Sexual and Reproductive Health Core package of activities In MSF projects

International Working Group on Sexual and Reproductive Health

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List of acronyms

ANC	Antenatal care
ARV	Antiretroviral
BCG	Bacillus Calmette Guerin
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CD4	Cluster of differentiation 4
D+C	Dilatation and curettage
FGM	Female genital mutilation
HAART	Highly active antiretroviral therapy
Hb	Haemoglobin
HBV	Hepatitis B virus
HBIg	Hepatitis B immunoglobulin
HIV	Human immunodeficiency virus
IM	Intramuscular
IPD	Inpatient department
IPT	Intermittent presumptive treatment
IUD	Intra-uterine device
IV	Intravenous
LLIN	Long lasting insecticide treated bed net
LMP	Last menstrual period
MCH	Mother and child health
MSF	Médecins Sans Frontières
MVA	Manual vacuum aspiration
OPD	Outpatient department
OPV	Oral polio vaccine
PHC	Primary health care
PMTCT	Prevention of mother to child transmission of HIV
PNC	Postnatal care
PO	Per os (medication taken orally)
RH	Reproductive health
RTI	Reproductive tract infection
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
TTV	Tetanus toxoid vaccine
VVF	Vesico-vaginal fistula
WHO	World Health Organization

Glossary

Antenatal care Health care provided during pregnancy

BEmONC Package of basic emergency obstetric and neonatal care at the primary health care level. Used for maternal and neonatal resuscitation, stabilisation and referral.
Marked by provision of the signal functions

- Administration of antibiotics, oxytocics, anticonvulsants
- Manual removal of the placenta
- Removal of retained products following abortion
- Assisted vaginal delivery, preferably with vacuum extractor
- Newborn care including neonatal resuscitation

CEmONC Package of comprehensive obstetric and neonatal care at the secondary health care level. Includes primary health care package as above PLUS ongoing management of emergency cases and surgical facilities.
Marked by provision of three additional signal functions

- Surgery (caesarean section, hysterectomy, laparatomy)
- Safe blood transfusion
- Care to sick and low birth weight newborns

Postnatal care Health care provided from 24 hours until 6 weeks post delivery to mother and infant

Family planning Planning whether or not and when to have children including provision of contraception

Abortion care Complete package of abortion care including both post-abortion care (management of abortion both spontaneous and induced) and safe abortion care (provision of safe termination of pregnancy)

Fistula Abnormal communication between the vagina and bladder, and/or urethra, urethra and rectum, or uterus and bladder, as a result of:

i) prolonged obstructed labour (obstetric fistula)
ii) an intended curative action by health staff (iatrogenic fistula)
iii) sexual violence, torture, FGM (traumatic fistula)

Skilled attendant Accredited midwife, doctor or nurse, educated and trained to manage normal pregnancies, childbirth and the postnatal period, and in the identification, management and referral of complications in women and newborns

Reproductive tract infection
includes all infections presenting in the reproductive system irrespective of cause

Introduction

The aim of this document is to clarify for operations (headquarters, coordination and field teams) which type of sexual and reproductive health activities should be put in place in different MSF projects. These guidelines have been put together to complement the international Sexual and Reproductive Health policy. The document is laid out in the following manner:

1. Minimum package in emergency settings: This section details the services that should be available from commencement of a project in emergency settings until further activities are implemented.

2. Core package: This section details the activities that, IN ADDITION to the minimum package, constitute a complete service. These activities should be adapted according to the local context. Once the minimum package is in place, these core package activities should be added as soon as possible, depending on the objectives of the project and the resources available. For both the minimum and core package sections, we describe:

- **Objectives:** Helps teams decide if the service meets the objectives of the program.
- **Setting and required resources:** Provides information on the type of setting where the activity could be incorporated and the level of human resources required to implement the activity
- **Activities:** Lists the activities that should be implemented to provide the service

3. Minimum data to collect: These are the basic indicators required to track the implementation of reproductive health activities at sectional and intersectional level. They do not monitor quality of interventions, staff workload, etc.; quality indicators can be added according to the section's and the field's requirements. Further indicators will be reviewed and added when available.

4. Reference Documents: References, including protocols and guidelines, are listed here. These documents are routinely provided through medical departments.

Essential components that MUST ALWAYS BE PROVIDED as a minimum standard for all activities include:

- **Provision of suitable privacy and confidentiality** to allow history taking and examination to be performed with respect for the patient

- **Counselling and education** including providing information on prevention, signs of disease, interventions available and side effects of medication etc.

- **Female staff** should be available for all services related to SRH respecting cultural/traditional gender division

1. Minimum package in emergency settings

1.1 Objectives

Maternal and neonatal mortality and morbidity linked to sexual and reproductive health emergencies occurring during the emergency phase is reduced through provision of life saving services and the essential services for patients presenting on an opportunistic basis.

1.2 Setting and required resources

- The minimum package can be incorporated at the IPD or OPD level
- Skilled birth attendants –identify trained medical staff member to manage obstetric and gynaecological cases
- Drugs and equipment according to the activities below and ensured water and light source

1.3 Services

1.3.1 At IPD/Emergency room/Hospital-level

Normal deliveries (with women presenting in labour) and possibilities of:

BEmONC -Basic Emergency Obstetric and Neonatal Care

- Administration of antibiotics, oxytocics, anticonvulsants
- Manual removal of the placenta
- Removal of retained products following abortion (spontaneous/induced)
- Assisted vaginal delivery, preferably with vacuum extractor
- Newborn care including neonatal resuscitation

CEmONC -Comprehensive Emergency and Neonatal Obstetric Care
Refer or provide services as for BEmONC **plus**

- Surgery (caesarean section, hysterectomy, laparotomy)
- Safe blood transfusion
- Care to sick and low birth weight newborns

Safe abortion care
Refer/provide where appropriate (according to risk analysis)

1.3.2 At OPD/Emergency room-level

Sexual violence

- Provide wound care and anti-tetanus prophylaxis
- Provide STI prophylaxis (HIV, HBV, RTI)
- Discuss/provide options for managing pregnancy (emergency contraception, safe abortion, or ANC)
- Provide/offer safe storage of medical certificate
- Offer psychological support within the consultation or refer as appropriate
- Identify a location to send patients who need a place of safety to protect them from further abuse if required and refer if necessary

Antenatal care

Must be provided for patients that are visibly pregnant.

- Identify potentially complicated deliveries for early referral (previous scar in uterus, multiple gestation, severe pre-eclamsia, abnormal lie at term, poor obstetric history etc.) and discuss facility based delivery if facility exists.
- Conduct antenatal check (examination for hypertension, oedema, abdominal palpation of foetus)
- Provide Ferrous Sulphate + Folic acid and tetanus toxoid, malaria prevention, screening, treatment and prophylaxis, nutritional support according to protocol, non-food items according to local protocol (LLIN, blankets, soap and delivery kits etc.)where appropriate as in situations of insecurity or where transport is limited and/or there is limited access to safe delivery services.

Postnatal care

Treat or refer complications as appropriate.

- Maternal: sepsis, haemorrhage etc.
- Neonatal: asphyxia, sepsis, tetanus, respiratory distress etc.
- Particular care for low birth weight babies

Reproductive tract infections

Treat by syndromic approach (using bi-manual examination and estimation of risk and/or speculum examination)

Safe abortion (termination of pregnancy on request)

Provide or refer where appropriate

Contraception

Must be available on request. Emergency contraception (pills and IUD[1]), condoms, injectable and oral contraceptive pills (combined and progestin-only)

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[1] Note that IUD use is for emergency contraception post sexual violence only and in settings where an appropriate provider is available. For routine contraception, other forms are sufficient to cover needs during the emergency phase.

2. Core package

2.1 Antenatal care

2.1.1 Objectives

Maternal and perinatal health is improved through screening, prevention, diagnosis and treatment of diseases during pregnancy and through birth planning

2.1.2 Setting and required resources

- Out-patient department
- Trained medical staff (midwife, nurse, doctor, clinical officer or MCH-aid)
- Antenatal care should be provided only when there is access to (referral) obstetric services (provided by MSF or partners)

2.1.3 Activities

Four visits during pregnancy are recommended.

General history and examination

- Identify and refer, where necessary, any patients that require higher level monitoring during pregnancy or special precautions during delivery
- Assess, investigate and treat any concurrent illness including RTI, TB, avitaminosis, malnutrition, malaria
- Encourage delivery with a skilled attendant-birth planning

Genital examination

- Perform once during the second or third trimester to identify possible complications, e.g. FGM
- Perform if suspicion of RTI or if complaints
- If FGM present identify type and discuss/offer de-infibulation (-and whether to de-infibulate in pregnancy or during labour according to context)

Obstetric history and examination

Every visit should include examination for:

- Presence of foetal movements
- Anaemia
- Oedema
- Hypertension
- RTI symptoms
- Abdominal examination for foetal position, growth and heart tones

Screening and tests

- Haemoglobin (1st visit)
- Syphilis (1st visit)
- Rapid test for malaria (every visit)
- Urinalysis for nitrites, white blood cells (every visit)
- HIV (if access to PMTCT program –by MSF or partners)
- CD4 count (if locally available and if access to HAART –by MSF or partners)

Treatment

Provide according to location and signs or symptoms:

- Tetanus toxoid (routine for all unvaccinated patients)
- Ferrous sulphate + Folic acid (routine for all patients)
- Hookworm prevalence >20%: Give prophylaxis systematically
- Malaria region: LLIN (give 2 bed nets at first consultation) + treatment if malaria test is positive. Give IPT and bed nets if negative.
- Iodine deficiency: Give supplement
- Infibulation: De-infibulate in pregnancy or in labour
- Symptomatic vitamin deficiency or according to national protocol: Give vitamin A,D or K supplement
- Malnutrition: Give nutrition supplement
- STI/RTI: Give antibiotics
- HIV positive pregnant women: Enroll in PMTCT program if available
- Ensure continuation of initiated HIV/AIDS treatment (Cotrimoxazole/ARV)
- Ensure continuation of initiated tuberculosis treatment (Rifampacin)
- Treatment for any other concurrent disease

Community network and liaisons with traditional birth attendants

Build a link between the community (via civic and religious leaders and TBA's) and the health care team. Draw on this link to encourage women to use the sexual and reproductive health facilities.

- Identify potential barriers the women might face in accessing skilled attendant and access to emergency obstetric and neonatal care at delivery
- Identify the means to address barriers (e.g., transport, maternity waiting homes, communication systems –radios, mobile phones, etc.).
- Work with the community and TBA's through providing health promotion, peer support initiatives and community follow-up schemes to overcome some of the identified barriers

2.2 Obstetric care

2.2.1 Objectives

The risk of obstetric related maternal and neonatal morbidity and mortality is reduced through improved access to a skilled attendant at birth and emergency obstetric and neonatal care.

2.2.2 Setting and required resources

BEmONC (minimum: four centres per 500 000 population)

- In-patient or delivery facility available 24 hours (according to security)
- Skilled birth attendants -medical staff trained to manage deliveries and complications

CEmONC (minimum: one centre per 500 000 population)

- Surgical facility[2] and laboratory services plus in-patient department and delivery facility
- Skilled birth attendants plus obstetrician/gynaecologist (or medical doctor with surgical/obstetrical skills)

2.2.3 Activities

Management of normal delivery

- Identify onset of labour
- Encourage supportive care (e.g. presence of relatives) at early stage of labour
- Offer following tests if not yet done: HIV, syphilis, blood group (and HBV if immunoglobulin is available for the neonate)
- Monitor mother and foetus throughout the labour (partograph)
- Consider pain management
- Actively manage third stage of labour (clamp and cut cord, systematic oxytocin, controlled cord traction to deliver placenta)
- Manage normal deliveries complicated by FGM (de-infibulate)

It is recommended that the mother and her newborn stay in the facility for at least 24 hours post partum.

Management of healthy neonate post delivery (see also section 2.3)

- Perform general clinical examination of newborn
- Provide thermal protection, cord care, early and exclusive breastfeeding, tetracycline eye ointment, immunisation (BCG, HBV, OPV), vitamin K1 injection

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[2] Follow the standards for surgical services (appropriate structure, trained anaesthetist, oxygen therapy, recovery room and postoperative surveillance, pain management etc.)

Basic Emergency Obstetric and Neonatal Care

- Administration of antibiotics, oxytocics, anticonvulsants (Magnesium Sulphate)
- Manual removal of the placenta
- Removal of retained products following abortion (spontaneous/induced) -MVA
- Assisted vaginal delivery, preferably with vacuum extractor
- Newborn care including neonatal resuscitation

Comprehensive Emergency Obstetric and Neonatal Care

- Surgery (caesarean section, hysterectomy, laparotomy)
- Safe blood transfusion
- Care to sick and low birth weight newborns

In deliveries of women with FGM type 3 (infibulation)

De-infibulate in labour (or during pregnancy). Do not perform re-infibulation after birth. Do not perform episiotomies to avoid de-infibulation

In deliveries of HIV-positive women

- Avoid artificial rupture of membranes and avoid prolonged labour after rupture of membranes to decrease risk of mother-to-child transmission.
- Avoid episiotomy and other invasive interventions as vaginal tears elevates risk of mother-to-child transmission.
- Provide ARV at onset of and during labour

Case review

- Review all maternal and neonatal deaths as well as severe morbidities and near-miss-cases
- Review caesarean sections for appropriate indication

2.3 Neonatal care

2.3.1 Objectives

The risk of neonatal morbidity and mortality is reduced through improved access to a skilled attendant at birth and emergency obstetric and neonatal care.

2.3.2 Setting and required resources

All projects providing obstetric care by any trained health care provider

2.3.3 Activities

Newborn resuscitation

- Cut umbilical cord immediately if resuscitation is required
- Dry and stimulate
- Provide bag and mask ventilation
- Provide oxygen therapy for persistent hypoxemia/and central cyanosis
- Perform cardiopulmonary resuscitation

Routine preventative care

- Delay 1-3 minutes before cutting the umbilical cord
- Tetracycline eye ointment and Vitamin K1 supplementation
- Cord care
- Vaccination: BCG, OPV, HBV (HBIg if available and the mothers status is known and is given within 24 hours of delivery)

Detection and treatment of complications

If danger signs are detected, start treatment and refer to medical doctor or hospital for comprehensive management:

- Hypoxemia: oxygen therapy
- Convulsions: anticonvulsants
- Hypothermia: drying, keeping warm, kangaroo care
- Hypoglycaemia: early and exclusive breastfeeding/replacement feeding/dextrose
- Infection: IM/IV antibiotics, malaria treatment
- Jaundice: sunlight, hydration, treat possible causal infection

Routine neonatal history and examination pre-discharge

- Review maternal history and delivery
- Head to toe check including eyes, palate, genitalia/anus and reflexes
- Feeding
- Weight and head circumference
- Stool and urine passed
- Give birth (or death) notification to mother (where appropriate)

2.4 Postnatal care

2.4.1 Objectives

The risk of maternal and neonatal morbidity and mortality is reduced through prevention, diagnosis and treatment of health problems for mother and newborn.

2.4.2 Setting and required resources

- Out-patient department
- Any trained health care provider
- Routinely include with antenatal care activities (see 2.1)

2.4.3 Activities

Two visits within the first six weeks after delivery are recommended, the first within one week and the second at six weeks after delivery[3]. Referral should be made to specialist services where necessary and available.

Maternal review

- Vital signs
- Uterine involution
- Secondary postpartum haemorrhage (lochia)
- Perineum/vulva e.g. after suturing/de-infibulation
- Anaemia, sepsis or breast complications
- Any concurrent illness, e.g. urinary incontinence
- Contraception options
- Assessment of psychological well-being

Neonatal review

- Maternal history (fever, treatments, prolonged rupture of membranes etc.)
- Head to toe check including eyes, palate, genitalia/anus and reflexes
- Temperature
- Weight and head circumference
- Cord care (keep clean and allow to dry)
- Feeding
- Signs of danger/illness, e.g. infection, convulsion, birth injury

Prophylactic treatment (Carry out activities according to setting and patient)

- Mother: TTV, vitamin A, Ferrous Sulphate + Folic acid and bed-net. Food supplementation, contraception and ARV where appropriate
- Neonate: vaccinations if not already given at birth (BCG, OPV, Hepatitis B). HBIg (within 24 hours of delivery) and ARV where appropriate

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[3] If a patient is discharged after >24 hours in hospital, their discharge review will consist of a postnatal check and can be counted as one of the two recommended visits.

2.5 Family planning

2.5.1 Objectives

The risk of maternal mortality related to unsafe abortions due to unplanned pregnancies is reduced. The life time risk of maternal mortality is reduced. The maternal and child morbidity and mortality is reduced through birth spacing.

2.5.2 Setting and required resources

- All levels of care
- Routinely include with nutrition, ANC/PNC, post-abortion, HIV/STI and OPD/PHC activities
- Any trained health care provider

2.5.3 Activities

- Provide family planning counselling systematically for any female patient and opportunistically with male patients

- Provide information about the advantages and disadvantages of each method to allow the patient to make an informed choice

- A wide variety of methods should be made available to the patient, e.g. emergency contraception, male and female condoms, contraceptive pills and injection, implant, intra-uterine device. Dual protection should always be promoted due to risk of STI transmission

- Provide (or identify referral structure) tubal ligations/vasectomies according to context

- Attend special needs for family planning education and provision for people living with HIV/AIDS in order for them to make an informed choice related to their special situation and needs

- Attend special needs for family planning education and provision for adolescents as both needs for and access to family planning services might be different for them than for those of adults

2.6 Comprehensive abortion care

2.6.1 Objectives

The risk of maternal morbidity and mortality related to unsafe and incomplete abortions are reduced and the needs of women with unwanted pregnancies are met through provision of comprehensive abortion care.

2.6.2 Setting and required resources

For medical intervention:

- Out-patient/in-patient department with referral facility for any complications identified
- Trained medical staff (doctor, clinical officer, nurse or midwife)

For surgical intervention:

- MVA: Out-patient/in-patient department (if possible with separate procedure room and possibility for post-procedure hospitalisation) and sterilisation
- MVA or D+C: In-patient department with surgical facilities and anaesthesia

2.6.3 Activities

Post abortion care

Ensure that staff, drugs and equipment are available to manage incomplete abortion or complications of induced abortion (according to level of facility)

Safe abortion care (Termination of pregnancy on request)

- Perform context analysis
- <9 weeks LMP: use medical method (Misoprostol +/- Mifepristone)
- 9-12 weeks LMP: MVA with Misoprostol pre-intervention
- >12 weeks LMP: not recommended –refer if possible
- Alternative method: use D+C if first line choice of treatment (MVA) is not available

Support activities in all cases

- Provide pre- and post-procedure counselling
- Ensure counselling and provision of family planning options (see 2.5)
- Arrange follow-up consultation at 14 days

2.7 Sexual violence

2.7.1 Objectives

The physical and psychological consequences of sexual violence is reduced through provision of medical and mental health care

2.7.2 Setting and required resources

- Any level of care
- Any trained health care provider (a female is preferable) according to context. (e.g. in some settings only medical doctors or only national staff are allowed to provide this service)
- It is of utmost importance that victims are provided with anonymous and confidential services with 24 hour access and limited waiting time

2.7.3 Activities

Medical care

- Take and document history and perform examination
- Refer or treat physical injuries, including traumatic genito-urinary and/or recto-vaginal fistulas (please refer to fistula section)
- Provide prevention and treatment for STI's (including HIV, HBV, RTI)
- Vaccinate against tetanus
- Prevent and manage unwanted pregnancy (emergency contraception, pregnancy test, safe abortion) or refer to ANC for a continuing pregnancy
- Provide psychological support within the consultation
- Provide a medical certificate (to be signed by an authorised medical person)

Provide or refer to other actors:

- Management psychological consequences
- Support for social and legal issues

Additional services (according to setting)

- Provide mental health care
- Collect forensic samples
- Connect with community network and link with other actors in the field for referral of survivors and community support for survivors if desired
- Identify site of safety for protection from abuser if needed, e.g. children, domestic violence

In general seek to encourage uptake of services through community awareness campaigns and reduce the risk of sexual violence via camp site-planning, providing security and lighting, etc.

2.8 Reproductive tract infections

2.8.1 Objectives

The risk of transmission of STI's[4] and the adverse health consequences of STI and RTI's[5] are reduced through diagnosis and treatment.

2.8.2 Setting and required resources

At any level of care and by any trained health care provider

2.8.3 Activities

Diagnosis and treatment of genital tract infections

- Examination and treatment should be available in the same location.
- Take a systematic history of symptoms in women of reproductive age
- Perform examination including speculum exam
- Use syndromic approach/lab tests according to setting
- Give stat dose and observe ingestion wherever possible
- Treat or refer complications needing surgery (peritonitis, pelvic abscess)
- Adapt treatments according to resistance levels

Additional services

- Distribute condoms
- Offer strategy for partner tracing and treatment
- Provide education on all forms of STI's and offer screening/treatment as appropriate
- Provide information to the community about available services
- Follow up until treatment completed

People living with HIV/AIDS are at higher risk of developing RTI and when having untreated STI's/RTI's the risk of transmission of HIV is increased.

Note: Not all patients will volunteer information, so the medical practitioner must systematically ask adult patients about symptoms and history.

[4] HIV, Syphilis, Chlamydia, Gonorrhoea, HBV, Donovanosis and Trichomonas
[5] Bacterial vaginosis, Candidiasis, and bacterial sepsis

2.9 Fistula

2.9.1 Objectives

Suffering of fistula patients is alleviated and chances for their social rehabilitation are improved through and treatment of obstetric and iatrogenic fistulas and treatment of traumatic fistulas.

2.9.2 Setting and required resources

- Medical staff working in OPD and maternity departments –for prevention, identification of cases and for initial supportive/conservative treatment
- Trained fistula surgeon –for conservative treatment, surgical repair and if need be (combined with) incontinence surgery
- Established surgical service and set-up in place (OT, sterilization, anaesthetist, recovery room, postoperative surveillance, blood transfusion etc.)

2.9.3 Activities

Prevention of fistula

- Provide health education to health care staff and communities about fistula prevention
- Provide emergency obstetric care, including family planning, skilled attendance at birth and functional referral system
- Provide routine bladder catheterisation of any woman who may have gone through an episode of prolonged obstructed labour
- Train in techniques in obstetric surgery and manoeuvres (vacuum extractions, destructive delivery etc.), in indication setting for these interventions and in monitoring of the quality of care provided

Identification of cases

- Provide health education and community sensitisation campaigns about fistula
- Medical and obstetric history and physical examination of suspected cases (incl. classification of type of fistula if trained staff are available)
- Registration of individual patient data on a separate register should be implemented where there is a reasonable potential for future fistula treatment or if possibilities for repair are already available in our projects or with a partner organisation (in which case routine registration should be implemented)

Fistula treatment

- Address nutritional status and anaemia, as well as conditions common in fistula patients e.g. urine dermatitis, chronic cystitis
- Ensure patient has a high fluid intake
- ***Conservative treatment:*** catheterisation and, if trained staff are available, debridement and approximation of fistula edges in case of fresh, small to medium-sized fistulas
- ***Surgical treatment:*** repair performed by a trained fistula surgeon

- Provide pre and post-op bladder training and physiotherapy
- Provide clear instructions at discharge and during follow-up consultations including family planning and subsequent delivery (elective Caesarean section)
- Provide follow-up system for 6-12 months post-op
- Collect and analyse data on separate fistula database according to context/section

Supportive care (depending on need and context)
- Hygiene support
- Psychological care
- Social re-integration

2.10 PMTCT of HIV/AIDS

2.10.1 Objectives

The transmission of HIV from mother to child in pregnancy, during labour and in the breastfeeding period is reduced through integrated provision of PMTCT.

2.10.2 Setting and required resources

- Access to PMTCT should be ensured as soon as possible and feasible in projects offering ANC and/or deliveries and/or PNC (by MSF, partner organisations or Ministry of Health). It is acceptable to introduce program components stepwise but we must give perspective of treatment to the women diagnosed HIV positive as fast as possible. Activities can be complementary to existing programs and MSF does not need to take on all levels of care if acceptable quality is available with partners

- Laboratory facilities needs to entail Hb and HIV rapid tests as minimum (access to CD4 highly desirable -liver transaminases if possible)

- Additional human resources and training needs to be considered. ARV prophylaxis can be undertaken by midlevel providers and does not require specialized medical staff

2.10.3 Activities -minimum* and desirable[6]

In initial ANC	Complete ANC package* Counselling and testing in ANC* CD4 counts Initiation on HAART when relevant
During pregnancy	Hb follow-up before starting ARV prophylaxis* Malaria prophylaxis and treatment special for HIV+ pregnant* Cotrimoxazole prophylaxis* ARV prophylaxis during pregnancy* Liver function monitoring when pregnant on HAART Counselling on feeding options for the infant*
During delivery	Counselling and testing in labour ARV prophylaxis during labour* Management of labour to decrease transmission risk*

[6] The* indicates that this activity should be part of the minimum package, whereas the other activities are highly desirable, but not mandatory from the start

Post partum & infant follow up	ARV prophylaxis for the newborn post partum* ARV prophylaxis for mother post partum* Cotrimoxazole prophylaxis* Feeding support*[7] Testing of the infant* Access to HAART for mother and infant when needed

Throughout the entire program period:

- Psychosocial support
- Provide ongoing counselling on birth plan, feeding choice, adherence to drugs and program steps, sexual health, family planning etc.
- Creation of peer support system
- Creation of social support

Sexual and reproductive health for women living with HIV and AIDS

- Provide family planning
- Diagnose, treat and prevent RTI

[7] Counselling on feeding method of choice, provision of formula milk where relevant and counselling +feeding support in the weaning process.

3. Minimum data to collect

The following indicators monitor sexual and reproductive health activities in the field and are used in the annual intersectional activity report on sexual and reproductive health. This list details the minimum that must be collected. Each indicator must be collected in accordance with each section's current system and guidelines.

Number of projects with RH activities
Number of ANC consultations
Number of PNC consultations
Number of deliveries
Availability of BEmONC (Y/N)
Availability of CEmONC (Y/N)
Number of caesarean sections
Number of family planning consultations
Number of projects offering elective termination of pregnancy on request
Number of survivors of sexual violence managed
Number of patients treated for RTI
Number of PMTCT patients admitted to program
Number of VVF repairs done

4. Reference documents

MSF Policies and Guidelines
MSF 1998. "MSF position on Female Genital Cutting"
MSF 2006. "MSF Sexual and Reproductive Health Policy" (intersectional)
MSF 2006. "Essential drugs –practical guidelines" (3rd edition)
MSF 2007. "Obstetrics in remote settings –Practical guide for non-specialized health care professionals" (1st edition)
MSF 2007. "Clinical guidelines" (7th revised edition)
MSF 2007. "MSF policies on HIV/AIDS recommendations for MSF programmes"
MSF 2007. "Prevention of HIV mother to child transmission-recommendation for MSF programs"
MSF-OCA 2008. "Obstetric fistula camp preparation"
MSF-OCB 2008. "Pocket guide –Treatment of VVF"
MSF Abortion policy and protocols from each section
MSF Clinical management of sexual violence -guidelines/protocols from each section
MSF Malaria policy

MSF Tool
MSF International 2007: "Sexual and Reproductive Health" (double CD)

Other guidelines and literature
WHO 2002. "WHO ANC care randomised trial"
WHO 2003. "ANC care in developing countries"
WHO 2003. "Managing complications in pregnancy and childbirth "
WHO 2003. "Managing newborn problems: A guide for doctors nurses and midwifes"
WHO 2003. "Safe abortion: technical and policy guidance for health systems"
WHO 2004. "Kangaroo method: practical guideline"
WHO 2004. "Beyond the numbers"
WHO 2004. "Medical eligibility criteria for contraception"
WHO 2004. "Clinical management of rape survivors"
WHO 2005. "Decision making tools for family planning clients and providers"
WHO 2005. "Sexually transmitted and other reproductive tract infections"
WHO 2006. "Obstetric Fistula"
WHO 2006. "Pregnancy, child birth, postpartum and newborn care"
WHO 2006. "Opportunities for Africa's Newborns"
WHO 2006. "Sexual and reproductive health of women living with HIV/AIDS"
WHO 2007. "Hospital care for children"
WHO 2007. "Family planning handbook"
WHO 2007. "Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies"
Thaddeus & Maine 1994: "The Three Delays"
Paxton 2003: "AMDD (Averting Maternal Death and Disability Program) workbook". Columbia University
Ipas 2004: "Women centred abortion care"
RHRC 2005: "Field friendly guidelines to integrate emergency obstetric care in humanitarian programs". Reproductive Health Response in Conflict Consortium
Gynuity 2005: "Medical abortion guidebook"
CDC 2006: "Sexually transmitted diseases guidelines". Centers for Disease Control and prevention -Mortality and Morbidity Weekly Report