancers will be thoroughly addressed.

3.8.1 Policy Statement

To reduce morbidity and mortality from the common reproductive tract organ cancers among men and women of all ages and to improve the quality of life.

3.8.2 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Provide information, education and counselling on all reproductive tract cancers in all health facilities and women centres.
- II. Produce user friendly material for dissemination to the public and clients on common reproductive tract malignancies.

- III. Educate communities and health care providers on the risk factors for the common causes of the reproductive tract organs and provide counselling on self examination in the case of cancer of the breast.
- IV. Develop and disseminate the standards and guidelines for adequate management of reproductive tract cancers to health service providers.

Health Service Delivery

- I. Strengthen facilities including the mobile services (Caravanes de Santé), for early detection and management of common malignancies at all levels of the health services.
- II. Provide services to women through the Caravanes de Santé at least once a week at the Women Centres and to expand the availability of information and improve on accessibility for screening of cancers.
- III. Establish facilities for palliative Care.
- IV. Provide vaccines against Human Papilloma Virus (HPV)
- V. Train Officers in Charge of Women Centres to encourage women to report early for screening.
- VI. Develop and make readily available and accessible guidelines for referral of patients in conjunction with the Cancer Action Plan.
- VII. Link the National Cancer Registry Database to the new patient information system to facilitate the monitoring of patients, to identify trends in the pattern of diseases in the country and to evaluate the effectiveness of services.

Research

- I. Conduct epidemiological, clinical and operational research to improve detection, investigation and treatment of reproductive tract malignancies.

3.9 Gender and Sexual and Reproductive Health

The socio economic achievement of the Government of Mauritius in the last three decades and universal access to health care is reflected in the improvement in the health status with increased life expectancy for both men and women and a low population growth rate.

The ageing population poses a concern as this category of men and women have specific needs. There are a greater proportion of women than men in this age group.

Non communicable diseases are reported to be major causes of death and ill health among women. Mental problems, heart diseases and cerebrovascular diseases are on the increase and especially among the elderly. There is also an increase in the number of cancers of breast, cervix and uterus in among women 35-60 years. Cancer of the prostate among men is also on the increase.

In most cases due to ignorance, women and men report too late to benefit from the available treatment. Screening tests need to be done periodically if the cancers are to be detected early.

Adolescent and youth reproductive health are gender concerns in the health sector. Young people (10-24 years) are becoming sexually active at an increasingly earlier age with high rates of teenage pregnancy and sexually transmitted infections including HIV/AIDS. By the end of 2006, about 18.6 percent of HIV cases were reported among 15-24 years. They are likely to have been infected at an earlier age.

Although the HIV/AIDS prevalence is still low at 0.19 percent in 2006, of the 2,587 cumulative Mauritian HIV/AIDS cases reported by end 2006, there were 138 Mauritian men, 42 Mauritian women and 3 Mauritian children who have died.

(Note: The above issues have been handled in the relevant sections of the policy document.)

Violence against women and children is a key concern to the Government of Mauritius and is covered under the Protection from Domestic Violence Act of 1997, which is being reviewed as per Government Programme 2005-2010 for better protection of victims of violence. The Ministry of Women's Rights, Child Development, Family Welfare & Consumer Protection (MWRCDWFPC) has adopted a broad framework to respond to the problem of violence against women and children.

In 2006, 1041 cases of domestic violence were recorded at the Family Welfare Unit, out of which 65 were males. During the same year 48 cases of sexual abuse were reported.

The Child Development Unit recorded 2218 female cases and 1673 male cases of child abuse, out of which there were 213 female victims and 31 male victims of sexual abuse.

3.9.1 Provision for Victims of Domestic and Sexual Violence

The Ministry also assists victims of domestic violence by providing services of Barristers as and when required at Court Level as well as financial assistance when victims leave the shelter. The Ministry further refers victims to the Ministry of Social Security for social aid in cases where the victims have been abandoned by their spouse and are faced with financial constraint.

A Protocol of Assistance to Victims of Sexual Assault is operational since March 2006. The purpose of the Protocol is to ensure a prompt and timely assistance to victims of sexual assault. With the application of the Protocol, victims may now call either at the Police Station of the region where the incident took place or directly to any of the 5 regional hospitals. In line with the provisions of the Protocol, the MWRCDFWCP is informed of the case by the Police and arrangements are made for psychological assistance and legal counseling to be provided to the victim.

A fast track service has been established at the Regional Hospitals to assist victims of sexual abuse. This also includes the assistance of a psychologist, police officer and medical social worker.

The MWRCDFWCP provides temporary shelter for physical care and psychological support for battered women. SOS Femmes, which is an NGO, also provides such services.

The MWRCDFWCP has set up a Drop-In Centre with the collaboration of the MFPWA. The Drop-In Centre provides to all children at risk or victims of sexual exploitation all relevant information, education, psycho-social medical and logistic support to ensure their protection, rehabilitation and reintegration in the family, in school, at work and in the community at large.

There are Zero Tolerance Clubs at the community level which operate as watchdogs to ensure that their localities are free of violence. Members of the community are empowered through various training programmes to detect and report cases of domestic violence including sexual violence.

3.9.2 Policy Statement

To create an environment in which relationships are free from all forms of violence (sexual, verbal, physical, sexual, psychological) and provide care and support for victims.

3.9.3 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall

IEC/BCC

- I. Create awareness among communities about physical and sexual violence and create networks for local and domestic resolution and support for children, individuals and couples.
- II. Ensure that FLE in schools and colleges is conducive for creation of non-gender based violence attitude.
- III. Develop life skills for youth, men and women to improve their responses in conflict situations.

Health and Legal Services

- I. Train health, security and judiciary personnel to create a victim friendly environment at health facilities, police posts and in the courts.
- II. Develop guidelines for the management of victims and appropriate tools for recording of evidence.
- III. Ensure the availability and accessibility of Post Exposure Prophylaxis for HIV (PEP) and Emergency Contraception for victims on a 24 hour basis.
- IV. Strengthen training of health providers in the procedures and maintenance of records.
- V. Strengthen collaboration between the health, social and legal sectors for the early reporting of such incidents, treatment and long term counselling of victims and prosecution of the offenders.
- VI. Create facilities for immediate and long term protection and rehabilitation of victims and offenders.
- VII. Implement the Child friendly/Family Courts.

- VIII. Promote research to determine the prevalence of domestic and sexual violence, its impact on Sexual and Reproductive Health and ways to improve the detection and management of victims.

3.10 Male Involvement and Participation in SRH

Discussions indicate that men are reluctant to participate in family planning activities as it is seen as a woman's affair.

Moreover, providers report that when they provide family planning services in factories, men rarely participate or attend the counselling sessions. Likewise, when couple counselling sessions, about family planning and safe motherhood, are carried out, men rarely participate in these sessions.

The 2002 CPS showed that although knowledge of the male condom among currently married women aged 15-49 years is 94.4 percent, the current use of the male condom is only 9.1 percent and it is the 3rd most popular method, while the most common method is withdrawal.

The 2002 CPS also reports that knowledge of vasectomy by currently married women 15-49 years is 28.1 percent, but its use is only reported by 0.1 percent of the women. The reasons are that the men believe that they may become impotent after vasectomy. Other people indicate that it is women who are opposed to vasectomy, in case they need to have children later.

The fact that there are limited male contraceptives and most RH services are provided in women oriented settings such as MCH/FP clinics, indirectly exclude men. As a result men have not benefited from the information and education provided at the facilities and lag behind women with regard to knowledge about available contraceptive technology, benefits and where to obtain them. This makes men less supportive of family planning programmes, but through getting involved in risky behaviour, men increase the risk of their female partners contracting STIs/HIV/AIDS.

The MWRCDFWCP with UNFPA funding is working with MFPWA on a special project "Men as Partners Initiative" to enlist their support to foster more responsibility among them. This project is a gender sensitive project that aims at promoting responsibility and participation within the family and the community so as to enable the effective empowerment of women and the enhancement of quality of life of the family.

Several other programmes have been implemented by the MWRCDFWCP such as the "Marriage Enrichment Programme" and "Pre-Marital Counselling". The "Marriage Enrichment Programme" aims at

strengthening and promoting understanding and respect between married couples for a more stable married life.

There is also a network of 175 welfare centres and community centres whereby community based activities are organized to reach more underserved men and women

Action Familiale targets couples for counselling in the use of the symptothermal natural family planning method. They also have programmes that target men in the workplace, with emphasis on responsibility for the family. Their youth programmes also include education for parents and community leaders, but male involvement is reported to be very weak.

3.10.1 Policy Statement

Men to be well informed about the benefits of sexual and reproductive health for themselves, their partners and families and to actively participate in the SRH activities.

3.10.2 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

- I. Intensify programmes to create awareness among boys and men on their role in sexual and reproductive health so that they take responsibility for their partners, families' and own health.
- II. Sensitize boys and men on gender and sexual and reproductive health issues to stimulate discussions and promote violence-free relationships.
- III. Ensure that sexual and reproductive health services are men friendly and adequately caters for their needs.
- IV. Promote SRH programmes in work places and ensure the active involvement and participation.
- V. Make male and female condoms more available and accessible including all public and entertainment places such as night clubs, bars, lodges and hotels.
- VI. Conduct research to identify ways of promoting men's participation in sexual and reproductive health activities.
- VII. Make services become more male-oriented.

3.11 Male Sexual Dysfunction

Male sexual dysfunction is a health problem affecting men and is more common with increasing age. Male sexual dysfunction can be caused by physical or psychological problems. There are various types of male sexual dysfunction of which erectile dysfunction (ED) is the most common form of male sexual dysfunction.

Erectile dysfunction or male impotence is defined as the inability of a man to achieve and maintain an erection sufficient for mutually satisfactory intercourse with his partner.

The variations in severity of erectile dysfunction make estimating its frequency difficult. Many men also are reluctant to discuss erectile dysfunction with their doctors, and thus the condition is under-diagnosed. While erectile dysfunction can occur at any age, it is more common in the elderly. By age 45, most men have experienced erectile dysfunction at some time.

The causes of erectile dysfunction include

Ageing: Older men are more likely to experience erectile dysfunction than younger men.

Diabetes mellitus: Erectile dysfunction tends to develop 10-15 years earlier in diabetic men than among non-diabetic men.

Hypertension and Cardiovascular diseases: Persons with hypertension and cardiovascular disease have an increased risk of developing erectile dysfunction.

Cigarette smoking: Cigarette smoking aggravates atherosclerosis and thereby increases the risk for erectile dysfunction.

Nerve or spinal cord damage due to disease, trauma, or surgical procedures, can cause erectile dysfunction.

Substance abuse: Marijuana, heroin, cocaine, and alcohol abuse may contribute to erectile dysfunction. Alcoholism, in addition to causing nerve damage, can lead to atrophy of the testicles and lower testosterone levels.

Low testosterone levels: Men with hypogonadism (diminished function of the testes resulting in low testosterone production) can have low sex drive and erectile dysfunction.

Medications: Many commonly used drugs produce erectile dysfunction as a side effect. This includes drugs used to treat high blood pressure, gastritis, as well as antihistamines, antidepressants, tranquilizers, and appetite suppressants.

Depression and anxiety: Psychological factors may be responsible for erectile dysfunction. These factors include stress, anxiety, guilt, depression, low self-esteem, and fear of sexual failure.

In Mauritius, there is no available data on the incidence of ED. However, based on the above-mentioned causes of ED, it can only be inferred, when examining the 2004 NCD survey results, that a significant proportion of men may have experienced ED at least some of the time. The survey results reveal that, among men of 30 years and above, the prevalence of diabetes is 19.3% and that of hypertension is 29.7%. Moreover, the prevalence of abusive intake of alcohol and smoking among men aged 20 years and above is 19.1% and 35.9% respectively. Further the prevalence of physical inactivity among men in the age group of 35-54 is 75.5%.

3.11.1 Available Services

Management of male sexual dysfunction is done at hospitals and health centres. However, medical professionals are not trained in counselling patients with male sexual dysfunction and in treating them. There are no specialized centres where these problems can be addressed.

3.11.2 Policy Statement

To provide men, women and youth with accurate information about male sexual dysfunction. To ensure that men adopt a life style that does not put them at risk of male sexual dysfunction. To sensitize health care providers about male sexual dysfunction in order that they may diagnose and treat the condition.

3.11.3 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Raise awareness among women, men, youth and the community at large about the physiological, psychological and social changes associated with aging in both men and women.
- II. Provide accurate information about possible causes, symptoms and management of ED.
- III. Counsel men on the dangers and side effects of using some of the medications to correct ED without consulting a doctor.
- IV. Develop guidelines/protocols for the prevention and management of ED and ensure that they are accessible to health service providers.

Health Service Delivery

- I. Provide/maintain services to address the sexual problems that men and women experience.
- II. Maintain and strengthen programmes that enhance the life and well-being of all men.
- III. Train health providers in the provision of quality care for ED.

Research

- I. Conduct research on ED problems, to identify and improve on the delivery of health and social services for the men and couples with such problems.

3.12 Geriatrics

It is projected that the size of the population will grow by 18.7 percent between 2005 and 2045. Furthermore the proportion of young people aged less than 15 years will decline from 24.2 percent in 2005 to 17.8 percent in 2045 while the proportion of people aged 60 and above will increase from 9.6 percent in 2005 to 24.8 percent in 2045. Consequently in absolute numbers, the elderly population will rise from 116,224 in 2005 to 355,351 in 2045, exhibiting a three fold increase.

The ageing population poses a concern as this category of men and women have specific needs. Common geriatric problems include sexual dysfunction including menopause and andropause, cardiovascular diseases, cancers, orthopaedic problems, and psychiatric illness among others. It is reported that violence against the elderly is on the increase

There is evidence to show that timely and preventive strategies can reduce subsequent morbidity and mortality.

3.12.1 Menopause and Andropause

Menopause is a normal physiological process signifying the end of the reproductive capacity for women and occurs at the mean age of 51 years.

There are problems that occur after the menopause. Examples are bone demineralization that can lead to easy fracture of long bones. This is preventable. Cancers of the breast, cervix, uterus and genital tract are common; sexual problems like reduced libido and dryness of the vagina may also occur, leading to marital disharmony.

Andropause may be defined as a physiological process leading to a decline in the proportion of male hormones resulting in reduced sexual drive that may be associated with depression.

3.12.2 Available Services

The Ministry of Social Security, National Solidarity, Senior Citizens Welfare and Reform has services for senior citizens that include financial assistance (basic pension) for all people aged 60 years and above as well as social and recreational facilities. The Ministry has also set up an Elderly Protection Unit that deals with cases of abuse and neglect among elderly.

The health services include media programmes for the elderly, regular health education talks on preventive health care, and NCDs screening in 25 health clubs by trained Nurses.

Those who are ill or need screening have access to health facilities for free screening and medical care including those in charitable institutions. Those aged 75 and above, who are bed ridden and those aged over 90 receive monthly domiciliary free medical care. Anti-influenza vaccine is provided annually to those over 65 years of age.

The MOH & QL carries out a series of activities to improve the health and quality of life of the elderly. A fast track system for elderly is available at all levels of the health care delivery system. There are separate queues for elderly people at the Casualty and Pharmacy Departments. Elderly people are also provided with free spectacles and hearing aids. Regular health education programmes including screening are organised to prevent complications of chronic diseases such as diabetes.

As the population of elderly women is higher than that of men, a more focused and targeted approach is operational for health problems of elderly women in relation to menopause, reproductive health cancer, nutrition and mental problems, through the various national programmes.

The MFPWA has got programmes for the welfare of the senior citizens that include screening for cervical, breast and prostate cancer, management of male and female sexual dysfunction, and hormonal replacement therapy for menopausal symptoms.

Action Familiale includes information about menopause in the package given to its natural family planning users and in the group talks for women.

Mauritius Alliance of Women supports the elderly women by providing information and IEC/BCC on their health, SRH and conducting exercise sessions within their premises for the elderly.

3.12.3 Policy Statement

To ensure that women and men continue to enjoy good physical, psychological and social well-being as senior citizens.

3.12.4 Strategies

Through this policy, Government, NGOs, private sector and other stakeholders shall:

IEC/BCC

- I. Raise awareness among women, men and the community at large about the physiological, psychological and social changes associated with post menopausal and post andropausal period.

- II. Promote the right to sexual and reproductive health for the elderly by disseminating information through all channels of communication about the available health services.
- III. Educate the women, men and the community at large on the special problems for this age group and the services available for them.
- IV. Counsel all the men and women about the risk of STI/HIV/AIDS and its impact on their health status.
- V. Train service providers for the management of menopause and andropause.

Health Service Delivery

- I. Provide/maintain services for the elderly to include the management of NCDs, post menopausal and andropausal problems and screening tests for and reproductive health cancers for the elderly.
- II. Maintain and strengthen programmes that enhance the life and well-being of the elderly.
- III. Train health and social workers in the provision of quality care for the elderly.
- IV. Reform any laws that discriminate against the elderly and ensure the protection from violence of the elderly population.
- V. Conduct research on geriatric problems, so as to identify and improve on the delivery of health and social services.

CHAPTER 4 - INSTITUTIONAL FRAMEWORK FOR THE IMPLEMENTATION OF THE POLICY

4.1 Management of the Delivery of Sexual and Reproductive Health Services

The Ministry of Health & Quality of Life will be responsible for the following activities:

- I. Developing an Action plan.
- II. Developing service guidelines and protocols
- III. Training and deployment of service providers.
- IV. Providing adequate human, material and financial resources.
- V. Implementing the Sexual and Reproductive Health services.
- VI. Coordinating activities of all development partners and stakeholders in SRH service delivery.
- VII. Ensuring RHCS.

4.2 Partnership and Coordination

The objectives and strategies of this policy are linked with various sectors so there is no single stakeholder or institution that can undertake the implementation alone. Effective implementation will involve the establishment of partnership between and among ministries, NGOs, private sector, development partners and communities.

The main stakeholders for the implementation of the policy include Government Ministries and Departments; Non Government Organizations; Religious Organizations; Community Based Organizations; Development Partners; Private Sector including Industries; the Universities; Health Training Institutions; Law Enforcement Departments/Organizations; Judiciary; Colleges and Schools; Professional Associations; women, men and youth associations; and other stakeholders.

The MOH & QL will oversee the implementation of the policy through a series of steps agreed to by all stakeholders. Most of the programmes related to Sexual and Reproductive Health are already in place and are being implemented by different government Ministries, NGOS and the private sector, but will need strengthening and better coordination.

The major steps for implementing the policy will be as follows:

- To establish a SRH Coordinating Committee.
- To set priorities.
- To agree on an implementation framework.
- To mobilize and allocate resources.
- To set a time frame.
- To monitor and evaluate implementation of the Policy.

4.2.1 Establishment of the SRH Coordinating Committee and Technical Coordination Committee

A high level SRH coordinating committee consisting of representatives from stakeholders should be formed. This committee will be chaired by the Permanent Secretary/Chief Medical Officer of the MOH & QL. The committee will set the timetable, define priorities, mobilize resources and monitor implementation.

The following institutions and organizations should be represented:

- Ministry of Health & Quality of Life:
 - Representatives from Primary Health Care Division, Dept Of Obstetric/Gynaecology, Paediatrics, Skin/HIV/AIDS Units, NCD unit, Demography/Evaluation Unit, Mauritius Institute of Health, HIEC, Midwifery and Nursing Schools
- University of Mauritius
- Ministry of Education and Human Resources.
- Ministry of Youth and Sports
- Ministry of WRCDFW & CP
- Ministry of Social Security, National Solidarity
- Home Affairs Division of the PMO.
- Ministry of Justice & Legal Affairs
- International Partners working in SRH (WHO, UNFPA & UNAIDS)
- MFPWA, Action Familiale, Mouvement Aide a La Maternite, Pils, Nurses Associations, Doctors Associations & Religious Groups
- The Civil Society

4.2.2 SRH Technical Coordination Committee

This committee will consist of technical officers from the MOH & QL and other ministries concerned, MIH, University of Mauritius, and School of Nursing ,etc. They will be responsible for a review of the technical issues on SRH. Their TOR will be defined by the SRH Coordination Committee

4.2.3 Agreement on Implementation Framework

Sexual and Reproductive Health status will be reviewed and criteria set to determine priorities. The information will depend on vital statistics and surveys. This will be adjusted as the implementation proceeds. The priorities will be determined by the SRH Coordinating Committee.

4.2.4 Setting Priorities

An SRH Strategy and an implementation plan with short, medium and long term goals will be developed and will include the activities of all stakeholders.

A Logical framework for the SRH will form the basis for programme monitoring and evaluation.

4.2.5 Resource Mobilization and Allocation

Resources for implementation will be provided by government depending on the annual work plans and will also be mobilized from development partners and private institutions. Some of the NGOs receive grants from government but also receive funds from their own mother institutions, for example IPPF.

4.2.6 Setting a Time Frame

A timeframe will be set by the Coordinating Committee.

4.3 Monitoring and Evaluation of Implementation of the Policy

- I. Monitoring and evaluation of implementation of the policy is to determine whether the implementation is on course and the objectives are being achieved. Problems affecting implementation will also be detected early. The SRH Coordinating Committee will be responsible for monitoring and evaluation
- II. Establish indicators for monitoring activities. The indicators will be from the vital statistics of the MOH & QL.
- III. Periodic surveys will also be used to validate the indicators.
- IV. Reporting frequency will be based on intervals established by the MOH & QL.

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25. HIV/AIDS Preliminary Report 2006

The Formulation Process of the National Sexual and Reproductive Health Policy

A request was made by the MOH & QL, Mauritius to UNFPA Technical Services Team in Harare, Zimbabwe to provide TA to support the development of the National Sexual and Reproductive Health Policy and to include Reproductive Health Commodity Security.

The funds for the activity was provided by UNFPA from the Commodity Trust Fund

Main steps

- a) A review of documents was done to provide information on the prevailing sexual and reproductive health situation, with emphasis on service delivery in SRH. Main indicators such as life expectancy, maternal and infant morbidity and mortality, skilled attendance, unwanted pregnancy rates, fertility rate, knowledge and use of contraceptive methods, use of condoms (female, male), availability of Emergency Obstetric Care (EmOC), use of available services, etc were reviewed. The analysis also identified enabling factors and constraints to SRH service delivery and utilization.
- b) A Review of policy documents in areas related to Sexual and Reproductive Health including the National Population Policy, Mauritius Economic Review - 1992-1995, Mauritius Vision 2020, Into the third Millennium, Mauritius National Strategy for Sustainable Development 1999-2005, Strategy Review and Development Report, Mauritius, prepared by UNFPA New York in 1994, Executive Summary of the Contraceptive Prevalence Survey, 2002, Family Planning and Demographic Yearbook 2005, the White Paper on Health Sector and Reform (2002), Health Statistics Annual 2005, STI/HIV/AIDS policy, Child Health and Youth Policy, National Gender policy and Action Plan, Policy Statements and other national level tools used to define the national policy and any others that were relevant.
- c) A Review of SRH policy documents from other countries to determine the extent to which all the policies and strategies are consistent with global and national commitments, to identify the gaps and to see how the different policies reinforce each other.

Another reason was to assist Mauritius in selecting the best strategic interventions based on scientific evidence, targeted and priority focal groups, areas of particular focus (Family Planning Maternal and Newborn Health, ASRH, HIV/AIDS including PMTCT as well as adolescent pregnancy prevention, unsafe abortion, gender based violence, male involvement, geriatric care etc to be emphasized

- d) **Meeting with stakeholders**

Consultations were held with different stakeholders either individually or in groups as follows:

The Chief Medical Officer and Principal Medical Officer (PHC) of the MOH & QL, Staff of the MOH & QL in Demographic /Evaluation Unit, PHC and Family Planning Unit, NCD Coordinator, UNAIDS focal person and Coordinator for HIV/AIDS programme, the consultants in charge of Pathology and Skin services in Victoria Hospital, staff of Flacq AHC & Flacq Hospital, The Minister and staff of the Ministry Women's Rights, Child Development and Family Welfare, Director and staff of the Ministry of Youth Affairs and Sports, The staff of Mauritius Institute of Health, the Medical Director of the Ministry of Social Security, Coordinator of Health and Anti Drug Unit in the MOE, the Ag Executive Director and staff of Mauritius Family Planning & Welfare Association, Staff of Action Familiale, Mauritius Alliance of Women, and Chair of Senior Citizens' Council.

- e) **Field Visit**

Visits were made to one Area Health centre (AHC) and a Regional Hospital to get a feel of what services are available at different levels of the health care.

- f) A workshop was held to present the draft document, receive comments before finalizing the draft document.
- g) Need to hold a validation meeting to build consensus, update data and eventually present to highest level.

Persons Contacted

Name	Position/Designation	Institution
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