NATIONAL SEXUAL AND REPRODUCTIVE HEALTH POLICY 2022

Ministry of Health and Wellness

World Health Organization
Mauritius

FOREWORD

Sexual and Reproductive Health (SRH) care is crucial to the achievement of universal health coverage and is included in the Sustainable Development Goals, which entrust countries to providing universal access to SRH services by 2030. The Ministry of Health and Wellness, as the Government entity responsible for the health and wellbeing of the people in Mauritius, has taken the lead in the development of this National Sexual and Reproductive Health Policy 2022, as a means of facilitating Universal Access to SRH.

Ensuring universal access to Sexual and Reproductive Health services is an ambitious objective which echoes with what has already been agreed to in the Programme of Action 1994 of the International Conference on Population and Development (ICPD) and their respective review conferences. The Ministry of Health and Wellness is renewing its commitment in addressing the sexual and reproductive health needs of the population so that all people, regardless of age, gender identity, sexual orientation, socio-economic condition and cultural background, are enabled and supported in achieving their full potential for sexual and reproductive health and well-being.

Sexual and reproductive health is an undeniable element of good health and human development and therefore calls for more progress on addressing the sexual and reproductive health needs particularly in respect to child and maternal health, HIV and AIDS and other communicable diseases, and gender equality. Moreover, a better sexual and reproductive health accelerates progress in achieving a sound mental and emotional health.

While my Ministry has already successfully adopted many components of the SRH, such as, the Family planning, including infertility information and services, prenatal care and safe motherhood, amongst others, the actual context demands a different approach to SRH***: "The life-course approach".***

People have different and changing sexual and reproductive health needs throughout their lives. Therefore, policies need to address the whole life course – from birth to old age. Applying a life-course approach to SRH is key to addressing these gaps: it improves access through integration of services, facilitates behaviour change at community level, and enables health systems to strengthen and adopt measures to prevent chronic diseases in old age.

Improving sexual and reproductive health is among the most cost-effective of all development investments, reaping personal, social and economic benefits. It will save and improve lives, slow the spread of HIV and AIDS and encourage gender equality.

As Government progresses towards ensuring healthy lives and the promotion of wellbeing for all, at all ages, this policy is timely as it will help to achieve Universal Access to Sexual andReproductive Health.

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EXECUTIVE SUMMARY

Good sexual and reproductive health (SRH) is fundamental to ensuring that individuals, families and populations enjoy lives that are healthy, sustainable and meaningful. Poor sexual and reproductive health is associated with a higher burden of disease at national and global levels.

A first National Sexual and Reproductive Health Policy was developed by the Ministry of Health back in 2007, following which two plans of action, namely the National Sexual and Reproductive Health Plan of Action 2009 – 2015 and the National Sexual and Reproductive Health Plan of Action 2018 – 2021 were developed.

At a time where the health climate around the world has been shaken up by economic and social shifts due to COVID 19, there is need for innovative and comprehensive tools to be developed to cater for the present challenges. The SRH is one of the many aspects of a person's good health. People are sexual beings at the core and high quality sexual and reproductive health services are essential to the well-being of every person.

At the heart of SRH lies the concept of healthy sexuality – meaning a safe and satisfying sexual life, a positive attitude to sexual relationships, and freedom to express sexual and gender identity. Healthy sexuality, in turn, relies upon the protection, promotion and enabling of fundamental human rights in relation to sexuality.

Evidence highlights that SRH outcomes are driven by policy and social structure and constructs, viz family, community and social norms and individual characteristics and behaviours. Importantly, many of these drivers are outside the sphere of influence of the health and population sectors - thus emphasizing the need for intersectoral coordination and collaboration to enable SRH goals to be reached. Furthermore, crosscutting issues such as gender act across all three levels should be taken into consideration in policy and program responses.

The National Sexual and Reproductive Health Policy 2022propose to provide guidance to the Ministry of Health and Wellness and all stakeholders on the coordination and implementation of relevant programmes in response to the country's Sexual and Reproductive Health and Rights and needs.

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LIST OF ABBREVIATIONS

AHC	Area Health Centre
AIDS	Acquired Immunodeficiency Virus
ANC	Antenatal Care
CBO	Community Based Officers
CBRO	Community Based Rehabilitation Officers
CHC	Community Health Centres
CHCO	Community Health Care Workers
COVID 19	Coronavirus Disease 19
CSE	Comprehensive Sexuality Education
GBV	Gender Based Violence
HIEC	Health Information Education and Communication
HIV	Human Immunodeficient Virus
HPV	Human Papilloma Virus
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MAM	Mouvement d'Aide à la Maternité
MDGs	Millennium Developmental Goals
MFPWA	Mauritius Family Planning and Welfare Association
MPDSR	Maternal and Perinatal Death Surveillance and Response
NEPAD	New Partnership for Africa's Development
NGOs	Non-Government Organisation
NICU	Neonatal Intensive Care Unit
NIPT	Non-Invasive Prenatal testing
PAP	Papanicolaou test
PDVA	Protection from Domestic Violence Act
PPP	Public Private Partnership
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PoA	Plan of Action
PrEP	Pre-Exposure Prophylaxis
PSA	Prostate Specific Antigen
SADC	Southern African Development Community
SDGs	Sustainable Developmental Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats
TFR	Total Fertility Rate
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
WHO	World Health Organization

SECTION 1

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so.

Source: UNFPA (1)

1.0 Introduction

Sexual and Reproductive Health and rights (SRHR) have been placed at the centre of programmes for sustainable social and economic development for at least the past two decades. In 1994, the International Conference on Population and Development (ICPD) identified access to reproductive and sexual health programmes as a key strategy for achieving overall development goals. "Population-related programmes play an important role in enabling, facilitating and accelerating progress in sustainable human development programmes, especially by contributing to the empowerment of women [and] improving the health of the people" (2).

Investments in SRH contribute to goals of empowerment, particularly women's, through increasing abilities to make informed decisions related to partnerships, sexual behaviour and family planning free of coercion, discrimination, and violence; all of which allows for greater female participation in the workforce - itself a logical requisite for equitable and sustainable economic growth (3).

Over at least the past two decades, countries have both embraced the concept of comprehensive SRHR, and simultaneously struggled to define what SRHR means to individuals, families, communities and populations, and how people can be supported to achieve their SRH goals. In the broadest terms, SRH goals are currently enshrined within the Sustainable Developmental Goals (SDGs). SDG 3 focuses on sexual and reproductive health.

This global focus on SRHR is partly based on a concern with the high contribution that risks arising from unsafe sexual practices make to the global burden of disease. Equally, there is a deep-seated global concern to ensure that everyone has the right to the highest attainable standard of health, and an acknowledgement that good sexual and reproductive health are fundamental to human well-being.

Twenty-eight years past the International Conference on Population and Development (ICPD) 1994, tremendous progress has been made in advancing sexual and reproductive rights. However, the future requires directly challenging the linkages between gender inequality, sexuality and reproduction and the patriarchal social norms that reinforce them. (4). The 4th World Conference in Beijing in 1995 brought significant contribution towards improving the sexual and reproductive health of women, where it was acclaimed that "Women rights are human rights". The conference advocated for empowerment of women with equal access to health care.

> ***"Ensure equal access to and equal treatment of women and men in education and health care and enhance women's sexual and reproductive health as well as education" (5)***

A National Sexual and Reproductive Health Policy was developed in 2007 followed by two plans of actions, namely the National Sexual and Reproductive Health Plan of Action 2009 – 2015 and the National Sexual and Reproductive Health Plan of Action 2018 – 2021 which guided policy makers and health professionals to deliver quality sexual and reproductive health services. The health system has known marked improvements and progress since then. Amongst others, maternal mortality ratio, neonatal, infant and under 5 mortality rates have decreased; a wide range of modern contraceptive methods are provided in primary health care; screening tests for HIV/STIs are provided.

Despite progress in recent decades—especially related to the development of standards to address sexual and reproductive health in crisis settings—services on the ground have lagged far behind the need, because of challenges relating to COVID 19, changing demographics with an ageing population, climate change, culture and ideology, insufficient data, financial and resource constraints, and inadequate health care systems.

Given the burden of disease on the health and socioeconomic systems in the Republic of Mauritius and the social determinants of health and sociocultural norms that affect SRHR services, this policy intends to highlight these pertinent issues and seek ways of addressing the multifaceted nature of SRHR service delivery.

Therefore, the development of a new National Sexual and Reproductive Health Policy provides a unique opportunity to define common vision and mission, set goals and objectives, identify priorities, assess emerging issues and challenges, as well as areas for action; and to elaborate a strategic plan to strengthen the health system delivery and to focus on health promotion, prevention and curative aspects of SRHR. The Republic of Mauritius National Sexual and Reproductive Health Policy 2022 aims to create the conditions under which all human beings of the Republic of Mauritius are able to enjoy good sexual and reproductive health across all stages of life.

1.1 Sexual and Reproductive Health and Rights (SRHR)

Sexual and reproductive health and rights (SRHR) are fundamental to people's health and survival, to economic development, and to the wellbeing of humanity. They are also essential for sustainable development because of their links to gender equality and women's wellbeing, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability. (5)

A comprehensive definition of SRHR

"A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right".

Source: Guttmacher–Lancet Commission (1)

Sexual health and reproductive health are linked at every level – from the experience of the individual, through the delivery of integrated and holistic packages of services and interventions aiming to improve SRH of individuals, communities and broader societal groups. At the core of SRHR lies healthy sexuality - defined as achieving a safe and satisfying sexual life, attaining a positive attitude to sexual relationships, and freedom to express one's sexual and gender identity. Recognition of the central role of sexuality is not a new concept (6), but it is nonetheless frequently overlooked at the level of policy and programmatic responses. Re-focusing policy and programme efforts to acknowledge sexuality is key to achieving good sexual and reproductive health outcomes.

Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to: (1)

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have; and
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Several decades of research have shown and continue to show the profound and measurable benefits of investment in sexual and reproductive health. Through international agreements, governments have committed to such investment. Yet, progress has been halted because of unwillingness to address issues related to sexuality openly and comprehensively, weak political commitment, inadequate resources, and persistent discrimination against women and girls. (7)

Health and development initiatives, including the 2030 Agenda for Sustainable Development and the movement toward universal health coverage, typically focus on particular components of SRHR: contraception, maternal and newborn health, and HIV/AIDS.

SRHR have far-reaching implications for people's health and for social and economic development. Unintended pregnancy, complications of pregnancy and childbirth, unsafe abortion, gender-based violence, sexually transmitted infections (STIs), including HIV, and reproductive cancers threaten the wellbeing of women, men, and families. (8)

1.2 Life course approach

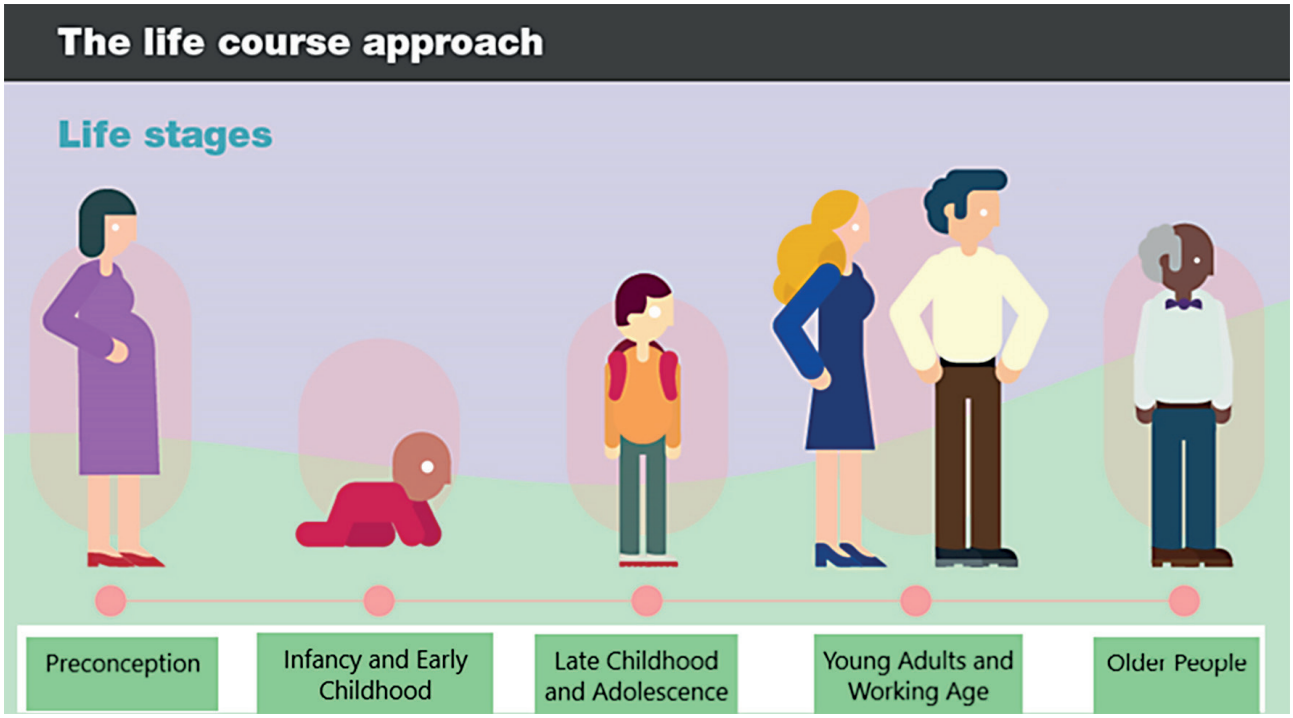


Figure 1: Life stages of an individual

A person's health and wellbeing are influenced throughout life by the wider determinants of health, which are a diverse range of social, economic and environmental factors, alongside behavioural risk factors which often cluster in the population, reflecting real lives. These factors can be categorised as protective factors or risk factor.

Table 1: Protective and risk factors across life stages

Positive and Negative Influences across life course	
Protective Factors	**Risk factors**
Healthy and balanced diet	Smoking
Physical activity	Adverse childhood experiences
Educational level	Crime and violence
Good income	Drug and alcohol misuse
Family and friends' support	Poor educational attainment
	Poor mental health
	Negative environmental impacts

Addressing the wider determinants of health will help improve overall health by optimising the conditions into which people are born, live and work. Rather than focusing on a single condition at a single life stage, a life course approach considers the critical stages, transitions and settings where large differences can be made in promoting or restoring health and wellbeing. (9)

Adopting the life course approach means identifying key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age, and into older age.

People have different and changing SRH needs throughout their lives; therefore, policies need to address the whole life course, that is, from birth to old age. Although many countries achieved improvements in areas such as maternal health, family planning and preventing sexually transmitted infections (STIs), much remains to be done to ensure continuity of services and equity in health access. Applying a life-course approach to SRH is key for addressing these gaps: it improves access through integration of services, facilitates behavior change at community level, and enables health systems to strengthen measures to prevent chronic disease in old age. (10)

SECTION 2

To maintain one's sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. And when they decide to have children, women must have access to skilled health care providers and services that can help them have a fit pregnancy, safe birth and healthy baby.

Source: UNFPA (1)

2.0 Sexual and Reproductive Health in figures

As at end 2020, the population of the Republic of Mauritius was estimated at 1,266,030, of whom 626,156 were males and 639,874 females. The population densities per square kmof the Island of Mauritius and the Island of Rodrigues were 654 and 387 respectively. The population of the Republic of Mauritius increased by only 393 (0.031%) between 2018 and 2020 and projection shows that that the population of Mauritius will show a declining trend after 2022.

2.1 Island of Mauritius

Mauritius has undergone a rapid demographic transition from high levels of fertility and mortality to lower levels, as a result of which, the country is facing a fast-growing population of the elderly. Crude birth rate which was 11.6 in 2011 has declined to 10.3 in 2020. Total fertility rate decreased from 1.53 in 2011 to 1.40 in 2020, while the life expectancy at birth was an average of 74.1 years in 2019 for both sexes. The low level of fertility, which is below replacement, remains the main factor behind low population growth.

The demographic changes are accompanied with significant changes in age structure resulting in an ageing of the population. The proportion of the population aged 0-14 years declined from 20.4% in 2011 to 16.7% in 2020.It is estimated that the proportion of people aged 60 and above will increase from 18.3% in 2020 to 32.0% in 2050. Demographic ageing has major implications for all facets of human life, including economic growth, savings, investments, consumption and labour force participation. It also influences family composition and living arrangements, housing demand, migration trends, epidemiology factors and the need for specific healthcare services.

There were 12,554 live births registered in 2020. The maternal mortality ratio was 0.64 per 1,000 live births (or 8 maternal deaths). It is noted that the maternal mortality ratio (i.e., maternal deaths per 1,000 live births) has fluctuated between 0.33 and 0.79 during the ten-year period of 2011 to 2021. Only 27.9% of first attendances by pregnant women were before 3 months of gestation. The percentage of caesarian section was 56.3% for both government and private clinics.

During the period of 2011-2021, the neonatal mortality rate has fluctuated between 7.6 and 10.5 deaths per 1,000 live births; in 2020, this rate was 10.1. Neonatal deaths accounted for 127 cases of all 184 infant deaths in 2020.The number of stillbirths was 132 in 2020. The percentage of low birth weight occurring in 2020 was 18.3%.

There were 165 infant deaths registered in 2021. The infant mortality rate has increased from 12.6 deaths per 1,000 live births in 2011 to 14.7 in 2021. The under-five mortality rate has decreased from 15.6 deaths per 1,000 live births in 2011 to 15.5 in 2020, resulting in a decrease of 0.64%. Moreover,

the data shows that the under-five year mortality rate for the five-year period has declined, from 15.3 in 2011-2015 to 14.9 in 2016-2020.

The total fertility rate dropped below the replacement-level fertility of 2.10 children per woman - the level needed for a woman to replace herself and her partner - for the first time in the mid-1980s; however, it was not until 1997 onward that fertility has continuously been at sub-replacement level. In 2020, the total fertility rate was 1.40 children per woman compared with 1.53 in 2011, resulting in a decrease of 8.5%. Interestingly, an increase in the total fertility rate has been noted from 1.35 in 2019 to 1.40 in 2020 – the year where the Covid-19 pandemic was declared and women aged 25 – 29 years had the highest fertility rate (82.7) followed by age group 30 – 34 years (79.8).

The fertility rate for women aged 15-19 years (adolescent fertility rate) has declined from 30.4 in 2011 to 21.7 in 2020, resulting in a decline of 28.6%. 979 cases of live births were recorded among mothers aged less than 20 years in 2020. There were 4 deaths, out of 8 maternal deaths cases recorded in 2020, where the mothers were teenagers (3 of them were 17 years and 1 was 19 years old).

The government family planning programme provides a wide range of short term and long-term contraceptive methods through a network of health service points. In 2020, there were 3059 new acceptors who were registered at the family planning service points. Current users as at 31st December 2020 were 57,695. From 2015 to 2020, there has been a decline of 12.3% of current users of methods of family planning services.

STI rates are high in Mauritius and assume a major contributing factor to infertility. In 2020, we had 78 cases of gonorrhea, 3386 cases of Hepatitis C and 312 cases of syphilis. About 50% of the estimated 14,000 people living with HIV in the country know their status. The HIV epidemic which is concentrated among the high-risks groups is driven by injecting drug use. With the harm reduction measures being implemented, the trend in the mode of transmission among the annual newly diagnosed HIV cases is now heterosexual. In 2020, about 65% of the new cases were through heterosexual route of transmission while vertical transmission stood at 1.1%, homo/bisexual was 2.2% and hetero/IDU was 2.8%.

Medical Termination of Pregnancy can be done under certain specific conditions laid down in section 235A of the Criminal Code. However, cases of unsafe abortion have presented to health facilities indicating the lack of contraceptive use in the context of unmet needs for family planning. There have been1338 cases treated for complications of abortion in 2020, however, these figures do not demarcate complications of spontaneous abortion from those of illegal abortion.

Cancers of reproductive tract have been increasing in number for both male (prostate) and female (breast, cervical, ovarian and uterine cancer). Most common reproductive tract cancer in female is breast cancer with 548 cases or 35.2% in 2019 followed by 135 cases of uterine cancer (corpus uteri or uterus – unspecified) and 74 cases of cervical cancer or 4.7% of total cases. 174 women died of breast cancer in 2020, 51 women died from cervical cancer and 44 women died from malignant neoplasm of female genital organs. 176 cases of prostate cancer were diagnosed in male which represent 15.9% of new cases of cancer registered and there were 99 deaths due to malignant neoplasm of prostate in 2020.

Women are more likely to be victims of domestic violence. The number of cases of domestic violence, reported at the Ministry of Gender Equality and Family Welfare, increased from 2222 in 2019 to 2425 in 2020, ie by 9.1%. There were 2116 cases of domestic violence against women and 309 cases against men in 2020.Types of assaults reported by women were verbal assault by spouse or partner (ill treatment, harassment, abuse, and humiliation), physical assault by spouse or partner or others living under the same roof, threatening assault by spouse. Reported cases by men were mostly verbal assault by spouse or partner, physical assault by spouse or partner and verbal assault by others living under the same roof.

2.2 Rodrigues Island

There were 911 live births registered in 2020. The crude birth rate was 20.8 births per 1,000 mid-year population and the crude death rate was 6.7 deaths per 1,000 mid-year population in 2020.

The crude birth rate has increased from 17.7 births per 1,000 live births in 2011 to 19.1 in 2019 and in 2020, it was 20.8. The infant mortality rate was 17.3 deaths per 1,000 live births in 2011 as well as in 2019 and in 2020, it was 17.6. The still birth rate has increased from 8.8 still births per 1,000 total births in 2011 to 9.6 in 2019 and in 2020, it was 9.8. The neonatal mortality rate was 12.1 in 2020. There were 98 low birth weight babies in 2020.

There were no maternal deaths in 2020 in the island of Rodrigues. The caesarian section rate was 38.4%. Concerning attendances to antenatal clinics, 48.8% attended during the first trimester.

The total fertility rate has declined from 3.19 children per woman in 1990 to 2.57 in 2019 and in 2020, it was 2.80. In 2020, the age-specific fertility rates showed that women aged 30-34 years had the highest fertility rate (147.4) among all age groups and that women aged 25-29 years (132.9) had the second highest fertility rate.

There were 306 new acceptors of family planning methods in 2020 and 3,978 current users as at 31 December 2020.

The number of teenage pregnancies has been on the rise with 139 cases registered in 2020 compared to 99 in 2014. Majority of teenage pregnancies occurred in the age group 15 – 19 years.

There were 10 cases of HIV, 69 cases of Gonorrhea and 126 cases of syphilis notified to sanitary authorities in 2020.

Statistics source: Demographic Yearbook 2020 (11), Health Statistics Report 2020 (12), Statistics Mauritius (13)

2.3 SRH Services in the Republic of Mauritius

The Republic of Mauritius provides health services free of charge and has a well-developed healthcare system. In the island of Mauritius, Sexual and Reproductive Services are delivered in primary health centres (1 community hospital, 6 mediclinics, 21 Area Health Centres (AHC) and 115 Community Health Centres (CHC) located across the whole country) as well as 5 regional hospitals.

In Rodrigues Island, there are 14 CHCs, 2AHCs with inpatient facilities (La Ferme and Mont Lubin) and one main hospital at Creve Coeur. In 2020, there were 15 government family planning service points in the Island of Rodrigues.

Sexual and Reproductive Health services provided in these health centres include:

i. Family Planning;
ii. Treatment of infertility
iii. Safe Motherhood: preconception care, prenatal care including EMTCT, safe delivery, emergency obstetric care, perinatal and neonatal care, postnatal care and breastfeeding;
iv. Prevention and management of complications of abortion;
v. Infant and Child Health;
vi. Promotion of healthy sexual maturation as from pre-adolescence, responsible and safe sex throughout the lifetime and gender equality;
vii. Prevention and management of reproductive tract infections, especially sexually transmitted infections (STIs) including HIV/AIDS;
viii. Prevention and management of sexual dysfunction in both men andwomen;
ix. Gender and Sexual and Reproductive Health including elimination of domestic and sexual violence against children, women and men;
x. Screening and management of non-infectious conditions of the reproductive system such as cervical, breast and prostate cancer;
xi. Geriatrics and reproductive health problems associated with the menopause and andropause;

2.4 Challenges

Sexual and Reproductive Healthcare is a core function of the Ministry of Health and Wellness. Continuous improvements have been made to the service delivery system, health promotion and prevention in terms of awareness and sensitisation. Yet, the country continues to face significant challenges and constraints that impede the delivery of quality sexual and reproductive health services at all levels of the healthcare system. The challenges are numerous and are as follows:

i. Changing demographics

Mauritius is currently experiencing an ageing population due to an increased life expectancy and a low Total Fertility Rate (TFR). The SRH health needs of an ageing population and population groups are different and this must be taken into consideration and should be addressed, for example, STIs, menopause, erectile dysfunction.

ii. Stagnating progress in key indicators

Health statistics from the past ten years showed irregular trends with regard to maternal and child mortality indicators. Even though we have achieved some of the targets set by the SDGs, yet further progress to reduce mortality to zero preventable deaths is being hindered.

iii. COVID 19

Unfortunately, COVID 19 had a great impact on SRH and the services offered. There was a temporary disruption of services such as Family Planning Clinics or Expanded Immunisation Program, school health programs or even HPV vaccination program due to lockdown, closure of schools or reallocating staff for COVID 19 related services. Gender Based Violence (GBV) cases were also on the rise. Also, there have been financial, social and mental repercussions of this pandemic. Lessons learnt from COVID 19 will allow for better preparation for any other pandemics or crisis.

iv. Social Media

The use of social media is an integral part of daily life. While the advent of the Internet has enhanced information dissemination and communication worldwide, it has also had a negative impact on the sexual and social wellness of many of its users, especially adolescents. Unfortunately, the very features of the Internet that facilitate new opportunities also create new risks for young people's SRH. One such phenomenon is revenge porn.

v. Vulnerable groups

Populations with a higher risk of poor health outcomes and healthcare discrepancies in access to healthcare are usually considered as being vulnerable and are often among those who are most affected by poverty, gender inequity, stigma and discrimination, hindered access to medical services. Examples of vulnerable groups are adolescents, disabled, elderly, commercial sex workers, people with diverse gender identities, inmates, homeless people or migrant workers.

Addressing SRH related health issues of these specific groups is mandatory if we want to end the STIs and HIV epidemics or bring down the number of cancer cases.

vi. Revenge pornography

Revenge pornography, which is mainly understood as the publication of nude or intimate pictures of another person without their consent, is a phenomenon that is increasing in occurrence and constantly changing in the manner in which it is carried out.Revenge porn refers to the online distribution of privatesexually-explicit profile of an individual by their partner on a social media site or pornography site.These activities can have damaging impacts on victims, such as humiliation, poor mental health, offline harassment or even sexual violence. One way of combatting this phenomenon is through Comprehensive Sexuality Education (CSE).

vii. Climate change

Climate change is inextricably linked with sexual and reproductive health and rights and gender equality. Any effort to mitigate and adapt to the impacts of climate change and environmental degradation therefore needs to include SRHR. The worsening climate crisis is disrupting access to SRHR services, especially during cyclonic conditions or flash floods. On the other hand, educating women on their SRH, ensuring a safe and satisfying sex life will impact positively on the quality-of-life of women. In this way, they can contribute in efforts to have resilient communities and therefore ensure secure livelihoods.

viii. Research

Research identifies sexual and reproductive health needs and priorities within communities. It generates new knowledge that can be used for advocacy and for policy and programme formulation, it identifies and promotes best practices, and it aids with the development of evidence-based interventions, guidelines and tools. Therefore, lack of research impacts negatively on policy making and type of interventions proposed to tackle an issue.

ix. Disaggregation of data

The ability to break down data by subpopulations is crucial to identifying inequities in access to and use of essential services and interventions. Disaggregation of data related to the indicators can help in assessing the scope and impact of health services and policies experienced by different segments of the population. It can also help show where targeted improvements can and should be made to ensure universal access, improve public health and fulfill human rights. Lack of data or data gaps need to be addressed through provision of disaggregated data.

x. Monitoring and Evaluation (M&E)

Understanding the dynamics of health outcomes requires a comprehensive and well-functioning M&E system. The M&E system provides stakeholders with the information necessary to determine the responsiveness of programme interventions and is considered a critical management tool for determining the effectiveness of health programmes in different contexts.

SECTION 3

Comprehensive education and information involve the provision of accurate, age-appropriate and up-to-date information on physical, psychological and social aspects of sexuality and reproduction, as well as sexual and reproductive health and ill health.

Source: World Health Organisation

3.0 Vision

A Republic of Mauritius where all people, regardless of age, gender identity, sexual orientation, socioeconomic condition and cultural background, are enabled and supported in achieving their full potential for sexual and reproductive health and well-being.

3.1 Policy goal

To promote quality and safe sexual and reproductive health among women, men and youth through informed choices and anchored on a rights-based approach.

3.2 Policy objective

To ensure that every person in the Republic of Mauritius has access to comprehensive and age-appropriate Sexual and Reproductive Health information and services across all life stages.

3.3 Guiding Principles

i. Human rights

- Protection against coercion, discrimination, stigmatisation and violence.
- Access to necessary information, education and services, as well as mechanisms for redress of abuses and violations of their rights.

ii. Stakeholders' involvement

- Shared ownership and responsibility
- Inclusiveness and representation

iii. Accountability and Transparency

- Answerability of actions and sanctions for non-compliance regarding the realisation of the rights to health

3.4 Core Values

Essential values espoused in the National Sexual and Reproductive Health policy are:

i. Universal access to health

- SRH services should be accessible to all, irrespective of age, gender, socioeconomic status or any other characteristics;

ii. Life course approach

- A tailored life – cycle approach to SRHR, recognizing the different reproductive and sexual needs of individuals at every stage of their lives;

iii. Best practices

- Commodities and facilities are of good quality and services are delivered in a safe, effective, timely, efficient, integrated, equitable and people-centred manner, based on care standards and treatment guidelines;

iv. Patient centered approach and care

- Care should be guided by patients' unique circumstances and preferences—while offering unbiased, evidence-based information;

v. Informed, autonomous and voluntary decision making

- Priority given to patient autonomy, deeming it ethically and morally necessary for the patient to make all medical decisions.

3.5 Specific objectives

OBJECTIVE 1 Empower all people to make informed decisions about their Sexual and Reproductive Health and ensure that their SRH rights are respected, protected, and fulfilled.

OBJECTIVE 2 Improve access to comprehensive and integrated Sexual and Reproductive Healthcare and treatment services across all life stages.

OBJECTIVE 3 Facilitate access to respectful and non-judgmental SRH services for priority and vulnerable groups.

OBJECTIVE 4 Strengthen the health system to deliver integrated SRH services at primary level in the healthcare system.

OBJECTIVE 5 Promote multisectoral engagement and shared accountability for a sustainable and rights-based service delivery.

SECTION 4

To effectively meet the SRHR needs of people, a comprehensive approach to SRHR is required. Taking a comprehensive approach to SRHR entails adopting the full definition of SRHR and providing an essential package of SRHR interventions with a life course approach, applying equity in access, quality of care, without discrimination, and accountability across implementation.

UNFPA 2019 (5)

4.0 Policy Alignment

The government of the Republic of Mauritius supports a rights-based framework for SRH – aligned with local, regional and international frameworks and recommendations. SRHR promotion, prevention, diagnosis, treatment and care should be in line with national and global policies, protocols and clinical guidelines.

Figure 2: Existing local, regional and international frameworks

4.1 Alignment with global strategies

4.1.1 International Conference on Population and Development 1994

In 1994, the United Nations International Conference on Population and Development (ICPD) held in Cairo concluded a Program of Action (ICPD PoA) that was a turning point in the field of sexual and reproductive health (SRH). The PoA positioned population and development programs in a broader framework of reproductive rights, gender equity, and women's empowerment. Three goals of the PoA made substantive contribution to the field of maternal health, including comprehensive and universal use of reproductive health services, universal education, and support of child health services. The PoA also moved population policies and programs towards a peoplecentered focus with a strong emphasis on environmental sustainability and the individual's needs and rights. (14)

4.1.2 4th World Conference on Women (Beijing) 1995

The 1995 Fourth World Conference on Women in Beijing marked a significant turning point for the global agenda for gender equality. The Beijing Declaration and the Platform for Action, adopted

unanimously by 189 countries, is an agenda for women's empowerment and considered the key global policy document on gender equality. It sets strategic objectives and actions for the advancement of women and the achievement of gender equality in 12 critical areas of concern: (15)

1. Women and poverty
2. Education and training of women
3. Women and health
4. Violence against women
5. Women and armed conflict
6. Women and the economy
7. Women in power and decision-making
8. Institutional mechanism for the advancement of women
9. Human rights of women
10. Women and the media
11. Women and the environment
12. The girl-child

This event, for the first time recognized the right of women to have control over their sexuality. Almost three decades later, every woman should be able to make her own choices regarding her life, her body and her health. She should therefore have access to information and high-quality services throughout her life as a teenager, as a woman and potentially as a mother. Every woman should be able to choose if and when she marries, whether or not she has children, how many she has and the space between them.

4.1.3 WHO's Reproductive Health Strategy 2004

The 57th World Health Assembly, for the first time in 2004, adopted a resolution on "Reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets". Five priority aspects of reproductive and sexual health are:

- improving antenatal delivery, postpartum and newborn care;
- providing high-quality services for family planning, including infertility services;
- eliminating unsafe abortion;
- combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and
- promoting sexual health.

This strategy responded to a resolution passed by the 55th session of the World Health Assembly calling on the WHO to develop a strategy for accelerating the progress made towards the realisation of the Millennium Development Goals.

4.1.4 Sustainable Development Goals (SDGs)

In 2015, the United Nations Sustainable Development Goals (SDGs) succeeded the Millennium Development Goals (MDGs) as the new development agenda until 2030. The 17 goals of the SDGs are far-ranging and ambitious. They are also interconnected, as are the strategies for addressing them. These strategies are reflected in the 169 targets listed under the various goals. Three of these targets are particularly relevant for promoting SRHR, one each under the health, gender equality and education goals.

Table 2: SRH related Sustainable Developmental Goals

GOAL 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES	
Target 3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
Target 3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
Target 3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and combat hepatitis, water-borne diseases, and other communicable diseases
Target 3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for contraception, information and education, and the integration of reproductive health into national strategies and programmes
Target 3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
GOAL 5: ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS	
Target 5.1	End all forms of discrimination against all women and girls everywhere
Target 5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
Target 5.3	Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation
Target 5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
GOAL 10: REDUCE INEQUALITY WITHIN AND AMONG COUNTRIES, RELATES TO ACHIEVING SRHR FOR PRIORITY POPULATIONS MOST AFFECTED BY HIV, DISCRIMINATION, AND FULFILLING THE RIGHT TO DEVELOPMENT	

4.2 Alignment with Health Sector Strategic Plan 2020 - 2024

The HSSP 2020 – 2024 is a strategic health plan which has been elaborated by the Ministry of Health and Wellness and endorsed by the Government of Mauritius. The guiding principles of the SRH policy are in line with those of the HSSP. The strategic plan sets ambitious targets to be achieved by 2024, through 25 strategic goals. Several of these strategic goals includes components of SRH.

Table 3: SRH related goals in the HSSP 2020 - 2024

Health Sector Strategic Plan 2020 - 2024	
Strategic Goal 8:	Sustain strong surveillance and response for emerging and re-emerging vector-borne and communicable diseases, including the new coronavirus disease and eliminate the Hepatitis C Virus
Strategic Goal 9:	Improve maternal mortality ratio per 100,000 live births
Strategic Goal 10:	Improve neonatal mortality rate per 1,000 live births and ensure optimal physical and psychological development of new-borns babies, children and adolescents
Strategic Goal 11:	Improve women's health and their well-being
Strategic Goal 12:	Improve population growth rate and provide high quality family planning services
Strategic Goal 14:	Enhance the health and well-being of the elderly
Strategic Goal 15:	Promote healthy behaviour among school going children and adolescents
Strategic Goal 19:	Institutionalise Health Research to improve quality of healthcare services
Strategic Goal 23:	Make provision of financial resources on a sustainable basis to accelerate progress towards universal health coverage

4.3 Key focus areas

This policy is aligned with the following key focus areas:

Table 4: Key focus areas of the National Sexual and Reproductive Health Policy 2022

Reproductive Health	Sexual Health
• Maternal health • Infant and child health • Breastfeeding • Family planning • Infertility • Abortion/ Medical Termination of pregnancy	• HIV/ AIDS/ STIs • Gender Based Violence • Special Groups (disabled, adolescents and others) • Geriatrics and Sexual needs • Sexual dysfunction • Male participation

4.4 The National Sexual and Reproductive Health Policy Development Process

4.4.1 Technical Working Group (TWG)

Sexual and reproductive health services span across many programs within the Ministry of Health and Wellness, as well as other departments, and include a variety of clinical services, educational and health promotion activities, screening and preventive services. Therefore, it is essential to have proper coordination and collaboration amongst the different units/ sectors of the Ministry and with relevant stakeholders.

A TWG was set up by the Honourable Minister of Health and Wellness and consisted of 14 members (SRH Coordinator, pediatrician, gynaecologist, dermatologist, oncologist, RPHS, National AIDS coordinator, Chief Demographer, Chief Health Statistician, Chief HIEC Officer, Principal CHCO, Acting Chief Midwife, Assistant Permanent Secretary and Office Management Assistant.

4.4.2 Desk Reviews

Reviews of existing documents were carried out as well as reviews of policies and action plans of international agencies such as WHO or UNFPA. All relevant information was gathered for guidance and reference purposes.

4.4.3 Consultations

Two consultative workshops were conducted in Mauritius to gather views and inputs from different stakeholders on the various components of the policy.

Stakeholders from the Health Sector included:

- Gynaecologists
- Pediatricians
- Regional Public Health Superintendents
- Community Physicians
- Oncologists
- Dermatologists
- Endocrinologist
- Demographer
- WHO representative
- MIH representative
- Central Health Laboratory Director
- Midwives
- Community Health Care Officers
- Medical Social Worker

Other governmental institutions included:

- Ministry of Education and Tertiary Education, Science and Technology
- Ministry of Foreign Affairs, Regional Integration and International Trade (Human Rights Division)
- Ministry of Gender Equality and Family Welfare
- Ministry of Youth Empowerment, Sports and Recreation
- Ministry of Social Integration, Social Security and National Solidarity
- Attorney General's Office
- Mauritius Institute of Education

Civil society organisations included:

- MFPWA
- Action Familiale
- MAM
- Gender links
- Fondation Joseph Lagesse
- Young Queer Alliance
- Link to life.

With regard to Rodrigues, 1 consultative workshop was conducted and participants included:

- Midwives
- Community Health Care Officers
- Medical Health Officers
- Community Physician
- NGOs
- Peer Educators
- Agents de Santé
- Representatives from Commission for Youth and Commission for Women and Family.

4.4.4 Recommendations

i. Information, Education and Communication (IEC)/ Behavioral Communication Change (BCC)

Much emphasis was laid upon the need to sensitise and create awareness among the population about SRH through a comprehensive approach, targeting all age groups.

IEC/BCC should be through an innovative approach, through social media, online forums, online platforms or through plays, role playing, theatrical shows. Sensitization should be appropriate and suited to the context, culture and age group and should be delivered in the language of target evidence.

ii. Health system delivery

The health system delivery should be upgraded in terms on services provided, new facilities and appropriate human resource. Health services should be provided in confidentiality and health personnel should be non-judgmental. Stakeholders laid emphasis on the fact that Health is a basic human right and should be free from bias, discrimination with regard to age, sex, religion, gender identity or orientation.

iii. Training

Training is considered as a very important aspect to achieve high standards of care and to implement specialized services such as management of infertility and cancers or reconstructive surgery. Training in other conventional fields is also very important to upgrade the level of care. Training has been advocated for all groups of healthcare professionals as well as members of Civil Society Organisations and people in the communities.

iv. Research/ Statistics

Stakeholders expressed their concerns about the lack of research in the medical field on the Mauritian population. Even though they agree that best practices adopted from other countries help policy makers, they clearly underlined the importance of research and setting research priorities in the SRH field. Integrating evidence-based practice is a vital component for an effective and sustainable SRH service. Furthermore, lack of disaggregated data hinders the interpretation of statistics and therefore, policy makers cannot point out real causes of health issues. Strong recommendations were made on the need for disaggregated data.

v. Legislation

Stakeholders viewed that restrictive view of legislations prevent people from accessing to health services, which in turn, denies them from the freedom of choice and accessing to SRH services as a universal right. They also pointed out that despite the existence of such prohibitive laws, people are having recourse to illegal practices.

SECTION 5

Sexual and reproductive health and rights (SRHR) are an essential part of Universal Health Coverage (UHC). Countries moving towards UHC need to consider how the SRHR needs of their population are met throughout the life course, from infancy and childhood through adolescence and into adulthood and old age.

UNFPA 2019 (5)

5.0 Policy Objectives

Objective 1 Empower all people to make informed decisions about their Sexual and Reproductive Health and ensure that their SRH rights are respected, protected, and fulfilled

Statement 1 The population should be informed about different SRH services available through media and other communication strategies.

Statement 2 Each and every one should be counselled on their SRH needs and should be oriented towards the appropriate services.

Statement 3 Through counselling, SRH services must focus on attracting new users, improving continuation rates, and encouraging past users who still want to avoid pregnancy to resume use of contraception, using effective, noncoercive counselling as a primary tool.

Statement 4 Sensitisation and awareness campaigns on SRH services should be conducted.

Statement 5 The different segments populations must be empowered and supported to manage their own sexual and reproductive health through self-care interventions.

Objective 2 Improve access to comprehensive and integrated Sexual and Reproductive Health and Rights care and treatment services across all life stages

Statement 1 Maternal and newborn health should include full range of services including preconception care, antenatal care, intrapartum care and postnatal care.

Statement 2 Provision must be made to improve maternal health during antenatal care by setting up new services and scaling up existing services.

Statement 3 Reduction of maternal and childbirth related mortality and morbidity, and the healthy growth of the surviving child, must be amongst the highest priorities in national health programmes.

Statement 4 Pregnant women should be sensitized on the ill effects of bad habits such as alcohol, tobacco and substance abuse on the pregnancy and the fetus.

Statement 5 Provision of contraception services must be guided by the principle of informed choice, non-coercion, and availability of a varied method mix.

Statement 6 Multiple contraceptive methods, including sterilisation, must be offered to meet the individual needs of clients.

Statement 7 Emergency contraception shall be made available to all women needing or requesting it at primary and secondary level of care.

Statement 8 Women should be informed about their options regarding abortion as per the provisions of section 235A of the Criminal Code. Safe abortion services must be provided and women should be made aware of the consequences of unsafe and illegal abortion.

Statement 9 All sexually active clients should be encouraged to practice dual protection — contraception plus HIV and STI prevention.

Statement 10 Childbearing decisions are the right of the client, irrespective of HIV status, and service providers must not interfere with those decisions.

Statement 11 Services for diagnosis and treatment of HIV and Sexually Transmitted Infections should be provided to everyone and in a confidential and non-judgmental way.

Statement 12 A National Chlamydia Screening Programme should be set up to detect undiagnosed chlamydia infection through screening.

Statement 13 Services for infertility management are provided at a tertiary level.

Statement 14 The HPV vaccine must be offered to all boys and girls aged nine and above after assessment and treatment, as primary prevention of cervical cancer.

Statement 15 Cervical cancer prevention, screening, and treatment of cervical lesions is a national priority and must be offered by the public healthcare system free of charge to all eligible patients.

Statement 16 All clients attending primary health care (PHC) clinics need to be sensitised and made aware of the importance of breast examination through HIEC materials and will be taught breast self-examination. They should also be encouraged to attend PHC for clinical breast examination and be referred to a Breast Health Unit as early as possible in case of need.

Statement 17 PReP and PEP should be made available at all levels of care and to anyone requiring these services.

Statement 18 Self-care interventions includingself-awareness interventions for health promotion; self-testing, screening, and diagnosis for disease prevention; and self-management for better treatment outcomes should be emphasized to improve the sexual and reproductive health of the population.

Statement 19 A Minimum Initial Service Package should be introduced to ensure provision of SRH services in times of crisis, emergencies or climate changes.

Statement 20 A comprehensive, multi-sectoral and full life cycle approach to menstrual healthshould be advocated to address the stigma, harmful stereotypes and gender-based discriminatory social norms and practices impacting the menstrual experiences of women and girls; an enabling environment to empower them to make informed choices about their menstrual health should be created.

Objective 3 Facilitate access to respectful and non-judgmental SRHR services for priority and vulnerable groups

Statement 1 All clients must be treated equally and promptly regardless of age, ethnicity, socioeconomic, marital status, or similar characteristic.

Statement 2 Adolescents and youth shall be empowered to decide on their sexual and reproductive health through the provision of Comprehensive Sexuality Education, both in and out of school.

Statement 3 The menopausal transition must be utilised as a window of opportunity to assess and manage specific SRH and general health matters.

Statement 4 Service packages shouldbe implemented to serve the needs of vulnerable and diverse groups in the areas of health information, promotion and services to end the STI and HIV epidemics.

Statement 5 Packages related to health services addressing the SRH needs of sex workers should be implemented.

Statement 6 People with disabilities should be given the opportunity to exercise choice, and control over their sexuality and relationships. Emphasis will be placed in reducing vulnerability to sexual and gender-based violence and HIV.

Statement 7 A Minimum Initial Service Package of SRHcareshould be offered in emergency situations.

Statement 8 Capacities of health care providers should be built and enhanced to render culturally competent, gender-sensitive, age-responsive, and migrant-friendly reproductive health services.

Statement 9 In implementing partner involvement, a client/ patient-centred approach must be adopted that does not limit engagement to legally defined groups such as husband and wife.

Statement 10 SRH services should be accessible, confidential and non-judgmental for young adults seeking them without the obligation of parental consent.

Statement 11 Individuals and couples should be empowered to decide freely and responsibly the number, spacing, and timing of children and be provided with the means to do so without coercion.

Statement 12 Relationships, sexual health and sexuality should be promoted as being an important aspect of health and wellbeing.

Statement 13 Sexual health and wellbeing through the life course should be promoted, ensuring support and access to services regardless of age, gender and sexual orientation.

Statement 14 Specialist sexual dysfunction/erection problems services must be provided and self-management of good sexual health and wellbeing needs to be promoted.

Statement 15 Restrictive legislations acting as barrier to accessing SRH services should be reviewed.

Objective 4 Strengthen the health system to deliver integrated SRH services at the primary and secondary level in the healthcare system

Statement 1 Health services are provided free of charge at all levels of care.

Statement 2 All facilities must adhere to approved standards to ensure all SRH services are offered, effective referral networks and practices are in place, and coordination between the units within hospitals and other larger referral facilities are functional.

Statement 3 Adequate financial resources are allocated for the creation, follow-up and evaluation of targeted programmes for the development of essential obstetrics adapted to the local context.

Statement 4 The person in charge of ordering drugs, supplies and other commodities must deal with the logistics of obtaining necessary equipment and supplies in time, and supervise its maintenance.

Statement 5 Staff must receive adequate training in SRH service delivery and linked to refresher training, debriefing and continuing professional development.

Statement 6 Health facilities must record and report accurate patient data to the national health information system. All patient data are treated as confidential.

Statement 7 The SRH Policy is underpinned by research evidence to guide best practices, policies, and the legal framework for improving SRHR outcomes for all.

Objective 5 Promote multisectoral engagement and shared accountability for a sustainable and rights-based service delivery

Statement 1 Collaboration with other stakeholders, organizations and networks is important to promote equitable sexuality programs.

Statement 2 The SRH Policy implementation framework depends on multi-stakeholder engagement and private - public partnerships.

SECTION 6

STRENGTHENING ACCESS TO THE SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND SAFEGUARDING THE RIGHTS OF EACH AND EVERYONE

6.0 Policy Briefs

Policy briefs have been included for the different components of the National Sexual and Reproductive Health Policy 2022. They provide an overview, trends and statistics over the last 10 years (where available), issues raised by different stakeholders, policy goals and strategies to address these issues.

Policy briefs are provided for the following components:

i. Family Planning

ii. Maternal Health

iii. Neonatal, Infant and Child Health

iv. Infertility

v. Abortion

vi. Sexually Transmitted Infections and HIV/AIDS

vii. Cancers of Reproductive Tract

viii. Gender Based Violence

ix. Adolescent Sexual and Reproductive Health

x. Elderly and Sexual and Reproductive Health

xi. Sexual Dysfunction

xii. Male participation

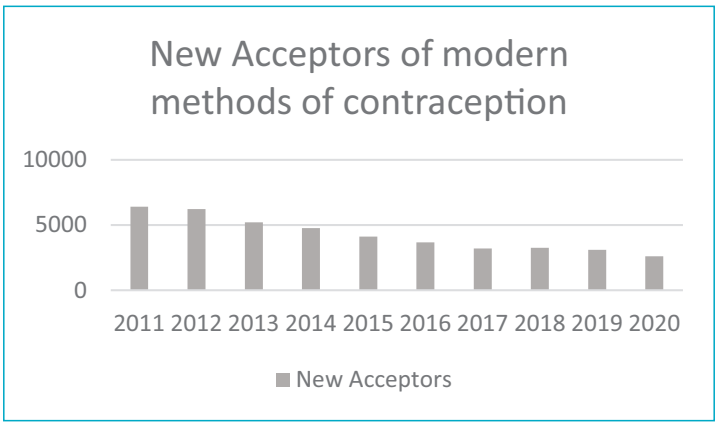
1. FAMILY PLANNING

Overview

Family planning is not only a matter of humanrights, it is also central to women's empowerment; itreduces poverty, boosts economic development andis a precondition for achieving the Sustainable Development Goals. When countries prioritize and invest in family planning, they promote healthier populations, more efficient health systems and strongeconomies.

Today, achieving universal access to reproductivehealth, including family planning, is at the centerof global development efforts. The global pandemic has further exacerbated the situation, and this threatens women and couples' ability to build a better future for themselves, their families and their communities.

Trends



The number of new acceptors of modern methods of contraception are decreasing constantly over the last 10 years and the same trend is noted in the number of current users from 57,781 in 2011 to 44,077 in 2020.

Modern methods of contraception

Modern methods of contraception are provided free of charge in primary health centres and include condoms, OCPs, emergency pills, injectable, implants, intrauterine devices and sterilization.

Issues

- Unmet needs of contraception among reproductive age group especially teenagers
- Increase in number of teenage pregnancies and unsafe abortions
- Low number of acceptors for long-acting reversible methods of contraception

- Low compliance to modern methods of contraception
- Lack of awareness and sensitization on modern methods of contraception
- Family planning services are not user friendly and not standardised
- Research is needed on the use of contraception, clients' expectations and satisfaction
- Remove restrictive legislation to allow access to contraception without parental consent

Policy Goal

To reduce unmet need for family planning services through provision of voluntary comprehensive family planning services at all levels to all men, women and young people of reproductive age group.

The Ministry of Health and Wellness is committed to:

- Offering person centred counselling.
- Creating awareness and improve knowledge to stimulate demand for family planning services in the population.
- Promoting dual protection among all sexually active persons.
- Conducting capacity building activities for healthcare professionals on modern methods of contraception.
- Making the family planning services more user friendly and standardized.
- Conducting research to determine rates of unintended pregnancies, abortion and contraceptive use as well as barriers to contraceptives use to inform the development of strategies to increase uptake.

2. MATERNAL HEALTH

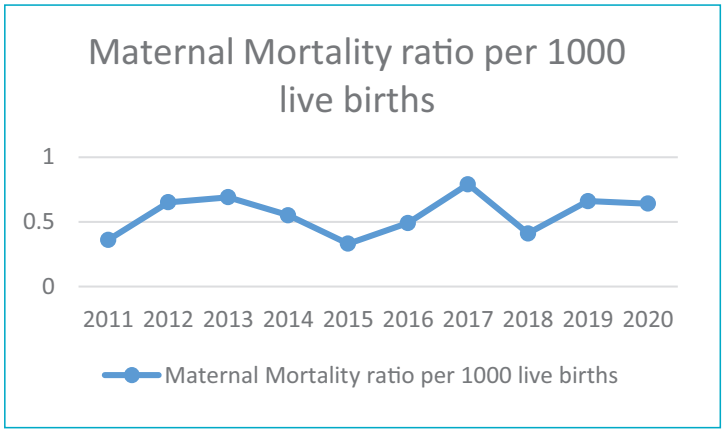
Overview

A maternal death is the "the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related or aggravated by the pregnancy and its management, but not accidental or incidental causes" (1)

Reducing maternal mortality and morbidity remains at the center of national and international commitments. At the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing, States recognized the right of women to safe pregnancies. In Sustainable Development Goal (SDG) 3, States have committed to reduce the maternal mortality ratio (from currently 216) to less than 70 per 100,000 live births by 2030.

Maternal services are provided free of charge in primary health centres and regional hospitals and consist of preconception care, antenatal care, obstetric care, postnatal care, management of complications of abortion. Almost all births are conducted in a health facility.

Trends



In 2020, we had 8 maternal deaths and 4 of them were teenagers less than 19 years. Though the SDG target has been met, the progress is stagnating and the maternal mortality ratio is not coming down to zero preventable deaths. Causes included postpartum hemorrhage, disruption of obstetric wound and other complications of puerperium, complications following abortion, amniotic fluid, pulmonary and other obstetric embolism, sepsis, pyrexia and other puerperal infections.

Issues

Lack of support to mothers during antenatal period
Undetected cases of HIV during pregnancy
Lack of standardized guidelines for conduct of antenatal care

Lack of postpartum contraception
Maternal causes of low-birth-weight babies
Lack of fetal medicine
Low attendance in the 1st trimester of pregnancy

Policy Goal

To improve maternal health before and after conception and to further reduce maternal mortality ratio and to eliminate preventable maternal deaths.

The Ministry of Health and Wellness is committed to improve maternal health and pregnancy outcomes and to reduce maternal deaths to zero preventable deaths by:

- Implementing and reviewing of the National Roadmap Framework to improve Maternal, Neonatal and Child Health.
- Ensuring every pregnant woman is provided with quality and focused antenatal care.
- Ensuring every woman has access to preconception care, essential obstetric care, well-equipped and adequately staffed maternal health care services, skilled attendance at childbirth, emergency obstetric careand postpartum care.
- Encouraging women to have a birth preparedness plan.
- Conducting training and capacity building of health professionals on maternal care.
- Institutionalizing Maternal and Perinatal Death Surveillance and Response and conducting further research on maternal profile and health status.

Reference

World Health Organization (2004) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, vol. 2, Instruction Manual, 2nd ed, pp. 98-99.

3. NEONATAL, INFANT AND CHILD HEALTH

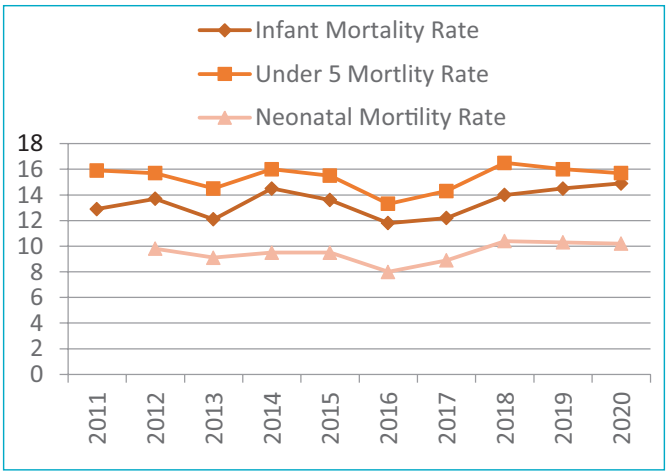
Overview

The first 28 days of a new-born's life is a critical window of opportunity for prevention and management of maternal and new-born complications, which can otherwise prove fatal.

Infant health shapes child health which in turn powerfully influences adult health.

The majority of all neonatal deaths (75%) occur during the first week of life, and many newborns die within the first 24 hours. Preterm birth, intrapartum-related complications (birth asphyxia or lack of breathing at birth), infections and birth defects cause most neonatal deaths. From the end of the neonatal period and through the first 5 years of life, the main causes of death are pneumonia, diarrhoea and birth defects. Malnutrition is the underlying contributing factor, making children more vulnerable to severe diseases.

Trends



The crude birth rate has increased from 17.7 births per 1,000 live births in 2011 to 19.1 in 2019 and in 2020, it was 20.8. The infant mortality rate was 17.3 deaths per 1,000 live births in 2011 as well as in 2019 and in 2020, it was 17.6. The still birth rate has increased from 8.8 still births per 1,000 total births in 2011 to 9.6 in 2019 and in 2020, it was 9.8. The neonatal mortality rate was 12.1 in 2020. There were 98 low birth weight babies in 2020.

Issues

Low breastfeeding rate
Lack of kangaroo mother care for preterm babies
Lack of protocols and guidelines
Lack of trained staff in NICU

Lack of NICU facilities in Rodrigues Island
Lack of dedicated pediatric hospitals
Improper diagnosis of congenital anomalies during pregnancy itself
Restricted facilities or delay in management of congenital abnormalies
EPI coverage decreasing and certain vaccines need to be incorporated in the schedule

Policy Goal

To accelerate the reduction of neonatal mobidity and mortality and to further reduce infant and under 5 mortality rates.

The Ministry of Health and Wellness is committed to:

- Institutionalize kangaroo mother care in the management of premature newborns.
- Ensure access of all infants and children to curative and preventive pediatric services to protect and safeguard their health.
- Ensure a well functional Neonatal services in each hospital.
- Develop a well functional preventive pediatric service to protect neonates, infants and children against common illness.
- Develop fetal medicine.
- Develop an Infant Nutrition/ Feeding programme.
- Provide “Integrated Management of Childhood Illnesses (IMCI).
- Implement, monitor and evaluate the National Breastfeeding Action Plan to support breastfeeding.
- Conduct training and capacity building of health professionals on neonatal, infant and child health.
- Institutionalize Maternal and Perinatal Death Surveillance and Response and conduct further research on causes of low birth and stillbirth.

4. INFERTILITY

Overview

Infertility affects some individuals and couples in Mauritius. Infertility occurrences can be prevented if the causes are detected early and reproductive tract infections are managed. The most prevalentis secondary infertility, which is preventable.

Infertility is a worldwide problem and is estimated to affect 8-12% of couples of reproductive age group (Vander Borght and Wyns, 2018).

The most common causes of female infertility are:

- Ovulatory disorders - 25%;
- Endometriosis - 15%;
- Pelvic adhesions - 12%;
- Tubal blockage - 11%;
- Other tubal/uterine abnormalities - 11%;
- Hyperprolactinemia - 7% (Walker and Tobler, 2021)

Males are found to be solely responsible for 20–30% of infertility cases but contribute to 50% of cases overall (Vander Borght and Wyns, 2018).

Secondary infertility occurs commonly in female infertility due to STIs (Vander Borght and Wyns, 2018).

The causes attributed to the low reproductive rate are:

- Change in lifestyle: smoking, alcohol, obesity, sedentary lifestyle
- Late age of marriage; delay in childbearing
- Treatment drop-out rate for male infertility

The consequences of infertility are:

- domestic violence
- marital disharmony
- social discrimination
- ageing population implying a decrease in the working class for economic development and progress.

The World Health Organization (WHO), has announced that 'Infertility generates disability (impairment of function), and thus access to healthcare falls under the Convention on the Rights of Persons with Disability'

(Morshed-Behbahani et al., 2020)

Infertility Treatment

Fertility Clinics have been set up at SSRH hospital in regional hospitals to provide treatment related to infertility to couples. Same facilities will be provided to other regional hospitals.

So far, Assisted Reproductive Treatment is not available.

Some figures...

The proportion of the population in the Island of Mauritius aged 60 years and above has increased from 9.1% of the total mid-year population in 2000 (estimated number 104,536) to 18.3% in 2020 (estimated number 223,010).

The total fertility rate dropped below the replacement-level fertility of 2.10 children per woman - the level needed for a woman to replace herself and her partner - for the first time in the mid-1980s; however, it was not until 1997 onward that fertility has continuously been at sub-replacement level. In 2020, the total fertility rate was 1.40 children per woman compared with 1.53 in 2011, resulting in a decrease of 8.5%. Interestingly, an increase in the total fertility rate has been noted from 1.35 in 2019 to 1.40 in 2020.

Policy Goal

To reduce the incidence of infertility among men and women.

The Ministry of Health and Wellness is committed to:

- Elaborate a policy on infertility to advocate for needs related to health promotion, prevention of infertility, training and new services related to infertility treatment.
- Strengthen awareness on the prevention and management of secondary infertility.
- Set guidelines and protocols on infertility managements.
- Ensure capacity building and training of health professionals in the management of infertility.
- Conduct research to investigate into the causes of infertility.
- Set a tertiary centre for the management of infertility.

5. ABORTION

Overview

Abortion is a common intervention which is safe if it is done by a skilled medical professional, according to the pregnancy period and following guidelines.

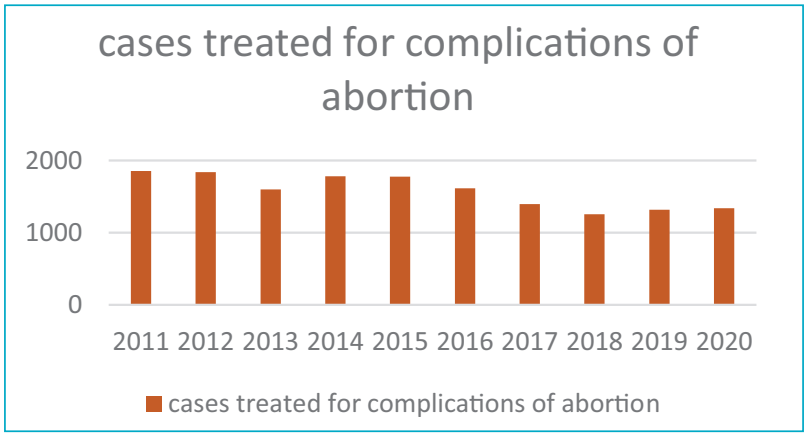
Currently, medical and surgical treatments are offered for cases of spontaneous miscarriage. For confirmed cases of induced abortion, the cases are notified to the police.

In 2012, the section 235A of the Criminal Codewas amended to allowabortion under 4 specific circumstances:

a. The continued pregnancy will endanger the pregnant person's life
b. The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman
c. There is a substantial risk that the continued pregnancy will result in a severe malformation of the fetus
d. The pregnancy has not exceeded its 14th week and results from a case of rape, sexual intercourse with a female under the age of 16 or sexual intercourse with a specified person, which has been reported to the police or medical practitioner.

Trends

From the 2020 statistics, the number of abortion-related complicated cases treated both in government and private clinics was 1338. In 2020, out of 8 cases of maternal deaths, 1 death was due to complications following unsafe abortion.



Issues

- Unsafe abortions and resulting complications.
- Lack of reporting on cases of induced abortion
- Lack of data to specify the type of abortion and our database covers both spontaneous and induced abortion under the same umbrella.
- Factors attributed to unsafe abortion are:
  1. lack of counselling on family planning;
  2. cultural barriers such as pregnancy out of wedlock;
  3. financial constraints of raising a child;
  4. age at which the woman is pregnant, either very young or elderly.

Policy goal

To provide post abortion care, to investigate the causes of unsafe abortion, to eliminate unsafe abortion and to advocate for safe abortion.

The Ministry of Health and Wellness is committed to:

- Provide quality post abortion care and services to women suffering from complications of abortion.
- Integrate counselling on contraception into the post abortion care and apply up to date clinical guidelines.
- Provide post abortion counselling including self-care.
- Conduct research to determine the cause of unsafe abortion, age group or any relevant details.

6. SEXUALLY TRANSMITTED INFECTIONS, HIV/AIDS

Overview

STIs refer to more than 35 infectious organisms that are transmitted primarily through sexual activity. STI prevention is an essential primary care strategy for improving reproductive health.

Despite their burdens, costs, and complications, and the fact that they are largely preventable, STIs remain a significant public health problem. This problem is largely unrecognized by the public, policymakers, and health care professionals. STIs cause many harmful, often irreversible, and costly clinical complications, such as:

- Reproductive health problems
- Fetal and perinatal health problems
- Cancer
- Facilitation of the sexual transmission of HIV infection

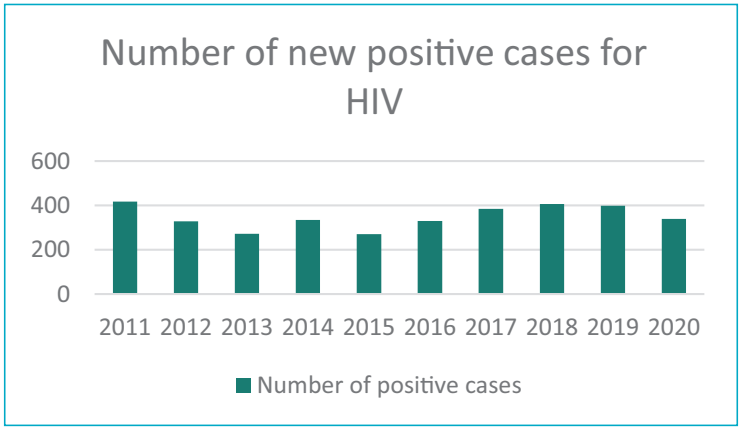
HIV continues to be a major global public health issue, resulting in many deaths.

There is no cure for HIV infection. However, with increasing access to effective HIV prevention, diagnosis, treatment and care, including for opportunistic infections, HIV infection has become a manageable chronic health condition, enabling people living with HIV to lead long and healthy lives.

Vulnerable groups

- Adolescents
- Disabled persons
- Commercial sex workers
- Homeless peoples
- Prison Inmates
- People Who Inject Drugs, Men who have Sex with Men, Transgender Persons

Trend



Statistics also show that there has been an increase in number of cases of syphilis diagnosed, in 2018, there were 292 cases and in 2020 there were 312 cases.

Issues

- Lack of knowledge on STIs and HIV/ AIDS
- Low Partner screening or contact tracing
- Low condom usage
- Area of great concern in Rodrigues
- Lack of human resources
- Lack of fruitful programs of awareness
- Social determinants affecting behaviours
- High risk behavior/ multiple partners
- Lack of training/ capacity building

Policy goal

To promote healthy sexual behaviours, strengthen community capacity and increase access to quality services to prevent the transmission and complications of sexually transmitted infections and HIV.

The Ministry of Health and Wellness is committed to:

- Providing and promoting education and resources for the prevention of STIs/HIV, and providing information, support and referrals for women, people with a disability and vulnerable groups.
- Working in partnership with other relevant organizations as appropriate to eliminate STIs/ HIV.
- providing HIV/ STIs testing and reproductive and sexual health care including for people living with or affected by HIV/ STIs.
- Setting up of a National Chlamydia Screening Programme.
- Providing HIV education, training and professional development programs for service providers
- Advocating on HIV issues particularly as they relate to women, young people and vulnerable groups.
- Ensuring a safe working environment and regular HIV education programs for all staff members;
- Providing access to PrEP and PEP to those at high risk of HIV acquisition.
- Strengthen the health service delivery by integration of HIV/ STIs services.

7. CANCERS OF REPRODUCTIVE TRACT

Overview

Cancer is a major health problem worldwide and it is the second leading cause of death. In the year 2020 an estimated of 10 million deaths had occurred, it is expected 1 in 6 deaths will be due to cancer. According to the WHO in 2020, around 10 million people were diagnosed with cancer and it is expected that these figures will double by the year 2040.

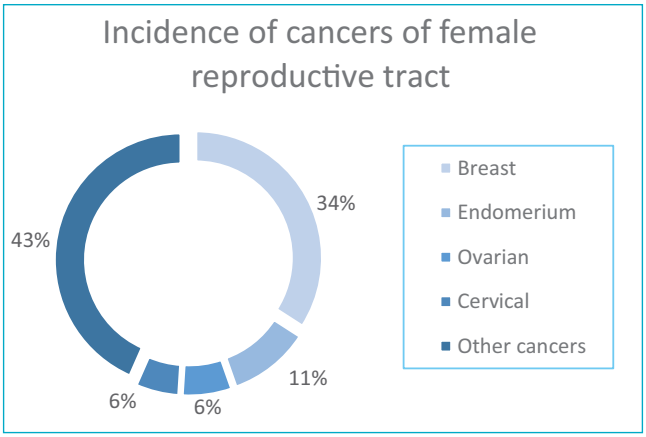
The incidence of cancer is expected to rise with an upsurge in lifestyle-related cancer and an ageing population. Over the past decades there has been an overall gradual rise in the incidence of cancer and the malignancy of reproductive tract was among the leading cause in both male and female patients.

A state-of-the-art cancer hospital will soon be inaugurated in Solferino, Vacoas to cater to the needs of patients with cancer where they will receive optimum care and timely attention.

Trends

In Mauritius, cancer is the third cause of death accounting for 1441 mortality (13.2 %) in the year 2020.Based on data collection from the National Cancer Registry, there had been an 8 % increase in the number of new cancer cases between year 2019 to 2020.The new Cancer cases registered in year 2020 were 2883, out of which males were 1198 cases and females 1685 cases.

In females:



In males: prostate cancer: 16.5 %
Colorectal: 13.9%
lung Cancer: 9.5%.

Issues

- Lack of awareness/ sensitisation
- Life style changes.
- Future pregnancy in patients with cancers
- Lack of support to survivors of cancer (psychologist/ medical social worker)
- Lack Breast reconstruction/ implants

Policy Goal

To lower morbidity and mortality from common reproductive tract organs cancers among men and women of all ages and to improve the quality of life and wellness

Through this policy, Government, NGOs, Private sector and other stakeholders shall contribute towards:

- Increasing awareness programmes through education via Mass Media, Pamphlet, social media, Newspaper on all reproductive tract cancers to all health facilities and in Women centers.
- Using Innovating technology such as User-friendly material to sensitize population for example mobile apps, hotline, etc.
- Promoting screening facilities to the population and educating communities on risks factors for common causes of reproductive tract cancer, plus counseling for self-breast examination.
- Enhancing the quality service delivery to all cancer patients including reproductive cancer, through early diagnosis, timely treatment and palliative care.
- Providing early diagnosis at primary level through educating healthcare professionals, regular seminars, workshops and Continuous Medical Education (CME).
- Improving the quality of life of cancer patients with psychosocial and physical rehabilitation (palliative care).
- Disseminating standard protocols and guidelines for adequate management of reproductive tract cancers to health staffs.
- Setting up a research programme, including disaggregated data collection so as to understand the pattern of the disease, its control in order to target specific population group.

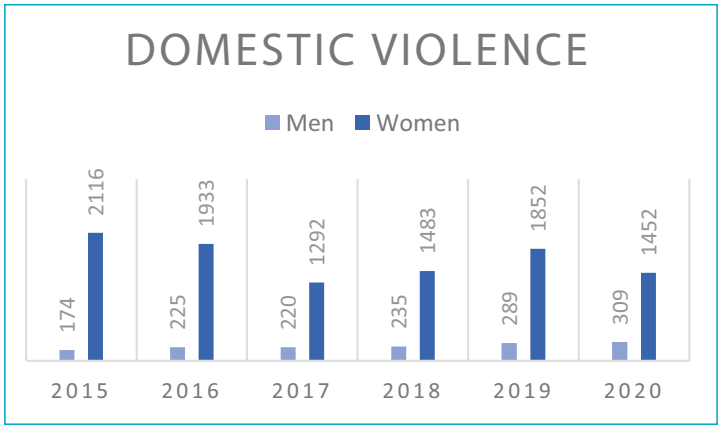
8. GENDER BASED VIOLENCE

Overview

Gender-Based violence refers to harmful acts directed at an individual based on his/her gender. It is rooted in gender inequality, the abuse of power and harmful norms. Gender-based violence (GBV) is a serious violation of human rights and a life-threatening health and protection issue.

Gender Based Violence is a public health issue
GBV has significant and long-lasting impacts on physical and mental health including injury, unintended pregnancy and pregnancy complications, sexually transmitted infections, HIV, depression, post-traumatic stress disorder, and even death. Gender-based violence response requires a multi-sectoral response and health systems have an important role to play in it.

Trends



In 2020, some 33.1% of women victims of domestic violence reported verbal assault by spouse or partner (ill treatment, harassment, abuse, and humiliation), 32.7% physical assault by spouse or partner, 8.7% threatening assault by spouse and 3.2% has been subjected to physical assault by others living under the same roof. Reported cases by men related mostly to verbal assault by spouse or partner (33.3%), physical assault by spouse or partner (19.8%) and verbal assault by others living under the same roof (10.8%).

Issues

- Increase in reported cases of GBV (socio-economic status of family, socio-economic crisis, drug and alcohol abuse, intake of psychotropic drugs, poor mental health, emerging epidemics/ pandemics).
- Viewing GBV as a 'women issue' rather than a social/health issue
- No standardized way of collecting data

- Improper allocation of resources
- Lack of integration of services
- Limited shared understanding of the concept of GBV and its root cause
- Limited involvement of men and boys as agents for change
- Limited motivation to innovate using new technologies, exploring pilot programmes and aligning to best practices to enhance institutional culture and operations
- High mobility of staff within the civil service may lead to unfinished programmes, limited succession planning and hinder the in-depth capacity-building of sectoral Staff
- Limited investment in capacity building programmes for staff on GBV in a tight economic environment
- Limited shared understanding on the concept and importance of gender responsive budgeting
- Limited project management skills

Policy Goal

To minimize the prevalence and impact of GBV though improved primary, secondary and tertiary prevention.

The Ministry of Health and Wellness is committed to:

- Increase awareness using local media (radio/television), printed media, social media (including influencers – more likes/followers.
- Improve sensitization of public regarding the existing services (hotline, application, mobile apps).
- Develop strong referral pathways.
- Set protocols.
- Train personnel to detect cases of GBV and to counsel and educate “knowledge and resilience”.
- Conduct capacity building of all stakeholders.
- Ensure proper collection and dissemination of data among all stakeholders.
- Provide regular update of statistics regarding GBV.
- Participate in research on GBV.

9. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Overview

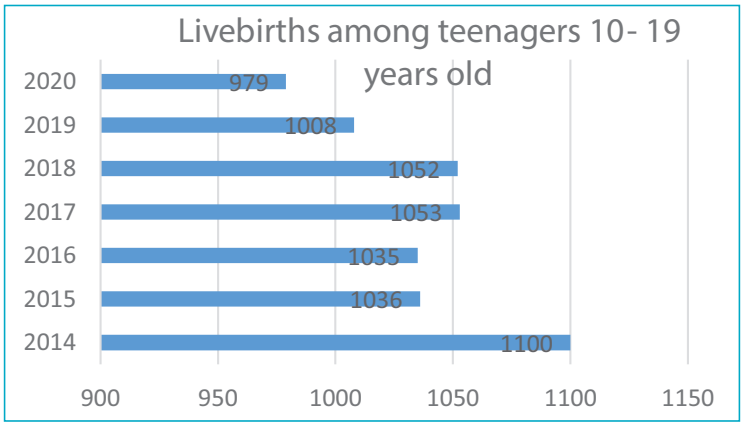
Adolescents and youth face significant barriers that undermine their sexual and reproductive health and rights—including lack of access to comprehensive sexuality education and to essential sexual and reproductive health services.

Because of failures to enable and empower adolescents to access comprehensive reproductive health care—including contraception, abortion and maternal health care— adolescents have unmet needs for contraception and give birth each year. In addition, early pregnancy and childbearing pose unique risks to adolescents' health and well-being.

Enabling girls to make informed and autonomous decisions about their sexuality and reproductive health is critical for fulfilling their human rights and ensuring access to education, economic opportunities, social empowerment, and financial independence.

Protecting the health of children and adolescents in relation to their SRH will support their growth and development and work towards achieving their full potential and eliminate gender inequalities and gender-based violence.

Trends



Issues

- Teenage pregnancies affecting the health of young mothers and increasing drop outs from schools
- Increasing incidence of STIs/ HIV in adolescents
- Peer Pressure
- Lack of Parental Authority

- Influence of social media/ digital media
- Pornography
- Sexual abuse
- Environment (Housing, Social Background)
- Hypersexualisation of Children
- Discrimination and barriers to access sexual and reproductive health services

Policy Goal

Young people (children, adolescents and youth) have access to and make use of youth friendly services to help them make responsible choices that protect their health; especially sexuality, reproductive health to prevent teenage pregnancies, STIs/ HIVs or high-risk sexual behaviours.

The Ministry of Health and Wellness is committed to:

- Assist in the provision of age-appropriate sexuality education in schools.
- Advocate for the implementation of Comprehensive Sexuality Education (CSE) as a mandatory part of the school curriculum and reach out of school adolescents.
- Advocate for removal of legal barriers to adolescents accessing SRH services.
- Conduct capacity building and training of trainers for health professionals on CSE to enable them to deliver age-appropriate information to children and adolescents.
- Collaborate with different stakeholders (Ministry of Education and Youth mainly) to ensure provision of CSE.
- Conduct research that informs the quality of comprehensive sexuality education delivery and contributes to increasing understanding of best practice and benefits of comprehensive sexuality education.
- Strengthen the capacity to collect and use disaggregated data in HMIS and surveys especially on vulnerable adolescents and youth, married adolescents (18 years and above) or those who have experienced violence.

10. ELDERLY AND SEXUAL HEALTH

Overview

It is now well established that the world's population is ageing, and has been doing so rapidly in the last century.

Ageing will have a significant impact on health and social policies, and the older people (both men and women) will likely be among the policy-making priorities in the next few decades. Indeed, there have been several areas of health of the elderly that are increasingly receiving attention including physical health, primarily focused on non-communicable diseases, and mental health, mainly dementia and depression.

However, sexual and reproductive health and rights (SRHR) issues in older adults remain a "taboo" among individuals and in many societies at large, a "topic of minimal interest" for health professionals and researchers; and a "blind spot" in the broader policy dialogue. This minimal focus remains despite the global call for the need to implement a life course approach, from pre-pregnancy to post-reproductive years, in tackling SRHR issues.

Awareness among geriatric population on safe and healthy sexual health include sexually transmitted infections, menopause and andropause.

Trends

The proportion of the population aged 60 years and above has increased from 9.1% of the total mid-year population in 2000 to 18.3% in 2020, and it is projected to increase to 28.6% in 2040 and 37.0% in 2060.

Issues

- Menopause
- Andropause
- Sexual abuse and violence
- STIs/ HIV infections prevalent in elders
- Elderly SRHR overlooked in society
- ageism – stereotyping, prejudice and discrimination against people on the basis of their age

Policy Goal

To ensure access of elders to proper SRH services free of prejudice, in privacy and confidentiality The Ministry of Health and Wellness is committed to:

- Promote active and healthy ageing through sensitization programs.
- Provide screening services for disease prevention in elderly.
- Use the menopausal transition as an opportunity to counsel women on other SRH related issues and help them better prepare for and prevent negative health outcomes inherent in the ageing process.
- Strengthen the health service delivery to cater for needs of elders.
- Conduct capacity building of health professionals and social workers.
- Conduct research to support policy makers and the implementation of programs.
- Ensure proper disaggregated data collection on different types of issues concerning SRH of elders.

11. SEXUAL DYSFUNCTION

Overview

Sexual dysfunction is any physical or psychological problem that prevents a person from getting sexual satisfaction. It affects both sexes.

Male sexual dysfunction

It is a common health problem affecting men of all ages, but is more common with increasing age.

The main types of male sexual dysfunction are:

- Erectile dysfunction
- Premature ejaculation
- Delayed or inhibited ejaculation
- Low libido

Causes are low testosterone levels, medications (antidepressants, high blood pressure medicine), cardiovascular diseases and hypertension, stroke, diabetes, smoking, alcohol or even substance abuse. Causes can be psychological as well.

Female Sexual dysfunction

Many women experience problems with sexual function at some point, and some have difficulties throughout their lives. Female sexual dysfunction can occur at any stage of life. It can occur only in certain sexual situations or in all sexual situations.

Sexual response involves a complex interplay of physiology, emotions, experiences, beliefs, lifestyle and relationships. Disruption of any component can affect sexual desire, arousal or satisfaction, and treatment often involves more than one approach.

Causes in females can be physical due to medical conditions, medications, hormonal or psychological.

Issues

- Lack of information on male or female sexual dysfunction
- Hormonal issues
- Diabetes and other chronic diseases related to SRH
- Increasing incidence of cancers in women of reproductive age impacting SRH
- Late marriage
- Associated with infertility
- Lack of competence to address sexual dysfunction in health care systems

Policy Goal

To promote healthy lifestyles and to address causes of sexual dysfunction to ensure a safe and satisfying sex life.

The Ministry of Health and Wellness is committed to:

- 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.
- Provide accurate information about possible causes, symptoms and management of erectile dysfunction.
- Counsel men on the dangers and side effects of using some of the medications to correct erectile dysfunction without consulting a doctor.
- Develop guidelines/protocols for the prevention and management of sexual dysfunction and ensure that they are accessible to health service providers.
- Provide/maintain services to address the sexual problems that men and women experience.
- Maintain and strengthen programmes that enhance the life and well-being of all men.
- Train health providers in the provision of quality care for sexual dysfunction.
- Conduct research on sexual dysfunction problems, to identify and improve on the delivery of health and social services for the men and couples with such problems.

12. MALE PARTICIPATION

Overview

Male involvement in reproductive, maternal, newborn and child health is known to improve maternal and child health outcomes. However, there is sub-optimal adoption of male involvement strategies.

The 1994 International Conference on Population and Development in Cairo and the 1995 World Conference on Women in Beijing marked the significant recognition that women's empowerment requires the engagement of men to advance positive improvements in reproductive, maternal, newborn and child health outcomes. The Beijing Declaration noted a broad consensus to "encourage men to participate fully in all actions toward equality". This intersectional approach demands meaningful male involvement to uncover and address male attitudes, beliefs and practices that sustain gendered power differentials and reinforce inequalities between women and men.

Issues

- "Stigma" associated with male involvement in SRH services
- Lack of male participation in family planning services
- Infrastructural barriers – Lack of space to accommodate the partners during consultations (especially in AHCs)
- Lack of focus on male's health
- Lack of awareness on male responsibility
- Lack of premarital counseling Social-cultural factors such as the feminization of reproductive, maternal and child health issues

Policy goal

To increase male participation in Sexual and Reproductive Health services and activities

The Ministry of Health and Wellness is committed to:

- Conduct research among both men and women's perception of males' sexual and reproductive roles and their participation in SRH services.
- Design more reproductive health programs that involve men and educate them about sexual and reproductive health, their own responsibilities, and that address men's own needs.
- Seek out opportunities to support male involvement through reproductive health norms and regulations.
- Work with stakeholders to develop guidelines on male involvement in reproductive health.

6.1 Expected Results

i. Implementation of the National Sexual and Reproductive Health Policy 2022;
ii. Informed and autonomous decision-making at individual levels;
iii. A comprehensive and integrated package of SRHR services is provided in an equitable, accessible and rights-based manner for all Mauritians; characterised by non-discrimination, confidentiality, and privacy;
iv. Enabling environment for high-quality services delivered by trained providers;
v. Coordinated implementation for a sustainable response;
vi. Elaboration of national costed plans for activities in SRH;
vii. Achievement of SDGs targets as reflected by key indicators;
viii. Achievement of targets as set by the Health Sector Strategic Plan 2020 – 2024;
ix. Setting up of a proper Sexual and Reproductive Health Unit with dedicated staff (technical and administrative cadre);
x. Setting up of a National SRH Committee at the Ministry level for monitoring and evaluation of the policy and SRH related activities; and
xi. Setting up of regional SRH committee at hospital level to ensure SRH services provision at primary healthcare level and secondary healthcare level, which will report to the National SRH Committee.

6.2 Roles and Responsibilities of different institutions

6.2.1 Ministry of Health and Wellness

i. Assume overall responsibility and commitment for improving SRH care;
ii. Plan, develop and coordinate the provision of SRH services;
iii. Provide overall guidance for provision of SRH care;
iv. Advocate for the highest priority to be accorded to SRH programmes as a necessary prerequisite for the attainment of SDGs and HSSP 2020 – 2024 targets;
v. Mobilise and leverage human and material resources for the implementation of SRH policy;
vi. Promote and coordinate partnership with Development Partners, International Organisations, Non-governmental Organisations, Private and Public sectors for cooperation and collaboration to accelerate implementation of National Sexual and Reproductive Health Policy 2022;
vii. Ensure that the provision of SRH services by all partners and stakeholders at all levels meets the required standards;
viii. Disseminate relevant SRH guidelines and standards; and
ix. Coordinate support and monitoring of progress towards implementation of SRHR policy.

6.2.2 Ministry of Education, Tertiary Education, Science and Technology/ Mauritius Institute of Education

i. Support services that address young people's SRHR issues;
ii. Implement Comprehensive Sexuality Education and life skills curriculum in both primary and secondary schools;
iii. Establish a counseling and referral system for boys and girls with SRHR needs;
iv. Strengthen school clubs to address SRHR issues;
v. Empower boys and girls to make informed decisions about their SRHR; and
vi. Provide age specific sexuality education to the youth.

6.2.3 Ministry of Local Government and Disaster Risk Management

i. Support the promotion of community initiatives for SRHR at community level;
ii. Support empowerment of men and women to make informed decisions on SRHR issues;
iii. Assist communities dispel misconceptions and eliminate barriers that could prevent use of SRHR services;
iv. Mobilize community leaders to participate in birth preparedness including organizing and supporting community transport for referral of women with obstetric complications;
v. Support empowerment of community leaders to promote SRHR; and
vi. Support men involvement in SRHR issues.

6.2.4 Ministry of Gender Equality and Family Welfare

i. Support empowerment of women to make informed choices on their sexual and reproductive health issues;
ii. Mainstream SRHR issues of equity and empowerment;
iii. Educate men to enhance their participation and involvement in the improvement of SRHR health of the community; and
iv. Prevent gender-based violence.

6.2.5 Ministry of Youth Empowerment, Sports and Recreation

i. Promote sports among in and out of school youth as a medium for development of positive and healthy life style;
ii. Raise awareness on practices that expose youth, especially girls, to HIV infection and SRHR complications;
iii. Promote behavioral change among young people and communities; specifically looking at modifying negative practices into safe practices;
iv. Raise awareness on gender relationships that increase vulnerability to HIV infection and SRHR complications;
iv. Equip youth with Life Skills and Comprehensive Sexuality Education; and
v. Mobilise youth to participate in programmes that promote safe sexual behaviour.

6.2.6 International Agencies (WHO, UNFPA)

i. Advocate for the mobilisation of resources and political will necessary to implement the SRHR policy;
ii. Foster the relationship and collaboration among all development partners to support Government in the implementation of policies and strategies to bring about necessary changes and improve health and quality of life and
iii. Support provision of technical and financial assistance to the Ministry of Health and Wellness in thematic areas relevant to implementation of SRHR.

6.2.7 Nursing Council and Medical Council of Mauritius

i. Provide guidance for certification to attain minimum standards, competence, and skills required for the provision of SRHR care;
ii. Support and promote inclusion of relevant components of SRHR into pre-service curricula of training institutions;
iii. Monitor and evaluate nursing midwifery/medical services to ensure adherence to acceptable standards of practice;
iv. Support development of SRHR standards; and
v. Reinforce professional conduct for health care providers to ensure provision of quality SRHR care.

6.2.8 Training Institutions

i. Incorporate emerging issues in SRHR into pre-service training;
ii. Conduct research for improvement of SRHR services;
iii. Increase output of professional health workers; and
iv. Institute in-service education training in SRHR services

6.2.9 Professional Associations

i. Support advocacy for prioritizing implementation of SRHR programmes;
ii. Promote community awareness and empowerment on issues of SRHR; and
iii. Support human resource development for SRHR care provision through advocacy.

6.2.10 Civil Society Organisations/ NGOs

i. Provision of SRH services;
ii. Support community initiatives related to sexual and reproductive health and rights;
iii. Create awareness of sexual and reproductive health and rights issues in the community; and
iv. Advocate for the strengthening of sexual SRH services.

7.0 Conclusion

Many global health and development initiatives call for action to improve sexual and reproductive health and rights. The links of SRHR to gender equality and women's wellbeing impact on maternal, newborn, child, and adolescent health. It also plays a role in shaping future economic development and environmental sustainability, thus making it essential. Indeed, progress towards fulfilling SRHR for all has been slow due to inadequate evidence to support relevant policy and programmatic decisions. Health care coverage decisions such as SHRH are complex, and well-defined research priorities could provide evidence to improve decision-making and accountability.

Many policy makers deliberating on comprehensive sexual and reproductive health and rights services need reliable evidence to make choices that benefit women, adolescents, children and the wider society. While universal health coverage discourse provides an opportunity to expand access through evidence-based interventions, many gaps exist. Research prioritisation has proved to be very helpful in identifying relevant areas, especially in constrained resource settings.

Stakeholders have made several recommendations to improve the SRH of each and every one. Services should be inclusive, free from bias, non-judgmental and provided in full confidentiality. Recommendations made pertain mainly to health promotion and prevention, strengthening the health care delivery, capacity building of health professionals and people from civil society organisations, conducting research, mainly into causes of health issues to guide policy makers and addressing existing data gaps. Much emphasis has been laid on social determinants and social phenomenon affecting the SRH of individuals as well as restriction that some legislations can have on SRH.

Therefore, the National Sexual and Reproductive Health Policy 2022 seeks to address all these issues to ensure accessible health services to all people of the Republic of Mauritius, which are of high quality and respectful.

Adopting a life course approach and a rights-based approach ensures proper implementation of the policy and a multistakeholder involvement will guarantee the achievement of the highest standard of comprehensive SRH services.

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