British Red Cross

A SILENT EMERGENCY

Sexual and Reproductive Health and Rights in Guinea

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Refusing to ignore people in crisis

Guinea has one of the worst maternal mortality rates in the world – the ratio of women that do not survive child birth is 679/100,000 live births. In comparison, the rate in the United Kingdom is 9/100,000 live births.[1]

Underlying this shocking statistic is Guinea's weak health infrastructure, including poor maternal health services and a lack of knowledge around sexual and reproductive health and rights. The high rate of adolescent pregnancies across Guinea, alongside the widespread practice of Female Genital Mutilation (FGM) further contributes to complications during childbirth and maternal mortality.

Across the country 97 per cent of women between the ages of 15-49 have undergone FGM.[2] Of those who have been cut, approximately 13 per cent have endured what is known as infibulation (FGM Type Three)[3]. This is a painful and highly dangerous procedure which can lead to infection, fistulas and other complications.

FGM is also linked with prolonged labour. In areas where skilled birth attendants are not available or accessible, this often equates to a death sentence. In many ways, the situation for women and girls in Guinea is a humanitarian crisis in its own right.

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1. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: Trends in Maternal Mortality 1990-2015 (2015)
2. Guinea Demographic Health Survey (2012)
3. WHO Classification of FGM (2007

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What are Sexual and Reproductive Health and Rights?

Sexual and Reproductive Health and Rights (SRHR) encompass four fields of study: sexual health, sexual rights, reproductive health and reproductive rights. All these areas are distinct, but intimately related to one another and to the concept of human rights. Maternal health and mortality, family planning, the use of contraception and sexual consent all fall under SRHR.

High profile emergencies, such as the Ebola Virus Disease (EVD) that spread through West Africa, exacerbate the daily struggle for women and girls, further reducing their access to basic sexual and reproductive health services in Guinea. Larger emergencies also monopolise public attention, and funding. While it is paramount to ensure adequate emergency response in low-resource settings, the attention given to SRHR remains inadequate and does not result in a proportionate response to the chronic danger that women and girls of child bearing age face.

Longer term issues, such as the lack of informed decision-making around sexual and reproductive rights and access to health services, have devastating effects on the lives of women, girls and their families. It is vital that the global community no longer turns a blind eye to the urgency of low-profile, silent emergencies in favour of the latest headline – grabbing crisis. Humanitarian practitioners know that simple and consistent reproductive health interventions at the community level save lives. So what is holding us back?

The following briefing note will highlight some of the statistics behind SRHR in Guinea and present findings from a study conducted by the British Red Cross in partnership with the Guinea Red Cross Society. The data collected sheds light on some of the subtle cultural barriers that prevent behavioural change and access to services. Policy-makers, donors and practitioners are encouraged to acknowledge that low-cost, targeted and culturally-sensitive SRHR programming not only improves the quality of life for women, girls and their families, but is an essential, life-saving component of humanitarian and development aid.

Data collection methodology

Data was collected to inform a baseline study on knowledge of SRHR and access to maternal health services in the Moyenne Guinée region, across six sub-provinces (sub-prefectures): Dionfo (province of Labe), Ninguélandé, Maci (province of Pita), Tangaly (province of Togué), Bodie and Mafara (province of Dalaba). Using a multi-stage cluster sampling approach, 687 households (HH) were sampled and 707 individuals interviewed.

For the qualitative component of the study 48 Focus Group Discussions (FGDs) comprising 480 individuals were carried out. Semi-structured questionnaires helped us understand underlying barriers to maternal health services and harmful practices including child marriage and FGM.

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The work of the Red Cross and Red Crescent Movement in Guinea

The Danish, Swiss and British Red Cross are jointly working in a consortium to support the Guinea Red Cross (GRC) developing integrated, high quality programmes. The GRC's Reproductive Health Project is implemented in six sub-provinces (sous-prefectures) in the Moyenne Guinée region. It aims at improving knowledge and access to SRHR, focusing on youth and women.

Regionally, the increase in knowledge should facilitate greater access to contraception and reduce maternal mortality by ensuring mothers seek, and are able to access, the advice of trained healthcare staff during pregnancy and childbirth. In order to achieve this community volunteers and community midwives are trained by Guinea Red Cross to provide information on reproductive and community health, as well as access to reproductive and ante-natal care.

Where local maternal health services are not available, or cannot be accessed, assisted deliveries in the community are supported. GRC, in collaboration with the Guinean Ministry of Health (MOH), trains, coaches, and supervises community midwives. This ensures that complications during childbirth are prevented, or adequately managed. The project is also piloting the use of digital technology in the form of a smart phone application to improve the management of obstetric complications called the 'Safe Delivery App'. It enables the community midwives to quickly review life-saving procedures for the most common obstetric emergencies, using mobile phones that are provided by the project.

A further area of work includes sensitising communities on SRHR and the potential risks of FGM. Proposed interventions include engaging a large range of stakeholders from 'youth champions' – such as girls who have not been cut – to traditional cutters and leaders. Culturally appropriate and targeted sensitisation will be required to significantly reduce FGM and the risk to maternal health as a result. The GRCS project will focus on youth (10-24 years old) and women of reproductive age.

The role of volunteers and National Humanitarian Actors

The work of the Red Cross and Red Crescent Movement would not be possible without the dedication and expertise of volunteers – National Humanitarian Actors. Local volunteers play a crucial role in the implementation and conception of humanitarian interventions as they are often the only ones who are able to assess whether a strategy will effectively work in a community. The Guinean Red Cross volunteers are engaged at all levels of society and lead efforts to advocate for Sexual and Reproductive Health and Rights.

Building the capacity of local volunteers is particularly important in community health programming. Embedded in the community, they do not only have insight into the cultural drivers that determine attitudes towards SRHR, they are also uniquely positioned to facilitate dialogue between groups. The community midwives trained by the GRC are widely accepted by people in the region and have greater access as a result. Providing local actors with midwifery skills is an investment into the future resilience of a population; during a crisis or displacement these midwives will continue to live within their communities and are able to provide care and assistance.

Guinea Red Cross is active across the region and throughout the whole country. There is a national Headquarters offices in Conakry and services are provided through 33 'rural' branches (comités préfectoraux); five 'urban' branches (comités communaux) in Conakry; and 202 sub-Branches (comités sous-préfectoraux) distributed among the 304 sub-provinces (sous-préfectures) of the country.

Of the approximately 17,400 volunteers at least 8,000 are active members at local level. They have access to the most hard-to-reach areas. Investment into the capacity of GRC to independently deliver simple health care interventions at the community level is a life-saving humanitarian intervention and bridges the gap between preparedness, response, recovery and resilience.

SUMMARY OF FINDINGS

1. **Sexual and Reproductive Rights** – Making informed decisions about your body

The first part of the study dealt with the use and image of contraception. Only one in four participants knew where to find contraception and discussing contraception within the family or with community leaders was identified as a strict taboo. Some participants in Focus Group Discussions (FGDs) said it would be viewed as "shameful" to use contraception in their communities.

One identified barrier to the effective use of contraception was a wealth of incorrect or misleading information. FGDs with young men and women in areas to be targeted by the project uncovered some false assumptions about the use of contraception:

"Using contraception can cause infertility or sterility" (Bodie, FGD with young men);

"It is said that if you use contraception, your periods are more painful" (Mafara, FGD with young women).

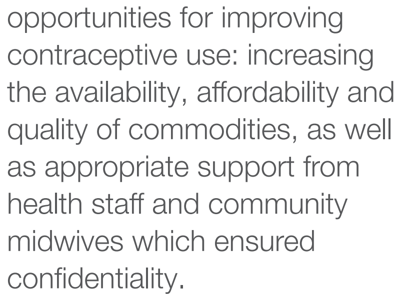
Some participants also held views that certain methods were less effective than others:

"Using condoms improves your health, but contraceptive injections and the pill are bad for your health" (Dionfo, FGD with young men).

Other participants believed that religion forbids the use of contraception. Health professionals, including midwives, identified a lack of confidentiality, at community level and within their own profession, which could dissuade young people from seeking out further information:

"Local culture and lack of confidentiality prevents talking of, and using, contraception in an open manner" (Dionfo, FGD with health professionals).

Practically, there is insufficient access to contraceptives – people either lack the knowledge, financial means or confidence to buy them. Often commodities are not available locally, or are not of good quality. Despite these challenges, all FGDs identified



opportunities for improving contraceptive use: increasing the availability, affordability and quality of commodities, as well as appropriate support from health staff and community midwives which ensured confidentiality.

The study further reveals that the women who were interviewed perceived their right to negotiate use of contraception as limited. With 26 per cent of girls in Guinea married before the age of 15 years, and the average age of sexual debut being 16 years old , early marriage dynamics contribute towards an imbalance in the negotiation power between men and women.

Two-thirds of the women surveyed did not believe their husband would agree to use modern methods of contraception. The same proportion of women felt they did not have a right to decide how many children they would bear:

"It's God who decides how many children women will have" (Survey participant, May 2016).

Three quarters of all surveyed participants believed that women did not have the right to refuse sex with their husbands.. Such perceptions around SRHR hinder women and girls from making informed decisions about their body, and can lead to devastating effects on their health and well-being in the long term.

2. **Maternal Health** – Healthy mothers and safe pregnancies

To ensure the health and safety of expecting mothers, four antenatal care (ANC) visits are recommended. Almost two thirds of all women surveyed had access to ANC. However, less than one third had access to all four. More research needs to be conducted into why the uptake of services is so low.

A very low proportion of women, only 5 per cent, could identify three danger signs that would require immediate care during a pregnancy, meaning that the likelihood of such signs being overlooked and potentially fatal is high. The risk of complications during delivery can be reduced by the presence of a skilled health attendant during child birth, yet less than one-third of deliveries in our study were assisted by somebody with

some level of formal training.

3. **Female Genital Mutilation**

At the age of 7, the majority of girls in Guinea will have been cut. It is a traditional practice and commands the respect and honour of the family and the community. Financial incentives both for the family and the traditional cutters, religious beliefs, as well as the improved prospect of marriage, perpetuate the practice:

"People give gifts, […] or money payment to the traditional cutters, so they can provide their blessing." (Dionfo, FGD with female community leaders)

"As a community midwife, I would only do it (practice FGM) for a minimum payment of 50,000 Guinean Francs [approximately 5 GBP]."

Deeply embedded in Guinean culture, there is reluctance among communities to be the first to break with tradition:

"Parents do not accept to end FGM, they do not want to be seen as the first ones to break with tradition." (Tangaly, FGDs with health staff)

Despite a certain level of knowledge about the health consequences of FGM, such as problems during delivery, fistulas and infertility, half of the surveyed population stated that FGM should continue. Across the various focus groups, suggestions for reducing FGM included the increased sensitisation of traditional and religious leaders, parents and traditional cutters. Negotiating a 'ceremonial only' cutting where the blade is placed close to the clitoris or labia, but not cut, could address the economic incentives of FGM. Most importantly, it is recognised that different groups within the population (e.g. traditional leader, religious leaders, teachers, parents, etc.) require bespoke sensitisation strategies.

RECOMMENDATIONS … for Practitioners

- Effective SRHR programming starts with simple measures around family planning, such as knowledge of how to use and where to find contraception. In the case of Moyenne Guinea this involves ensuring confidentiality and demystifying the shame around the use of contraception.
- Sensitisation must be tailored to a variety of stakeholder groups, as the stigma around contraception often prevents people from openly discussing the topic.
- Specifically, community and religious leaders are a key group to sensitize, as they continue to have an influential position within communities. Key messages should address the health and safety of women, benefits of spacing pregnancies and championing joint decision-making of couples on issues of fertility and reproductive health.
- During the Focus Group Discussions, some of the youth participants volunteered themselves to act as 'anti-FGM champions'. They would conduct peer sensitisation activities. GRC will support these young people to facilitate dialogue, as a first step towards changing attitudes and behaviours towards SRHR. In particular female participants who had not been cut and young men, who expressed a desire to enjoy a healthier and more fulfilling sex life with their partners, are groups that could facilitate successful peer-to-peer sensitisation.
- The evidence suggests that it is crucial to involve boys and men when sensitising communities on SRHR.
  To achieve a cultural and behavioural shift requires all members of a community be involved, and it is often the behaviour of men that needs to be challenged.
- Make full use of community-level volunteering and sensitisation, to consistently implement simple healthcare interventions which save lives. Do this by reducing maternal mortality in the short-term and by building the resilience of communities in the long-term.

These include:

> Building community knowledge on key danger signs during pregnancy and delivery, and promote health-seeking behaviour.

> Establishing robust and consistent referral pathways between communities and existing health services, through community midwives and community health workers.

> Enabling communities to access life-saving assistance, if women are experiencing obstetric emergencies – for example, establishing community funds to pay for transport to the nearest equipped health facility.

RECOMMENDATIONS … for Policymakers

- While some progress has been made to reduced maternal mortality, the proportion of mothers that do not survive childbirth is still 14 times higher in developing regions than it is in developed regions. Urgent action is required if we are to meet the Sustainable Development Goals (SDGs) by 2030.

- Currently Guinea's maternal mortality lies at 650 maternal deaths per 100,000 live births. The new Sustainable Development Goals (SDGs) aim to reduce maternal mortality to less than 70 deaths per 100,000 live births by 2030.

- More research needs to be conducted in order to understand the barriers women face to access assisted deliveries, which in Moyenne Guinea only constituted one third of all women with at least one child in the last five years.

- Universal access to sexual and reproductive healthcare services is also part of the SDGs and includes access to family planning information and education. Progress on this goal is stalling and needs urgent re-prioritisation.

- Ensuring the resilience of SRHR services should be part of routine humanitarian preparedness and health systems strengthening work. This should be carried out jointly by humanitarian and development actors, working through local and national partners who have proximity to communities to establish trust and an in-depth understanding of the local culture and context.

- Tackling violence towards women and girls, with clear strategies for prevention and response. This includes practical actions to prevent sexual and gender based violence (SGBV) and secure universal access to critical services for all survivors of SGBV. In practice, this should include a three-pronged approach providing access to legal assistance, health services (including counselling/ psycho-social support), and

implementing programmes for community change on gender equality.

> Among SGBV forms, FGM and early marriage should be priority areas for intervention. This requires further research and the identification/sharing of knowledge to eliminate or reducing these harmful practices.

RECOMMENDATIONS … for Donors

> SRHR and maternal health programmes should receive adequate prioritisation in terms of resources and funds. Chronic, silent emergencies are often drowned out by high-profile, acute crises. In terms of lives lost however, the high rate of maternal mortality globally should be considered an emergency in its own right.

> Donors should draft concrete strategies to meet the maternal health targets of the SDGs. They should make a concerted effort to eradicate avoidable maternal deaths, for example through earmarked and pooled multi-donor funding financing interventions that are as close to the community as possible.

> Low-cost, context-sensitive programming can have life-saving effects, especially in the area of maternal health. Supporting local actors who are often best placed to conduct such interventions does not only present good value for money, but is a preventative humanitarian intervention.

> Community based health programming is a vital, yet often over-looked, aspect of ensuring access to Sexual and Reproductive Health and Rights. More investment is required to support these programmes.

Red Cross National Societies are volunteer-based organisations and part of the world's largest independent humanitarian network: the International Red Cross and Red Crescent Movement. The Movement is committed to seven Fundamental Principles: humanity, impartiality, neutrality, independence, voluntary service, unity and universality.

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