Medicus Mundi Switzerland
Health for all

MMS Bulletin #132
„Not without us! " Youth and sexual and reproductive health in international cooperation

Access to quality services and realizing the rights to safe motherhood for young mothers

Promoting young women's rights related to safe motherhood

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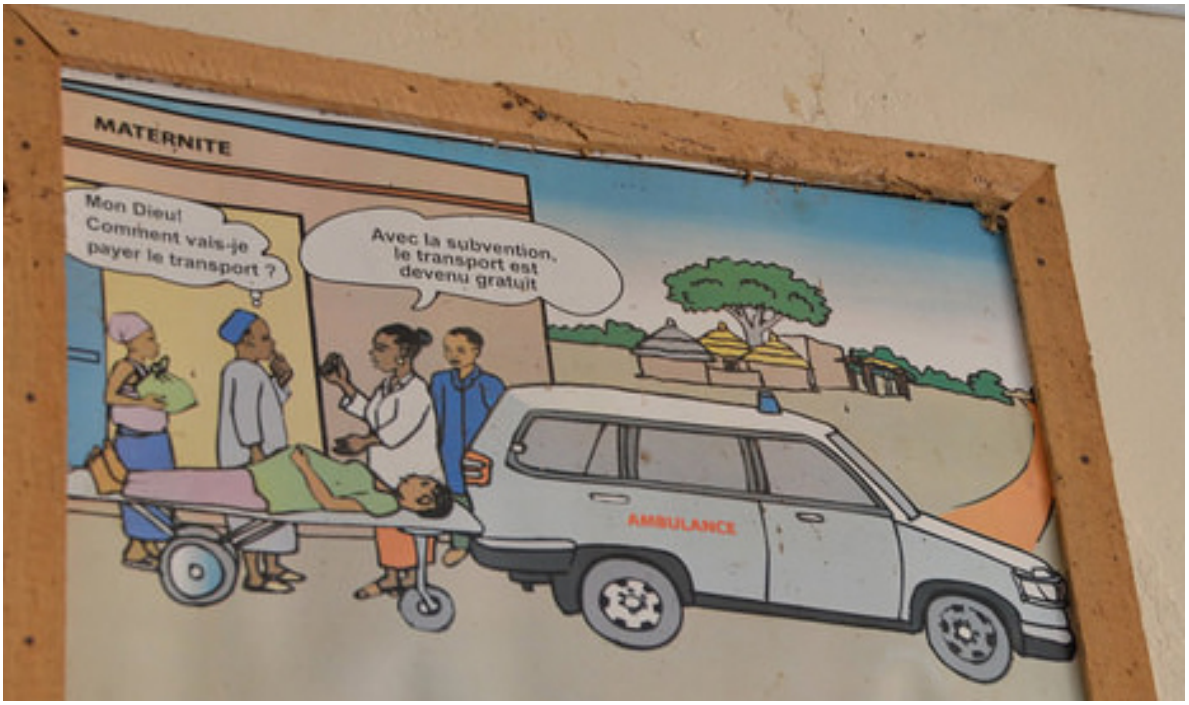
Assuring that women are able to exercise their rights to safe motherhood is critical to the health of all women during pregnancy, birth and following birth; however this is particularly true for pregnant adolescents. These young women face elevated risks when they experience pregnancy and birth and therefore have an increased need to be able to realize their rights. Enfants du Monde (EdM), in collaboration with local partners, is contributing to promoting women's rights related to maternal health in Bangladesh, Burkina Faso, Colombia, El Salvador and Haiti. In each of these countries, the percentage of women experiencing a first pregnancy before the age of 18 is particularly high, at 40%, 28.2%, 19.7%, 24.4% and 15% respectively. EdM's work in promoting rights related to maternal and newborn health (MNH) is occurring within the context of implementing programmes based on the World Health Organization's (WHO) framework "Working with Individuals, Families and Communities (IFC) to improve MNH." Programmes are implemented to promote the following rights: the right to health, including sexual and reproductive health services; rights relating to privacy, decision-making and security; rights to education and information; the right to respectful care; and the right to participate.

Burkina Faso (Enfants du Monde)

Of the approximately 289,000 deaths of women related to pregnancy and childbirth each year, approximately 99% occur in low- and middle-income countries. Tragically, the vast majority of these deaths are avoidable. Throughout that past decade the international community has increasingly come to recognize that maternal mortality is primarily a result of violations of women's basic human rights. In 2009, the Office of the United Nations High Commissioner on Human Rights (OHCHR) issued an historic resolution (pdf) denouncing preventable maternal mortality and morbidity as violations of women's rights to health, life, education, dignity and information. The following year, the first report of the High Commissioner to the Human Rights Council laid out a conceptual framework (pdf) for understanding the human rights dimensions of maternal mortality and morbidity. Subsequent reports were issued in 2011 (pdf) and in 2012 (pdf) highlighting best practices and technical guidance on applying a rights-based approach to maternal health. These documents emphasize the importance of targeting vulnerable or marginalized groups of women, including adolescents, when applying a rights-based approach to preventing maternal mortality and morbidity.

Assuring that women are able to exercise their rights to safe motherhood is critical to the health of all women during pregnancy, birth and following birth; however this is particularly true for pregnant adolescents. These young women, and their infants, face elevated risks when they experience pregnancy and birth and therefore have an increased need to be able to realize their rights (WHO Fact Sheet 364: Adolescent Pregnancy). In fact, in developing

countries, the leading causes of death of girls and women between 15-19 years old are complications related to pregnancy and birth, and 15% of all maternal deaths worldwide are among girls under the age of 20 (WHO: Women and Health 2009, pdf). Enfants du Monde (EdM), in collaboration with local partners, is contributing to promoting women's rights related to maternal health through programmes in Bangladesh, Burkina Faso, Colombia, El Salvador and Haiti. In each of these countries, the percentage of women experiencing a first pregnancy before the age of 18 is significant, at 40%, 28.2%, 19.7%, 24.4% and 15% respectively (UNFPA: Adolescent pregnancy). Many factors contribute to high rates of adolescent pregnancy, including early marriage, lack of family planning knowledge/services, inability of girls to refuse unwanted sex, and cultural practices (pdf). In our experience, these factors vary significantly by country. For example, the high rate of adolescent pregnancy in Bangladesh is primarily a result of early marriage of girls, consequently leading to early pregnancy. This is similar in Burkina Faso where early marriage is a primary factor contributing to young motherhood. In Colombia and El Salvador, by contrast, cultural expectations of girls and sexual abuse are important contributors.



Burkina Faso (Enfants du Monde)

EdM's work in promoting rights related to MNH for all women, including young women, is occurring within the context of programmes based on the World Health Organization's (WHO) Framework for Working with Individuals, Families and Communities (IFC) to improve maternal and newborn health (MNH). (pdf) These programmes aim to build the capacities of women as rights-holders to be aware of and claim their rights related to maternal health as well as those of duty-bearers, including both Ministry of Health as the principal duty bearer and moral duty-bearers such as male partners, other key household decision makers and community leaders, to contribute to assuring that these rights are respected, protected and fulfilled.

Among the rights that have been identified as critical to ending preventable maternal mortality and morbidity are the following:

- Right to health, including sexual and reproductive health
- Rights relating to privacy, decision-making and security
- Rights to education and information
- Right to respectful care
- Right to participate

In this article, we will discuss some of the interventions which EdM is supporting in Bangladesh, Burkina Faso, Colombia and El Salvador to promote these rights of young women related to safe motherhood.

Right to health, including sexual and reproductive health

The right to health, including sexual and reproductive health, requires that all individuals be able to enjoy the highest attainable standard of health and to have access to the means and services to enable them to maintain or restore health. The solutions to maternal mortality and morbidity are not unknown. The vast majority of death resulting from causes related to pregnancy and childbirth, and much of the morbidity, is entirely avoidable when women have access to health services which are routine and widely available in developed countries. Women have the right to access to the benefits of scientific progress regardless of where they live, age, ethnicity, socioeconomic status, or any other factor.

This right entitles women to receive timely and high-quality maternal care, including antenatal and postpartum care, assistance by a skilled birth attendant during birth, and access to emergency obstetric care. This also includes access to family planning throughout the course of a women's reproductive life, including postpartum family planning services.

Many factors contribute to preventing women from receiving services which that they need during pregnancy, birth and after birth. These are present both at the level of service-delivery (i.e. lack of available, quality service provision) and at the community level (i.e. the decision to seek services and reaching services one the decision has been made). In all of the programmes EdM supports interventions that have been put into plan to mobilize communities or strengthen mechanisms at the community level to overcome barriers so that women are able to access the care which they need when they need it.

In ***Bangladesh***, communities have been mobilized to overcome transport and financial barriers to health services. In several cases communities have come together to purchase means of transportation, such as rickshaw vans, specifically for assisting women to reach health facilities for pregnancy, birth or postpartum care. These means of transportation are managed by community committees. In addition, several emergency monetary funds have been created to support women and newborns to receive care in the case of an emergency. These funds are

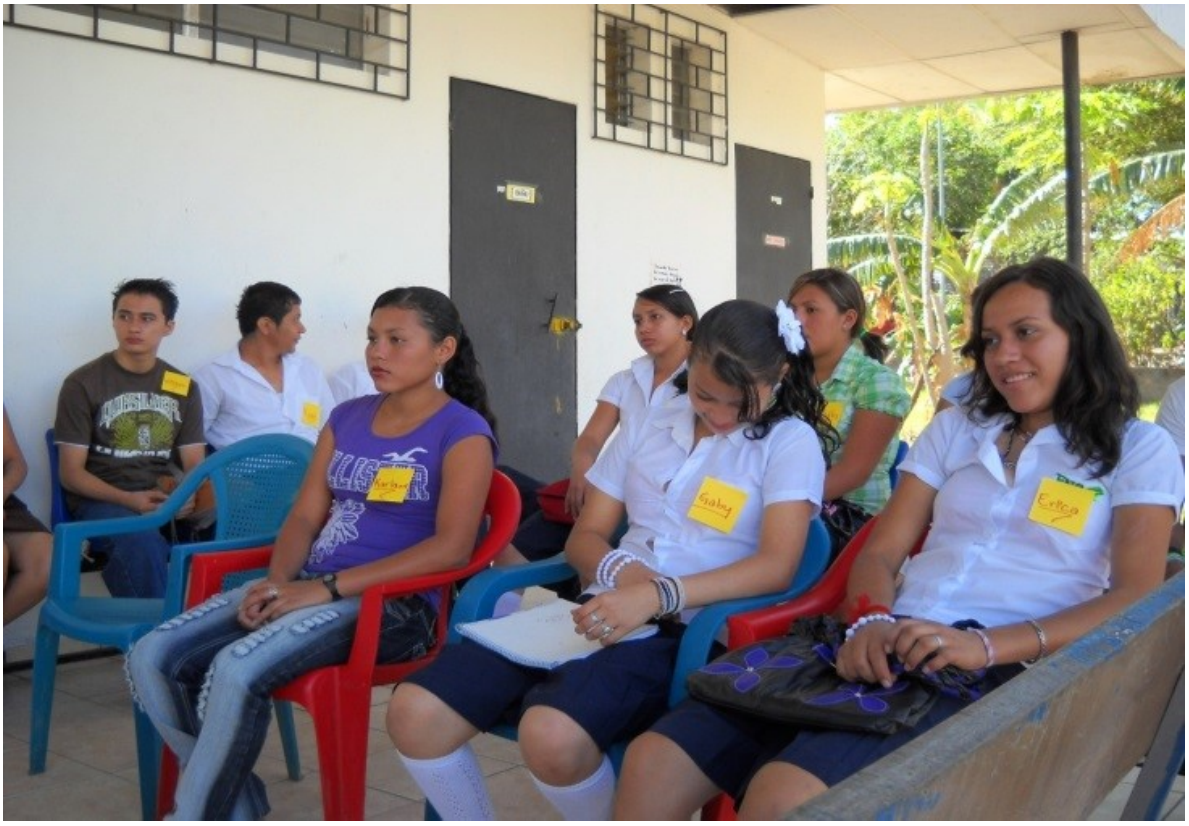
accessible for emergency care, to pay for hospital services, medications and transport according to specific criteria varying by the community group. The funds are collected from community members and borrowers return the funds at a 0%-interest rate. Programme evaluations have demonstrated that women and families are aware that these options are available to assist them to overcome barriers to health services access.

In ***Burkina Faso***, one of the planned pillars of the national MNH strategy is to put in place community bodies for managing maternal and neonatal emergencies. These bodies are created specifically to refer and help women to reach services that they need in response to maternal and newborn complications. EdM and its local partner are assisting MoH to strengthen these bodies in the districts where they are supporting implementation of the IFC framework. These community bodies are being trained to better manage maternal and newborn complications in their respective communities.

In *Burkina Faso and El Salvador* maternity waiting homes have been constructed close to the health centres. The waiting homes provide a way for women who live far from the hospital to come and stay near the health facility in the weeks or days leading up to birth so that they can be attended by a skilled attendant when they give birth and have access to emergency care if needed. In addition, in El Salvador violence is highly prevalent and maternity waiting homes were identified as a means for pregnant women travelling alone, including young pregnant women, to health facilities to be able to do so during daytime hours and therefore more safely. The health facility committees have taken the lead in mobilising the community for constructing and managing the homes. Women who have used them have expressed satisfaction with their use of the homes.

In order to overcome transportation barriers to care in El Salvador, agreements have been signed, following consultation with municipal authorities, with MoH ambulances, relief agencies such as the Red Cross and Salvation Army, and vehicles of the National Civil Police to transport pregnant women free of cost. In addition, at the community level meetings have been held with local transport drivers of pick-ups and minibuses to raise their awareness of the importance of transporting women to health facilities. These carriers have agreed to transport women to health services at the onset of labour and in the case of obstetric and neonatal emergencies and to receive payment later on if payment is required.

All of these interventions, while quite different as they are adapted to the local context, are contributing to assuring that women, including young women, are able to realize their right to access routine and emergency MNH services.



Sexual Education in El Salvador (Enfants du Monde)

Rights to education and information

Rights to education and information refer to right to receive and impart information, including education and information relating to sexual and reproductive health without any discrimination. Education and information can help families and communities provide women with the adequate care within the household which they need during pregnancy and to identify the signs indicating the necessity to seek out maternal health services. Women also need accurate information on sexual and reproductive health, such as family planning in the postpartum as well as during all other periods of their reproductive life. EdM is supporting activities which provide education and information to women and families so that they can know how to care for women and newborn during and following pregnancy and make health promoting decisions. In certain cases, education activities and tools are adapted specifically to target adolescents.

Birth preparedness and complication readiness

In all programmes one of the central interventions is birth preparedness and complication readiness. This intervention aims to build the capacity of women in making the choices in anticipation of birth and in the case of complications which will contribute to making sure that they are able to make optimal health choices (i.e., seeking skilled care) when the moment arrives.

In ***Bangladesh, Burkina Faso, Colombia and El Salvador*** a Birth and Emergency Preparedness Plan (BEPP) card has been produced in collaboration with local partners and endorsed by the respective Ministries of Health. A similar card is being developed in Haiti. These cards illustrate the following preparations that women should consider in anticipation of birth:

- selecting a birth attendant;
- choosing a birth place and transportation to reach the birthplace;
- organizing with a birth companion; identifying a potential blood donor;
- developing a strategy to save money for costs related to pregnancy;
- identifying where to seek care in the case of complications.

They also contain illustrations of the most common danger signs to help women and families identify complications and seek care in a timely manner. While containing the similar information, the cards are carefully adapted to each country context.

Women receive the cards either during antenatal care visits or during home visits and are assisted by a health worker to prepare a plan. As a result of these efforts, women and families have a greater awareness of the best decisions for women and newborns and a knowledge of danger signs for which skilled care should be sought. Moreover, the card is used as a tool for communicating the birth plan at home and with the intimate circle of friends, increasing the dialogue on MNH.

Community awareness

A number of community awareness activities are conducted in each programme to increase the awareness of the whole community on MNH rights and needs. These vary by country, but include community meetings, meetings with women's groups, meetings with men, meetings with grandparents, meetings with community leaders, theatrical performances, and radio emissions. These activities help to reframe MNH as a community issue, as opposed to an issue impacting women at the individual level, and increase the will of the community to work together to improve the health of all women and newborns.

Youth sexual and reproductive health education sessions

In El Salvador, sexual and reproductive health education is conducted with adolescents, who are also trained to serve as peer-educators in their own communities, with a primary aim to prevent early pregnancy. Topics of the education sessions include autonomy and future goals, self-esteem, sexuality and gender, sexual and reproductive rights, risks in pregnancy, family planning, sexually transmitted infections and HIV. At the conclusion of the educations sessions, the adolescents commit to conduct similar sexual and reproductive health education sessions in their communities and to act as peer-educators.
To complement the education of adolescents, parents are also invited to participate in the workshops on adolescent sexual and reproductive health and this is strengthening family relationships. Many have been enthusiastic in their participation and expressed that they have

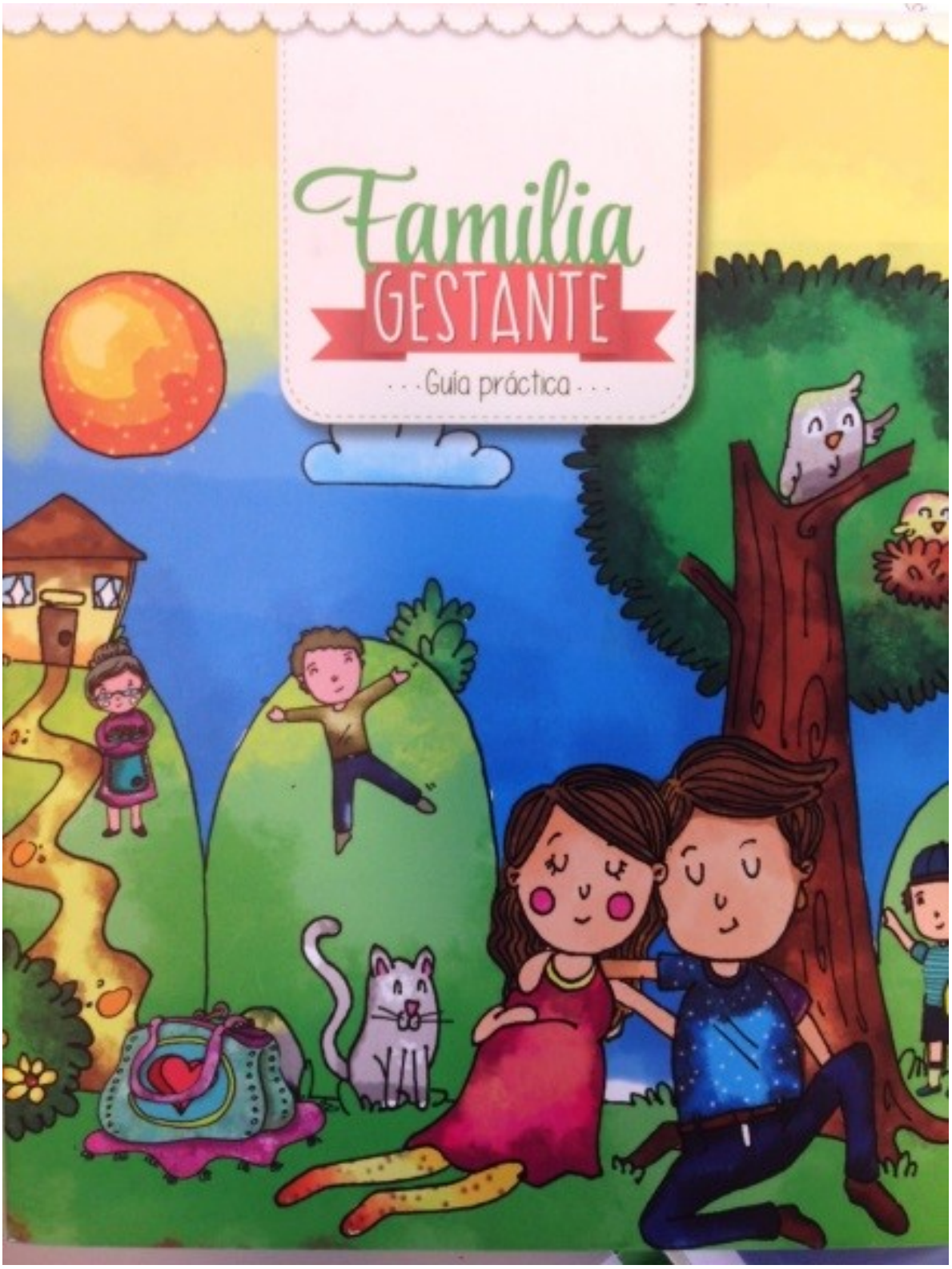
learned about and become more sensitive to the changes that their children are experiencing in adolescence and that they are putting into practice the knowledge acquired in problem-solving skills.

Pregnant teenagers clubs

In addition to the education of the general youth population on sexual and reproductive health, interventions also target pregnant adolescents in El Salvador. Notably, pregnant teenagers clubs have been formed. During club meetings, the pregnant teens are educated on how to care for themselves during pregnancy, the importance of skilled care at birth, postpartum care and care of newborns. This education increases their possibilities of experiencing childbirth and pregnancy safely and appropriately caring for their newborn.

To complement these meetings, tours of the local hospital are also arranged for the pregnant teenagers clubs. During the tours health workers discuss the benefits of clean delivery and complications of home births with the girls. They learn what to expect during birth at the hospital and what their rights are in the health facility. In some cases the girls are even invited to observe a normal birth and the care received in the hospital setting. This visit is particularly pertinent for girls living in rural areas where home births remain common. By visiting the hospital the girls can prepare psychologically and emotionally for an institutional birth, overcoming fear and hesitancy.

It is important to note that similar clubs have also been organized for pregnant adolescents in Colombia, yet with less success. While youth have been eager to participate in El Salvador, this eagerness has not been reflected in the Colombia progammes. This highlights the importance of carefully tailoring interventions to the context, as successful interventions in one setting cannot always be expected to achieve the same success in another setting.



Famlia Gestante, Colombia (Enfants du Monde)

Adaptation of educational materials to a young audience

In order to maximize the benefits of health education for girls, some educational tools have been specifically adapted for this audience. In Colombia, for example, a pregnancy book was developed specifically with young women in mind, using illustrations and text which appeals to this audience. This book (Familia Gestante, Guia practica) allows young women to fill in fields relating to their pregnancy experience, creating their own personal story, while presenting

important information regarding care during all phases of pregnancy, birth, following birth and caring for her newborn. This book is being used in a context in which girls often have a difficult time accepting the baby after birth. Therefore, in addition to the goal of educating girls on theirs and their babies' needs during this critical period, it also aims to help girls to create a story with their unborn child and thereby promote in-utero bonding and, in turn, acceptance at birth.

Rights relating to privacy, decision-making and security

These rights empower women in deciding for themselves, independently, whether and when to seek health care. Social or legal requirements that women obtain the consent of another person (such as a spouse) in order to obtain maternal health care deprive them of this autonomy and affect those rights. This autonomy is crucial to help women access the means to maintain or restore maternal health. While women of all ages can struggle to assert their needs and achieve decision-making autonomy within the household, this can be particularly acute for young women, who may experience even lower status within the family. Activities in each of the programmes empower women to participate in decision-making processes in the household.

Birth preparedness and complication readiness

While already discussed in a previous section, this intervention merits a special mention again here as one of the main objectives of this intervention is to empower women as decision-makers within the household. After health workers assist women in developing a personalized plan for birth preparedness and complication readiness, women are encouraged to share it with their husbands and other influential family members, such as mothers and mothers-in-law. This exercise, therefore, is intended not only to encourage women and families to choose skilled attendance at birth and seek skilled care in response to danger signs but also to empower women to participate in household decision-making processes.

Qualitative programme evaluation in ***Bangladesh*** has revealed that this intervention is in fact contributing to women's increased participation in household decision-making related to MNH. Women and men expressed that after the woman has worked with a health worker to prepare a plan for birth and potential complication using the official BEPP card (with MOH logo) she becomes a sort of household authority on the issue and family members include her input to a greater degree in MNH decision-making. Moreover, women reported greater autonomy in seeking care as a result of having pre-arranged transportation and financial means. Women also expressed an increased inclination to seek services if they or their infants needed it without first obtaining consent from other family members. Deeply engrained social norms such as these can often prove particularly resistant to change, and it is promising to see that they appear to be shifting in response to the intervention.

Pugsid Songo ("Model Husbands")

In ***Burkina Faso***, interventions aiming to influence the role of male husbands/partners in MNH have been implemented since 2010. Their role is critical in improving the health of young women as girls tend to marry young, either to young men or older men, thus increasing their likelihood for early pregnancy. Interventions targeting men include community meetings, household discussions with couples, and implementation of a strategy entitled Pougsid songo, or "Model Husbands." Within this intervention, designed collaboratively by health workers and community members, men who are exhibiting positive behaviours in supporting women in the area of MNH are trained to educate other men in the community on care for women and newborns, on accompanying women to health services and on danger signs. This intervention has been received with a great deal of enthusiasm by women and communities.

Preliminary results suggest that men are participating more actively in MNH as a result of the intervention. Notably, men are accompanying women to health facilities for antenatal care (ANC) and for birth in increased numbers and they are increasingly aware of care practices for women during and after pregnancy and for newborns, such as supporting women to avoid heavy labor and eat nutritious food during and following pregnancy. In addition, utilization of MNH services and family planning methods among women is increasing. Healthcare providers also report improved interactions with women and families, increased community participation in care and increased social cohesion.

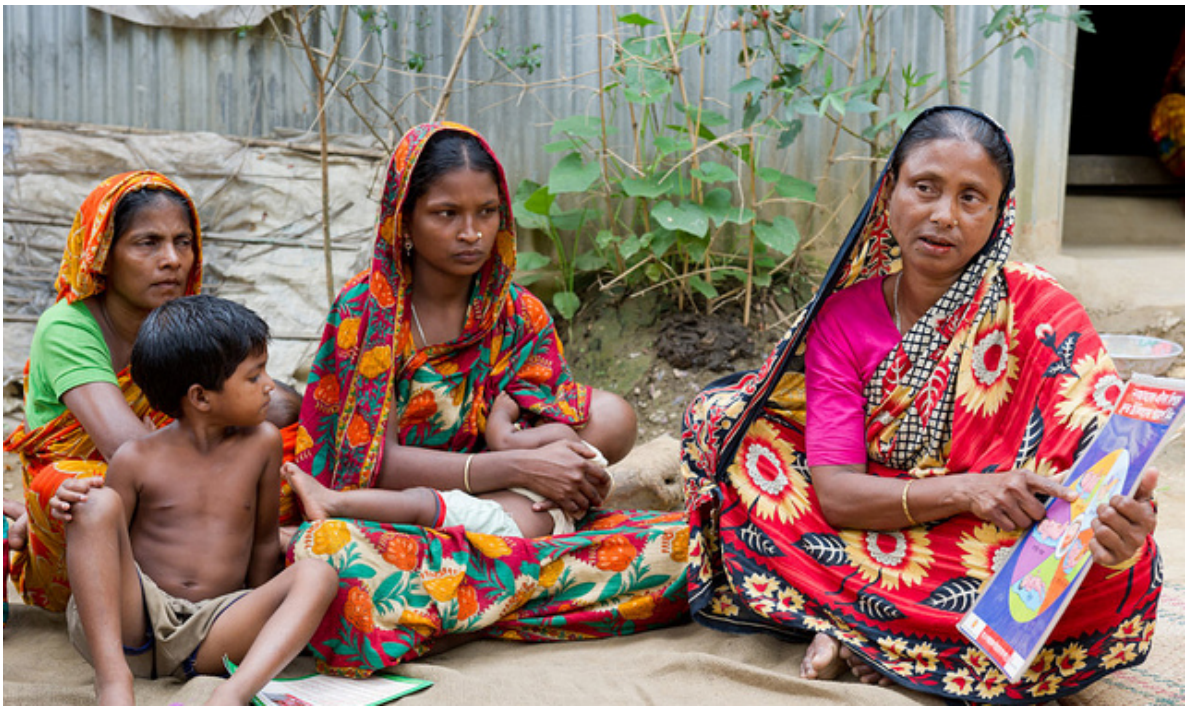
Right to respectful care

In addition to the barriers to care seeking previously mentioned, poor quality of services also represents an important deterrent for women who may otherwise seek health services. Notably, participatory community assessments conducted in the various countries revealed that often women do not feel that they are well received within the health services and that their interactions with providers when receiving care during pregnancy, birth and postpartum are often not satisfying to them. They reported poor reception when seeking health services and even experiencing verbal and physical mistreatment. Community members cited these experiences and the resulting poor perceptions of interactions with health care providers as representing a major barrier to women's and families' decision to seek needed services at health facilities. This can be particularly acute for young pregnant women who oftentimes face stigma, especially when they are unmarried.

All women have a right to be treated with respect and dignity when receiving MNH services, regardless of their socioeconomic status, ethnicity, age, etc. Health care providers in low-resource settings are often limited in their capacity to provide this type of care, as health facilities tend to be understaffed and health workers have not been trained to provide this type of care. In response to this identified need, health care providers are being trained in Bangladesh, Burkina Faso, Haiti and El Salvador to counsel women on MNH issues and to provide respectful care. This training also builds the capacities of health workers to respond to the specific needs of women, including young women.

This training is based on WHO's manual entitled, "Counselling for maternal and newborn health care: a handbook for building skills". This manual first covers theoretical issues related to counselling, including counselling principles and skills, as well as responding to personalized needs of women. The manual then covers MNH topics, including birth preparedness and complication readiness, care of women and newborns in the home, danger signs in women and newborns and how to address these subjects with women and families. The manual employs proven principles in adult education and uses participative methods including role plays and group work. Users of the manual, whether individually or in a group, are encouraged to integrate new knowledge into their current knowledge and practice.

Health care providers who have participated in the training have been enthusiastic about it and expressed a need for capacity building in this area. Knowledge acquisition from the training has been high as participants have demonstrated significant improvements between training pre-test and post-test scores. It is expected that this training will result in the increased capacity of health workers to respect, protect and fulfil the rights of women, including young women, to respectful MNH care.



Mother's sensitisation, Bangladesh (Enfants du Monde)

Right to participate

The right to participate is central to any rights based approach to programming, and is a central pillar of the IFC framework. Programmes in each country aim to institutionalize community participatory processes within the health system, including participatory planning processes, inclusion of community members in health facility general assemblies and supporting community groups to monitor the quality of health services.

Participatory community assessment

A first step in district level implementation of the IFC framework calls for conducting participatory community assessments. These assessments allow community members, with an emphasis on marginalized groups, to actively participate in prioritizing their needs and planning interventions. It is designed to provide community members a forum for voicing their concerns and perspectives and for contributing to the process of designing tailored solutions to address the needs which they have identified. The participatory community assessment is conducted in two phases. First, roundtable discussions are conducted with representatives of different groups in the community (i.e. women of reproductive age; male partners of women of reproductive age; influential family members of women of reproductive age; community leaders; and health care providers). In ***El Salvador and Colombia*** round table discussions are conducted specifically with adolescents. Following the roundtables, representatives from each of the discussions come together and meet with local development partners and leaders to prioritize needs and plan actions to address them. This process leads to the planning of interventions which are appropriate and specific to the context as well as the initiation of the empowerment of community members as they assume influence in improving the health of their community. Moreover, it provides a platform for community members and State actors to learn to dialogue and exchange on important issues.

While participatory planning processes are not new in planning health programmes, the IFC framework aims to institutionalize these processes within the broader health system to make marginalized voices systematically represented in health planning. With the endorsement of the national Ministry of Health, actors from the sub-national Ministries of Health are trained to conduct the participatory community assessments in collaboration with other actors working within MNH at the regional and district level. This process has created a mechanism by which community participation has been institutionalized within health planning processes. A win-win situation is created in which community members are engaged to actively participate in moulding their MNH situation and State actors are given the tools they need to concretely respond to fulfilling the right to participation to which they are obligated.

The participatory community assessment has been successfully institutionalized in ***Burkina Faso*** where it is routinely used in MNH planning in all districts where the IFC framework is implemented. In El Salvador, the participatory community assessment has elicited a great deal of enthusiasm by MoH at national and local level. Stakeholders have witnessed the benefit of working with communities using this tool and as a result MoH has adopted it for use beyond MNH for analysing and planning health action more broadly. A range of actors at national, sub-national and local level are being trained to use it, contributing its institutionalization. Particularly in El Salvador and Colombia, the participatory community assessment has been instrumental in giving a voice in adolescents in expressing their needs and empowering them to plan actions to address them.

Participation in general assemblies

In ***Burkina Faso***, one change that has been implemented in the IFC intervention zones is the inclusion of community members in health district general assemblies. This allows for community members to be able to have a voice in expressing local needs and in decision-making at the level of the health district. It can provide of forum for expressing the needs of special groups, such as young women.

Monitoring the quality of health services

In ***El Salvador***, a system of social audit has been developed in which community groups monitor the quality of the health services. These groups are recognized by MoH and can therefore legitimately demand that measures have to be taken when quality in the health services is not maintained. As one example, social audit groups denounced the situation of critical posts being left vacant in rural facilities. MoH responded to the community demand by placing gynaecologists and paediatricians in these health centres. Currently adolescents are not explicitly included in the social audit; however this could be an area of exploration for increasing adolescent participation.

Discussion

While quite broad, programme data and evaluations suggest that the mix of the interventions described in this article are contributing to building the capacities of rights-holders and duty-bearer so that all women, and young women in particular, are better able to realize their rights related to safe motherhood. Women, including young women, are more aware of and better able to claim their rights related to MNH. Simultaneously, the capacities of duty-bearers have been strengthened to contribute to assuring that these rights are respected, protected and fulfilled.

However, there are currently some important limitations in these efforts to promote young women's rights in this area. To begin with, the interventions to date have not been undertaken systematically. Certain components merit attention in all programmes but have not yet been addresse. For example, in all programmes postpartum family planning for adolescents must be strengthened as programme data demonstrates that adolescent first pregnancies tend to lead to subsequent pregnancies during adolescence. Girls need to have access to the information and services to prevent future pregnancies for occurring before they are ready and this can be effectively provided during postpartum care visits. In addition, monitoring of newborns of adolescents should be strengthened is all programmes, as they currently are not monitored systematically, and we know that newborns of adolescents are at greater risk of mortality and morbidity. Monitoring and evaluation of decision-making of girls in the household and in relationships should also be strengthened to better capture how interventions may be contributing to their empowerment.

It will also be important for EdM to strengthen its collaboration with the education sector on the front of improving MHH. In many ways, education can been seen as key to improving the sexual and reproductive health of girls, as it is one important way to get at the root of the

issues and transform social and cultural norms. In order to be effective, this education needs to target boys/men in equal measure to girls and work to promote healthy attitudes of boys/men toward girls and reduce coerced sex and other forms of sexual abuse.

Besides the education sector, it will be necessary to strengthen collaboration with other sectors and/or organizations working on issues related to women's and adolescents' health and rights. The problem of poor adolescent sexual and reproductive health is multifaceted and requires a holistic approach. Depending on the context, this can include reducing early marriage, preventing female genital cutting, and assuring that girls are able to live free from all forms of violence. In many cases organizations working on these issues exist and collaborations can be strengthened to work in tandem to promote girls' and women's sexual and reproductive health rights.

Conclusion

Preliminary evidence suggests the EdM and its partners are contributing to promoting adolescents rights related to MNH. As these efforts continue and are reinforced, we expect that this, in turn, will contribute to assuring that young women experiencing pregnancy and childbirth are able to access quality services and realize their rights to safe motherhood, as well as their broader sexual and reproductive health rights.

References

1) Human Rights Council. Resolution 11/8. Preventable maternal mortality and morbidity and human rights [Internet]. UN Doc. A/HRC/RES/11/8, 11th Session; 2009. Available from: http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf

2) Human Rights Council. Report of the Office of the High Commissioner for Human Rights on preventable maternal mortality and morbidity [Internet]. UN Doc. A/HRC/14/39; 2010. Available from: http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.39.pdf

3) Office of the High Commissioner for Human Rights. Practices in adopting a human-rights based approach to eliminate preventable maternal mortality and human rights [Internet]. UN Doc. A/HRC/18/27; 2011. Available from: http://www2.ohchr.org/english/issues/women/docs/WRGS/A-HRC-18-27_en.pdf

4) Office of the High Commissioner for Human Rights. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality [Internet]. UN Doc. A/HRC/21/22; 2012. Available from: http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

5) WHO. Fact sheet 364: Adolescent pregnancy. WHO: Geneva; 2014. Available from: http://www.who.int/mediacentre/factsheets/fs364/en/

6) WHO, Women and Health: Today's Evidence, Tomorrow's Agenda. World Health Organization: Geneva; 2009.

http://whqlibdoc.who.int/hq/2009/WHO_IER_MHI_STM.09.1_eng.pdf
7) UNFPA. Adolescent pregnancy: A review of the evidence. UNFPA: New York; 2013. http://www.unfpa.org/publications/adolescent-pregnancy
8) WHO. Early marriages, adolescent and young pregnancies. Sixty-fifth World Health Assembly Provisional Agenda Item 13.4; 2012. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_13-en.pdf
9) WHO. Working with Individuals, Families and Communities to improve maternal and newborn health. Geneva: The World Health Organization; 2010. Available from: http://whqlibdoc.who.int/hq/2010/WHO_MPS_09.04_eng.pdf
10) World Health Organization. Counselling for maternal and newborn health care. Geneva: World Health Organization; 2013. Available from: http://www.who.int/maternal_child_adolescent/documents/9789241547628/en/

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