



Five years of global academic
collaboration building evidence
for sexual and reproductive
health and rights policies



CANSER
A Ghent University led initiative



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Preface

“If men could get pregnant, abortion would be a sacrament.” This provocative quote by feminist and activist Gloria Steinem is perhaps an exaggeration, but it is less far from the truth than most men think. The right to self-determination is still shockingly unequal between women and men. No domain illustrates this better than the one of sexual and reproductive rights. The male body is the standard in medical services while there is not a single scientific argument why it should be this way. It is a social choice we made in the past and one we ought to change by making different health care decisions today.

It is absolutely vital to give women full control over their bodies and their reproductive rights in the same way men have that control. Not only to improve the individual lives of women, but societies as a whole. Including men. Happier societies are those where women have equal rights. Because when girls can decide for themselves, they become stronger women. Stronger mothers who can ask their partners to take up their fair share of the child rearing. And who could ever be against fathers developing a better bond with their children from day one? *“Empower the women and the rest will follow”*, to quote businessman and philanthropist Warren Buffet.

The importance of the fight for equal rights became clear to me after I became Minister for Development Cooperation. My blinkers came off when I noticed that far from all policymakers were convinced of the fact that child marriages should be a thing of the past or that female genital mutilation should be banned altogether.

But also, and perhaps more worryingly, closer to home, in the western world, the challenges remain huge. In some European countries, even the ones with a solid track record in women's rights, conservative movements and governments seek to curtail sexual and reproductive rights for women. In many American states, well-established organisations like Planned Parenthood are under pressure. Several of its operations have been closed down with a single goal in mind and that is to limit health care access for girls and women.

We must fight back against these reactionary policies. When in 2017, the Trump administration installed the global gag rule ending US funding for NGOs providing abortion services, we launched an ambitious counteroffensive with 'She Decides'. Belgium backed the initiative in a heartbeat and helped to grow it further. 'She Decides' ended up uniting 50 countries to finance family planning initiatives all over the world.

It must be clear that the fight for women's rights is a constant one. Social progress never comes automatically. Feminist policymakers must be vigilant and start protecting their achievements the minute they are signed into law.

Women's rights require our unrelenting energy. That is why I welcome this ANSER publication. It highlights the importance of this network, bringing together 38 academic institutions; all committed to improving health care for women around the globe. The ANSER projects do this by reaching out to policymakers and producing tangible results, making a difference to women's everyday lives.



ANSER does hugely important work that concerns all of us, and as such deserves our full support.

Alexander De Croo
Prime Minister of Belgium

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ANSER – Five years of global research and collaboration on sexual and reproductive health and rights

OLIVIER DEGOMME (ANSER COORDINATOR & DIRECTOR INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GENT UNIVERSITY)

The Academic Network for Sexual and Reproductive Health and Rights Policy (ANSER) celebrates its fifth birthday in 2021. We believe this is an excellent opportunity to look back on what the network has achieved these past few years.

First, some numbers: 38 institutional members; 13 research projects involving 2 or more network members; 9 jointly supervised PhD candidates; 2 doctoral schools for PhD students and 3 summer schools for master students; 4 video clips; 5 webinars; 4 annual conferences in Ghent, Belgium... all in less than 5 years.

ANSER's list of achievements is one we could only have dreamed of when we conceptualised the network in 2015. While our vision and mission seemed simple – *sexual and reproductive health and rights (SRHR) policies should be based on scientific evidence and it is our duty as an academic community to bridge this gap between science and policymaking* – how we would achieve this was much more uncertain. We envisioned a coalition of the willing that would organise workshops, produce policy briefs, teach capacity building modules, conduct joint research projects, and so much more. Needless to say that this would all have remained a utopia were it not for Ghent University supporting the creation of the ANSER network by means of a substantial

financial contribution. Thanks to the university's International Thematic Networks (ITN) initiative, launched in 2015 with the aim of establishing international academic networks on topics in which Ghent University had acquired international recognition, ANSER has grown into an internationally renowned network on SRHR research.

What we do

Connecting research and policy

ANSER is an international platform whose main aim is to foster interaction and knowledge sharing between academics and policymakers. Our members engage in joint research projects, weigh in on current policy debates and host innovative training programmes. As a global resource for SRHR policy research, education and service delivery, ANSER helps build evidence-based policies that support sexual and reproductive rights for everyone, everywhere. ANSER takes on a comprehensive approach to SRHR policies, including issues such as abortion, contraception and family planning, SRHR monitoring and evaluation, adolescent SRHR, sexual health (including sexual well-being, sexual identity and gender identity), as well as gender, rights and interpersonal violence.

Supporting the achievement of the Sustainable Development Goals

In September 2015, 193 governments formally approved a set of 17 Sustainable Development Goals (SDGs) to end poverty, protect the planet





← ANSER ANNUAL MEETING 2018 IN GHENT, BELGIUM © AÄRON BLOMME

← THE 16 INITIAL ACADEMIC MEMBER INSTITUTIONS AT THE LAUNCH OF THE ANSER NETWORK IN 2016 IN GHENT, BELGIUM

HIGH LEVEL SPEAKERS AT THE ANSER LAUNCH IN 2016 IN GHENT, BELGIUM. From left to right: Elke Steurs (former Belgian Secretary of State for Science Policy), Marleen Temmerman (former Director of the Department of Reproductive Health and Research at the World Health Organization), Yvon Englert (former Rector of the Free University of Brussels), Moazzam Ali (Epidemiologist in Reproductive Health and Research at the WHO), Sietske Steneker (Director of the Brussels Office of UNFPA), Neil Datta (Secretary of the European Parliamentary Forum for Sexual and Reproductive Rights), Sander Spanoghe (former Chairman of the board of the Special UN-Program for Research on Human Reproduction, representing the Flemish Department of Foreign Affairs)



and ensure prosperity for all by 2030. In light of this, governments across the world have been developing and implementing new policies in order to achieve the targets set for these goals. Sexual and Reproductive Health and Rights (SRHR) are directly at the heart of where SDG3 (ensure healthy lives), SDG5 (achieve gender equality) and SDG10 (reduce inequalities) meet, and can be directly linked to many other goals. As a consequence, SRHR should have a central position in these new policies.

The development of these new policies necessitates an evidence base to ensure their adequacy and effectiveness. Also, the success of their implementation is closely linked to reliable follow-up and monitoring by professionals with the required training and expertise. Finally, regular exchange of knowledge and sharing of experiences between different types of stakeholders and different countries can contribute to improving existing approaches and policies.

Our core activities

In the first five years of its existence, the ambition for the ANSER network was to achieve a true sense of community among its members by establishing frequent communication and meetings; making use of each other's expertise;

initiating preferential collaboration in research proposals and co-organising educational activities. Most of these objectives were successfully met, although sometimes through different activities than were originally envisioned.

Perhaps the topic where ANSER has made its biggest contributions, and actually secured a niche position, is linking academia with policy-makers in SRHR. While our original expectations included merely organising workshops and disseminating policy briefs, the scope of our activities expanded, resulting in ANSER becoming a preferential partner of the United Nations Population Fund (UNFPA) for Eastern Europe and Central Asia (EECA), working closely with WHO Europe and supporting SRHR policy on a Belgian level. Being a network also led to a more sustained collaboration with high-profile institutions, rather than the ad hoc collaborations that happened before. Ultimately, sustainable collaborations facilitated the penetration of donor organisations and non-academic circles, which resulted in ANSER presence at multiple high-level events worldwide, ANSER input in key UN policy documents and the participation of current Prime Minister (then Minister for Development Cooperation) Alexander De Croo – a true champion of SRHR – at an ANSER event.



OUR MEMBERS

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ALBANIA

- Institute of Public Health
- University of Medicine

ARMENIA

- Armenian Association of Obstetricians and Gynecologists

AUSTRALIA

- Burnet Institute, Melbourne

AZERBAIJAN

- Azerbaijan Association 'Support to Development of Gynecology and Perinatology'

BELGIUM

- Institute of Tropical Medicine
- Ghent University
- Centre for Population, Family & Health – University of Antwerp

CHINA

- Tsinghua University
- National Research Institute for Family Planning
- Peking University – HeSAY Institute of Population Research

ECUADOR

- University of Cuenca

ETHIOPIA

- Jimma University

GEORGIA

- Tbilisi State Medical University

GERMANY

- Klinikum of Ludwig-Maximilians-Universität
- University of Potsdam
- Federal Centre for Health Education
- Philipps-Universität Marburg – Center for Conflict Studies

KENYA

- Aga Khan University East-Africa
- Nairobi University
- Technical University of Kenya
- International Centre for Reproductive Health Kenya



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LATVIA

- Department of Obstetrics and Gynaecology – Riga Stradins University

MOLDAVA

- Nicolae Testemitanu State University of Medicine and Pharmacy

MOZAMBIQUE

- University Eduardo Mondlane
- International Centre for Reproductive Health Mozambique

NETHERLANDS

- Dance4life
- Rutgers

NORWAY

- Norwegian Centre for Violence and Traumatic Stress Studies

PORTUGAL

- Universidade NOVA de Lisboa

SOUTH AFRICA

- Foundation for Professional Development
- School of Public Health – University of the Western Cape

SWEDEN

- Karolinska Institutet
- Department of Women's and Children' Health – Uppsala University

UGANDA

- Mbarara University of Science and Technology

UK

- Coventry University
- Institute of Development Studies – University of Sussex

USA

- Johns Hopkins University



↑ THE 38 MEMBER INSTITUTIONS AT THE ANSER ANNUAL MEETING 2019 IN GHENT, BELGIUM

ANSER has attracted funding for joint research projects on various SRHR challenges for implementation and policy research. In this book you will read more about ANSER's involvement in large studies such as GEAS on gender norms, or UN-MENAMAIS on sexual violence, and many more. As for capacity building, ANSER organised three summer schools for master's students from all over the world, two doctoral school courses for PhD students from ANSER member institutions, several thematic webinars, and exchanges of teaching professors among the member institutions. Looking back, the capacity building component that was originally meant for policymakers evolved to activities that strengthened primarily the capacity of the academic communities.

Who we are

ANSER is a global network. Our members are primarily researchers from academic institutions

working on sexual and reproductive health and policy whose main activities aim to generate evidence on SRHR that can be relevant for policymakers. We also have partners that are not academic institutions but non-profit organisations engaged in SRHR policy work and with an interest in research. The objective of these associated members is to work with the network to translate the SRHR research agenda to policymakers and to help strengthen the policy expertise in the network.

A glance at the future

After two initial years of general excitement and ambitious thinking, and a subsequent three-year period in which more realistic goals were set and how the network functions was streamlined, ANSER is evolving into a mature organisation. However, there is still work to be done, and we are currently preparing the next five-year cycle of the network.

WE CANNOT CONFRONT THE MASSIVE CHALLENGES OF POVERTY, HUNGER, DISEASE AND ENVIRONMENTAL DESTRUCTION UNLESS WE ADDRESS ISSUES OF POPULATION AND REPRODUCTIVE HEALTH.

THORAYA AHMED OBAID, FORMER EXECUTIVE DIRECTOR OF THE UNITED NATIONS POPULATION FUND (UNFPA, 2001-2010)

In the next five years, we intend to focus on five specific aims:

Advocate for the importance of evidence-based SRHR policies among researchers and policymakers.

Network on a national, regional and global level within academic and policymaking forums in order to increase ANSER's visibility.

Strengthen the capacity of researchers to convey knowledge to policymakers, and likewise the capacity of policymakers to use evidence-based approaches for SRHR. To that end, we will organise more structural high-level capacity building sessions for our own researchers but also for external partners. This will be done through bi-annual doctoral schools, adapting the summer school for professionals and holding online training sessions on specific issues or covering specific needs. Ultimately, ANSER aims to become the leader of capacity building on SRHR policies.

Expand the network further by involving institutions in geographical areas that are currently under-represented in ANSER, but also by reaching out to non-academic partners. We are convinced that the network would gain from involving policymakers more in the day-to-day work of the network. In light of that, an ANSER Policy Advisory Board will be established with the aim of providing the researchers in the network with advice and input from policymakers at all stages of the research: from the problem identification and the definition of the research question to the development of evidence-based policy recommendations and effective knowledge translation.

Raise sufficient money through multiple channels in order for the network to become self-sufficient by 2025.

As you can see, we have big plans and are brimming with ideas for the future. But first and foremost, let us look back at what ANSER has achieved over the past five years.



IF POLITICS IS THE ART OF THE POSSIBLE,
RESEARCH IS SURELY THE ART
OF THE SOLUBLE. BOTH ARE IMMENSELY
PRACTICAL-MINDED AFFAIRS.

SIR PETER B. MEDAWAR, BIOLOGIST AND SCIENTIFIC WRITER (1915-1987)



The power of evidence-based SRHR policies

An interview with Marleen Temmerman

— EMILIE PEETERS (ANSER SECRETARIAT & INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GHENT UNIVERSITY) & HEDWIG DECONINCK (INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GHENT UNIVERSITY)

Professor Marleen Temmerman is best known as a gynaecologist who is committed to the health and rights of women and children worldwide. She is also widely known as a researcher, author and policymaker. In 1994 she founded the International Centre for Reproductive Health (ICRH), from which ANSER was created in 2015. In 2012 she became director of the World Health Organization's Department of Sexual and Reproductive Health and Research in Geneva. She left the WHO at the end of 2015 to become Director of the Centre of Excellence in Women, Adolescent and Child Health, and Chair of the Department of Gynaecology and Obstetrics at Aga Khan University in Nairobi. She has been fighting for equal rights for women for many years. Because she combines an academic background with solid experience as a policymaker, she is the ideal person to underline the importance of good collaboration between researchers and politicians.

The contributions in this book all show what can be achieved if researchers and policymakers join forces. On the one hand, this ensures that research can have a real impact on citizens worldwide. On the other hand, it ensures that policy is based on scientific evidence and thus brings about the desired outcome. In the course of your career, you have sat on both sides of the table. Why do you think it is necessary for academia and policy to collaborate?

I believe it is now more important than ever for researchers and policymakers to join forces, because there are so many different sources of information, and they are not always equally reliable – just think about how much fake news is being spread nowadays. Of course, it is fantastic that we can instantly find a lot of information thanks to the internet, but it is not always easy to determine how correct or well-founded this information is. Before you

can develop policy, it is important to look at the available background information to form your opinion on the matter: evidence-based research as well as the outcomes and best practices based on that research. Even if you do have all the right data at your disposal it can still be a challenge, because policy is obviously based on more than just factual information.

Let me give some examples of sensitive issues: access to contraceptives, access to abortion, access to sexual and reproductive health in the world. These topics give rise to heated discussions among policymakers, they are used in election campaigns, and laws and policies are developed around them, but often without being based on any research. After all, if you look at the scientific background with regard to gender equality, the impact of women on a



country's development and economy, and the role of family planning in all this, it becomes very clear that the countries where women have access to education, to health services including contraceptives and safe abortion, are in fact the same countries that report fewer unwanted pregnancies and abortions. An enormous amount of research has been carried out on this, for example by the Guttmacher Institute.

I always quote Karam Singh [politician, professor and scientist, editor's note] who said in the 1970s: "Family planning and women's rights are not priorities. We should focus on economic development, and everything else will follow." Twenty years later, this same man said exactly the opposite: "First we have to take care of issues like family planning, the empowerment of women, etc. and economic development will follow." This has also been confirmed in economic literature: there is sufficient scientific evidence to substantiate the claim that countries where men and women have more equal rights, e.g. Canada and the Scandinavian countries, simply do better economically.

So it is important for policymakers to take into account research results. Do you think researchers succeed in communicating their results in such a way that they effectively reach policymakers?

First and foremost, scientists owe it to themselves to conduct good research, which can be defined by publications, scientific indexes, methodologies used and so on. That is the core task of academic institutions and networks. There is no discussion about the fact that the quality of this research must be excellent. But keep in mind that not all research can be translated directly into policies and best

practices. There is also basic research, e.g. clinical or biomedical research, that follows different paths. And I think it is just as much a task of the scientific world to communicate about that kind of research. For scientists of my generation this was not a priority, but I feel that has changed in recent years. More attention is being paid to science communication, and the current generation of scientists is already handling it better than we did at the time. I am also convinced it is not just a matter of translating scientific data in order to reach policymakers, but just as much the media or other constituencies. There is a positive trend, but there is still work to be done.

What are, in your opinion, the main challenges for sustained collaboration between researchers and policymakers on a global level?

I think we still have a long way to go in terms of global health diplomacy. For example, in the area of peace diplomacy, we are already much further ahead. Conveying well-founded, evidence-based information and explaining it clearly is the first step, but we have to go a step further: researchers should be able to sit around the table with policymakers and to 'infiltrate' politics, as it were. I am really convinced that we need to put a lot more effort into diplomacy. I do not mean that every health diplomat should be a doctor or have a PhD in health-related topics, nor that every doctor should be trained as a diplomat, but it would already be a big step forward if we could find a way to communicate with each other on a permanent basis.

Do you think a network like ANSER could play a role in this?

Yes, it certainly could. ANSER is an excellent forum to bring people together whose research results can be translated into policy at the national and global level. Until now, ANSER has mainly done this internally, among like-minded people. This is not unusual, as the network has only been around for five years. But the next step should be to involve institutions such as the European Parliamentary Forum for Sexual & Reproductive Rights, to have a seat at the table in parliamentary working groups, to bring scientists and opinions together in committees in order to make a real difference. We experienced something similar at the WHO: conducting research and translating it into policy at a global level simply does not happen overnight. We are now working hard on this global health diplomacy, and I clearly see a role for networks such as ANSER in all this.

Can you think of an example of a collaboration that went really well? Where policymakers were prepared to rely on evidence-based research, which resulted in positive outcomes?

At the WHO, a large UN organisation that is the secretariat of all Ministries of Health around the world, the General Assembly adopted the resolution 'Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children' in 2014. Research on sexual and gender-based violence played a major role in the preparatory work. There was a great deal of scientific and evidence-based information on sexual and gender-based violence available in order to convince all Member States, but even then it was not self-evident as this is a very sensitive topic in some Member States.

On the eve of the assembly, we had an agreement in principle on the text from all the Member States. The next morning, however, just before the adoption of the Resolution, one Member State suddenly withdrew its agreement because the text referred to 'intimate partner violence'. They would have preferred the term 'partner violence'. At that point it was no longer about science, but about local, context-specific sensitivities. So yes, we used thorough scientific research to convince people, but at one point a great deal of diplomacy and negotiation was also needed. This is why I'm convinced we need to work on both levels.

In my experience, researchers often fear that getting involved in policymaking goes against their neutrality as a researcher. To what extent is that true?

It is indeed a fact that many scientists consider it their primary task to provide good-quality research and to publish it, but that they want to remain neutral as far as the societal impact is concerned. However, it is also important to train our researchers in connecting the dots, in leaving their comfort zone and acquiring the skills and knowledge on how to position their work in a social, economic, cultural and planetary context, and to build partnerships to leverage the impact of their work for the good of all mankind.

A new screening programme for cervical cancer in Albania: from research to policy

**ALBAN YLLI, ALBANA FICO & GENTIANA QIRJAKO (INSTITUTE OF PUBLIC HEALTH, FACULTY OF MEDICINE, TIRANA UNIVERSITY OF MEDICINE)
DORINA TOCAJ (UNFPA ALBANIA)**

Cervical cancer is one of the most common cancers among women worldwide. It also puts a heavy burden on Albanian society, and unfortunately trends do not show a decrease in the number of Albanian women diagnosed with cervical cancer, especially women in vulnerable situations. This demonstrates the limited effects of the traditional Albanian health services approach. Research had shown that a large number of cases and even deaths could be prevented with proper follow-up and better preventive strategies. Therefore, a large-scale early detection screening programme was needed, as this could prevent the disease from developing and drastically reduce the number of fatal cases.

A global challenge

Cervical cancer is a global public health problem. It is one of the most common cancers among women, with almost 600,000 new cases worldwide and over 300,000 deaths in 2018. The distribution of cervical cancer incidence and mortality reflects global disparities in access to health services, with nearly 90% of deaths

happening in low- and middle-income countries. Yet, it is a preventable disease, with effective prevention programmes established, especially in high-income countries.

The main cause of cervical cancer is persistent or chronic infection from oncogenic human papillomavirus (HPV), typically spread by sexual contact. Preventive strategies for cervical cancer are based on vaccination, screening and treatment of precancerous lesions.

A health problem and an economic burden on Albanian society

Cervical cancer is, together with uterus cancer, the second most frequent cancer among Albanian women of reproductive age (15-49 years). The most frequent is breast cancer, mainly due to its characteristic increase of risk in middle age. Compared to most cancers, the risk of cervical cancer reaches the highest incidence level at a relatively young age. In Albania the risk is highest at 40-49 years of age, decreasing thereafter.

The sexual lifestyle trends among Albanians point to a potential increase of this cancer in the absence of preventive strategies. According to official country-level data, between 2013 and 2018, an average of 40 women died of cervical cancer each year. During the same period, 120-130

women were diagnosed with cervical cancer in Albania. The rate is lower compared to other Southeast European countries but much higher than in Eastern Mediterranean countries.

While in most EU countries the mortality and incidence of cervical cancer are on the decrease, in Albania trends have not shown signs of decline, demonstrating the limited effects of traditional health services, which have been mostly based on small-scale, episodic and opportunistic early detection.

Needless to say, there is a great deal of potential for prevention, with prevention efforts expected to result in a number of remaining healthy years. It is estimated that, every year in Albania, 2,000-3,000 healthy and productive years are lost to cervical cancer-related diseases and deaths. At a conservative estimate, cervical cancer has cost Albanian society at least six million US dollars yearly because of productivity loss and health system-related costs. Other family- and society-related long-term costs may add to that figure.

From evidence to policy reform

Prior to 2010, interventions in the field of cervical cancer prevention were not systematic or sustainable. During the last decade, the efforts started to be better coordinated and integrated into national health policies. A number of health system-based analyses, capacity building, awareness activities, policy development and guidelines preparation have been carried out by the Ministry of Health, the Institute of Public Health, and University Hospitals in partnership with United Nations or European Union agencies.

The process, which culminated in the National Screening Programme, was initiated with the National Cancer Control Plan 2011-2020. During 2012-2013, the Institute of Public Health in collaboration with University Hospitals and supported by the United Nations Population Fund (UNFPA) carried out initial health system capacity analyses and developed the first recommendations

on cervical cancer screening to the Ministry of Health. In 2014, the Declaration of Wisdom was signed by ministers, deputy ministers, members of parliament and other public figures. The document underlined the need to do more to prevent cervical cancer and to protect women from this disease. In 2015-2016, an inter-institutional working group developed Clinical Guidelines for Cervical Cancer at Primary Health Care level, which were approved by an order of the Albanian Minister of Health. In 2017, a pilot programme for cervical cancer screening was organised in the Fieri district, in collaboration with specialised Italian and French Institutions. High-risk HPV tests were used for primary screenings. By 2018, a WHO technical mission on breast and cervical cancer screenings was carried out and recommendations were used by the Institute of Public Health in developing the technical framework for a national screening programme.

The National Screening Programme

The National Screening Programme for cervical cancer was approved by a government law and included in the 2019 budget of the Ministry of Health and Social Protection. Women aged 40-49 years old are now offered free screening, based on high-risk HPV tests, at primary health care level.

During the last decade, and following the intensification of efforts to introduce systematic prevention programmes and to strengthen health system capacities for early diagnoses, activities aimed at improving Albanian women's awareness of cervical cancer prevention have had substantial success. Despite geographical differences, the proportion of women of reproductive age who have knowledge about prevention has increased by more than 55% in 2018 compared to 2008, especially in rural areas, where the knowledge has doubled.

The goal of the new screening programme is to provide all women in this age group with high-risk HPV screening tests, as part of the routine examinations done at primary health care

centres. The screening programme will improve the identification of women who are at higher risk for cervical cancer, detect precancerous lesions over time, and treat them accordingly. Under the new programme, all primary screening tests and further examinations are provided for free at the point of care, regardless of the patient's health insurance status.



THANKS TO THE EFFORTS TO IMPROVE ALBANIAN WOMEN'S AWARENESS OF CERVICAL CANCER PREVENTION, THE NUMBER OF WOMEN WHO KNOW ABOUT PREVENTION HAS INCREASED SIGNIFICANTLY, ESPECIALLY IN RURAL AREAS, WHERE THE KNOWLEDGE HAS DOUBLED.

To minimise the added workload every screening programme brings about, nurses at primary health care services are taking more responsibilities away from general practitioners. In addition, screening tests based on self-sampling are very practical for women and guarantee a minimal workload for health care providers. Under the new National Screening Programme, 538 health professionals from around 400 health centres all over the country have already been trained.

First results

The screenings started in May 2019. By December, about 15,000 women had undergone a screening, and around 6% of them were considered high-risk HPV and are being followed up. Although the likelihood of being high-risk HPV was higher in cities, the programme was used more by women living in rural, poorer areas, where access to quality health care is more difficult.

The majority of women found the vaginal sampling procedure very simple and not at all painful. Almost all of the screened women received their results within two months. By December 2019, more than 90% of women whose results came back positive had already gone for a follow-up visit or were planning to go soon. One of the issues identified during the first year of the programme was the relatively high proportion of women who had chosen private health care for the follow-up visit. Higher education increased the odds of using a private facility or going abroad for the follow-up visit. While the majority of women reported substantial worries about being high-risk HPV, almost 90% of them rated the overall service as 'good' or 'very good'.

Stakeholders, organisational and political landscape

Since the signature of the Declaration of Wisdom in 2014, it seems that policies and investment in the field of cervical cancer prevention have enjoyed large political support in Albania. The Ministry of Health and Social Protection remains the main driver, and is expected to continue to provide leadership in expanding the existing programme.

Meanwhile, the Institute of Public Health, with its central role in health prevention programmes, has proven to be another key stakeholder. Hence, its evidence-based analyses, coupled with increasing public awareness of cervical cancer prevention, has helped convince the Ministry of Health and Social Protection to provide the necessary leadership for the programme, to design the policy framework, and to involve the whole government in the cause.

The National Screening Programme could be neither effective, nor ethical without full involvement of specialised health care, mainly in gynaecology and biopsy. The two university gynaecological and obstetrical hospitals in Tirana are crucial, not only in providing the diagnoses and treatment for high-risk HPV cases, but also in

supporting other regional hospitals in strengthening their capacities, this way lowering the geographical barriers for women during follow-up visits.

The screening programme is being provided by coordinating roles of primary health care services and regional public health institutions, assuring easy access to screening services for the target population. This model of inter-institutional organisation should be used in the future for other components of cervical cancer prevention programmes, such as HPV vaccination.

UNFPA has always been a partner of public health institutions and a catalyst for moving ahead the agenda of cervical cancer prevention in Albania, while the WHO has also provided key technical assistance. Their support will be continuously needed along with EU and other regional networks and partnerships. Civil society organisations, such as the Albanian Centre for Population and Development, or women's networks, would also be indispensable in a range of actions, including advocacy and raising awareness among marginalised and hard-to-reach women, as well as providing specific complementary prevention services.

The way forward

- Although there is an effective vaccine against HPV and its administration among girls of pre-puberty age is important, it has been demonstrated that vaccination alone is insufficient. To successfully achieve the elimination of cervical cancer as a public health problem, within the shortest time and with maximum impact, a combination of intensive vaccination, screening and treatment must be applied to the population at scale.
- Albania has yet to set up a vaccination programme against HPV alongside its newly developed screening programme. For that, analysis about a cost or price benchmark for the dose of vaccine and recommendations

in the context of low- and middle-income countries is needed. For example, what would be the target price to be negotiated for two doses of vaccine in Albania? The WHO and UNFPA could assist in this process.

- The initial reaction of women towards the screening programme has been very positive, and the original projected coverage of 40% for the first year is successfully being achieved. It is necessary to assure the support for the programme, while raising awareness among women, to continuously increase the screening coverage, aiming at 80% of the target population by 2023.
- As more women are being reached by screening services, it is paramount to continue the efforts towards strengthening capacities for better diagnoses and treatment of precancerous lesions, improving women's access to specialised follow-up for colposcopy and biopsy. All women identified as having cervical diseases should receive treatment and care. This could be achieved by providing appropriate training, tailored continuous medical education and professional networking for gynaecologists at regional hospitals.
- Finally, while the cervical cancer incidence cannot be reduced to zero with the current knowledge and technology, its elimination threshold as a public health problem is achievable within the next decades.

Making the case for better SRHR policy in Indonesia and Belgium through the Global Early Adolescent Study (GEAS)

SARA DE MEYER & KRISTIEN MICHELSEN (INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GHEENT UNIVERSITY)
ANNA PAGE, WINA BAEHA, KRISTI PRAPTIWI & MIRANDA VAN REEUWIJK (RUTGERS)

Early adolescence (10-14 years) is one of the most critical periods of human development, as health and well-being at this age have lifelong consequences. While it is considered one of life's healthiest periods, it is also a period in which many transitions occur and health behaviours are established. During this phase of life, sexual feelings emerge, sexual experimentation begins, and gender and related roles and norms become more important. These crucial developments make early adolescence an optimal window of opportunity for promoting more gender-equitable attitudes. However, despite the importance of this age, early adolescence remains one of the most poorly understood stages of life. To address this gap, Johns Hopkins Bloomberg School of Public Health, the World Health Organization and research partners in 11 countries have implemented the Global Early Adolescent Study (GEAS – www.geastudy.org).

The Global Early Adolescent Study: examining the impact of gender norms on health and well-being trajectories

GEAS is a multi-site longitudinal study designed to explore the role of gender norms in informing the health and well-being of urban poor adolescents from early to late adolescent years. The study is being coordinated by the World Health Organization and Johns Hopkins Bloomberg School of Public Health, and implemented in 11 countries across five continents. The GEAS currently operates in urban poor communities in the following regions: Shanghai (China); Kinshasa (Democratic Republic of Congo (DRC)); Flanders (Belgium); Semarang, Denpasar, Lampung (Indonesia); New Orleans (USA); Blantyre (Malawi), Cape Town (South Africa); Nairobi (Kenya); Sao Paulo (Brazil); Cuenca (Ecuador) and Santiago (Chile). Various partners of the GEAS are also ANSER members: the International Centre for Reproductive Health (Belgium), the University of Cuenca (Ecuador), University of the Western Cape (South Africa), Rutgers (the Netherlands), Karolinska Institutet (Sweden) and Johns Hopkins Bloomberg School of Public Health (USA).

The GEAS consists of three phases. During the first qualitative phase, young adolescents and their parents/guardians were interviewed about how it felt to become a wo/man in their neighbourhood. The results of this phase were then, in a second phase, combined with existing scales to design new scales that allow measurement of gender norms and young adolescents' sexual health and

well-being. In the third phase, a longitudinal cohort study has been implemented using these scales. In most countries the third phase is ongoing. In four countries, the GEAS is paired with an intervention to evaluate their impact.

The GEAS in Belgium and Indonesia

The following text presents findings from the GEAS in Belgium (led by Ghent University) and in Indonesia (led by Rutgers, in partnership with Universitas Gadjaja Mada (UGM)).

In Belgium, 1,008 first-grade students from 23 Flemish (the northern part of the country) secondary schools completed the survey. In Indonesia, survey responses were collected from 4,684 adolescents in the seventh grade from 18 junior high schools across three sites.

As the survey is part of an international research project, a standard set of questions was used across the countries. Nevertheless, each country was also allowed to add other questions to the survey or to focus on specific topics in their analysis, based on their societal, political and programmatic context. Therefore, in Belgium, the survey was complemented with questions related to gender identity, sexual orientation and gender expression. In Indonesia, GEAS data was collected from nine schools delivering a comprehensive sexuality education curriculum, and nine control schools, with the aim of showing the impact of the curriculum on gender norms and sexual well-being outcomes. Questions were added to reflect specific areas the curriculum aims to influence, such as feelings of guilt about sexuality, and confidence in accessing contraception.

At the time of publication, the research teams in both countries have completed the baseline study and have started to disseminate the research results among politicians. To do so, they each used different strategies. The Belgian team developed an infographic and disseminated it within their networks. In Indonesia, the GEAS is part of a broader research and advocacy programme in

which results have been used in a range of influencing activities at national and local levels. Below we present the results and strategies of both research teams so far.

Influence of gender norms on the (sexual) health of young adolescents in Belgium

The Belgian GEAS team has chosen to publish the research results at a number of levels: (1) a classic final report for fellow researchers and other stakeholders; (2) an infographic which presents the main findings for policymakers; and (3) an extensive article in one of the largest newspapers in the country for the general public. In addition, the team also plans to contact a number of policymakers to explain the results in person. On the next page you will find the infographic the team has developed.

The full research report is available in Dutch on the ICRH website: <https://www.icrh.org/storage/attachments/attachment/57.pdf>.



SELECTED FINDINGS FROM THE GEAS BELGIUM: INFLUENCE OF GENDER NORMS ON THE (SEXUAL) HEALTH OF YOUNG ADOLESCENTS (11-14 YEARS OLD)

RESEARCH QUESTIONS

- ❓ How do adolescents think men and women should behave in society?
- ❓ How do gender norms evolve during adolescence and what are the main influencing factors?
- ❓ How do gender norms influence health during adolescence?

POLICY RECOMMENDATIONS

- 1 Offering comprehensive sexuality education in each school, paying attention to:
 - equality and respect for sexual diversity and gender diversity
 - mutual respect and building nonviolent relationships
- 2 Raising awareness about the fact that sexuality is part of human development and that gender diversity and sexual diversity exist, also among young adolescents, through:
 - awareness campaigns
 - offering thematic educational tools for schools
 - including these topics in the curriculum of future teachers and youth educators
- 3 Supporting research that investigates gender norms and their consequences on health.

STUDY

WORLDWIDE

11 countries

coordination by

Focus on vulnerable adolescents (11 to 14 years old) in cities

BELGIUM

ICRH International Centre for Reproductive Health - UGent

7 Flemish cities
23 schools first grade 2018-2019

The mothers of half of the respondents were not born in Belgium.
The material welfare of the adolescents is limited.

RESULTS

Gender diversity and sexual diversity

0.8% of the boys and 7.6% of the girls were once in love with someone of the same sex.



Gender identity: 2.6% of the boys and 11.4% of the girls don't feel 100% like they are a 'typical' boy or girl.

16.7% of the boys and 14.3% of the girls are not exclusively attracted to the other sex.

Gender norms

Adolescents often have stereotypical attitudes related to:

- male toughness versus female vulnerability
- relationship expectations
- homosexuality
- freedom to express oneself (gender expression)
- freedom to express sexual feelings (sexual expression)



Physical and mental health

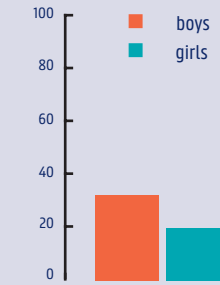


Social media: 96% of the adolescents have their own mobile phone and a social media account. One fifth of the respondents spend more than five hours a day on social media, chatting online with friends, playing computer games or using interactive media.

More boys (85.2%) than girls (80.5%) indicate being in good health.

Adolescents indicate being happy (average of four (max. five) on happiness scale).

Substance use is limited and is mainly related to alcohol.



32.3% of the boys and 19.7% of the girls feel good about their bodies.

Substance use (ever)	Total	
	%	amount
Cigarettes	9,3 %	93
Alcohol	23 %	232
Marijuana	2,7 %	27
Other drugs	1,3 %	13

Sexuality

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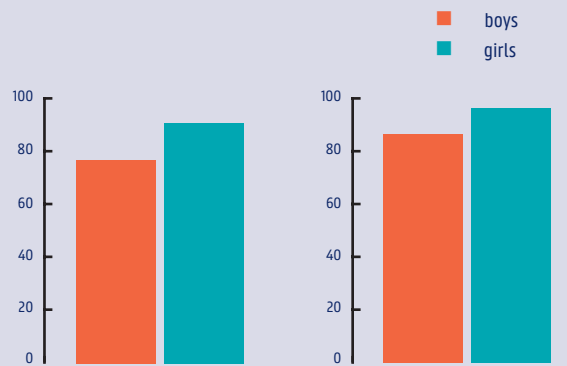
Lack of knowledge about sexuality. Adolescents mainly score lower on questions related to HIV.

For girls, friends are very important for exchanging information about health. Boys and girls also ask other people they trust for information, such as a teacher, trainer, youth worker or religious figure.

About half of the adolescents indicate that they would be embarrassed buying a condom if they needed one. Boys are less embarrassed than girls.

Boys are a little bit more experienced sexually than girls, but in general the respondents have little experience.

About 40% of the adolescents have flirted on social media. Fewer than 5% have ever sent a sexual picture to someone and just over 30% of the adolescents have already received such a picture.



76.9% of the boys and 91.2% of the girls have never touched the genitals of someone else or have ever had their genitals touched by someone else.

86.3% of the boys and 96.1% of the girls have never had sexual intercourse.

3.2% of the girls and 8.2% of the boys have experience with oral sex, and 0.4% of the girls and 3.2% of the boys have experience with anal sex.

50%

of the adolescents who had ever been intimately touched (84 of 1008) indicate that the first time they were touched was without their full consent.

40%

of the adolescents who had already had sexual intercourse (37 of 1008) indicate that their first sexual experience was without their full consent.

Relations



More than half of the adolescents have friends of the other sex.



Three out of five adolescents had already been in a relationship. Boys have more experience with relationships than girls.



A quarter of the adolescents that were ever in a relationship have been the victim of physical partner violence.



One fifth of the adolescents that were ever in a relationship say they were once a perpetrator of physical partner violence.

SELECTED FINDINGS FROM THE GEAS INDONESIA

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SRH knowledge and communication

Adolescents have low knowledge of sexual and reproductive health (SRH) topics including pregnancy, contraception, HIV prevention and access to SRH services.

44.7%

Only 44.7% of students know that a girl can get pregnant the first time she has sexual intercourse.

31.5%

Only a third (31.5%) believe that using a condom can prevent pregnancy.



Girls have less knowledge than boys on all SRH topics.



Communication between parents and children on SRH topics is low.

Pornography and sexting

82.6%

Most respondents (82.6%) have never watched pornography.

4.3% **0.5%**

4.3% of boys and 0.5% of girls reported ever sending a sexual picture of themselves to someone (sexting).



Gender attitudes

- Both boys and girls endorse stereotypical gender traits (such as boys being tough and girls being quiet and humble) and stereotypical gender roles (such as a woman's role being to take care of the home and family, and a man's role being to bring home money and make decisions). Boys had a slightly higher average score than girls.
- Both boys and girls endorse a sexual double standard, meaning they have different views about men and women for similar behaviours. Girls and boys had almost the same score.

Making the case for sexuality education in Indonesia using GEAS data

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In Indonesia, the Global Early Adolescent Study (GEAS) is part of a broader research and advocacy programme, Explore4Action, a joint initiative between Rutgers, Universitas Gadjja Mada (UGM), three local chapters of the Indonesian Planned Parenthood Association (PKBI), Johns Hopkins University and Karolinska Institutet. Explore4Action aims to build evidence to support the scale-up of comprehensive sexuality education (CSE) in Indonesia. GEAS data was collected in 'intervention schools' delivering the Rutgers SETARA CSE curriculum, and in control schools, allowing an investigation of how adolescents' gender socialisation and sexuality development is affected by the curriculum. The GEAS is complemented by a qualitative participatory research track, Youth Voices, and an implementation research track evidencing what is needed for successful implementation of CSE in Indonesia. Findings from the three research tracks are combined in advocacy efforts at both local and national level, aiming to make the case for the scale-up of CSE across the country.

Policy background

The Indonesian government has officially approved sexuality education in schools. However, this pledge has not yet been implemented. UNFPA and a range of other organisations have worked with the government to develop modules, which have been approved, but there has been no commitment in terms of budget and no consensus on how these can be implemented within saturated school curricula. With adolescent sexual and reproductive health (ASRH) a shared responsibility across multiple departments (including the Ministries of Education, Health, and Women and Family Affairs, and the National Population and Family Planning Board (BKKBN)), no one department is taking responsibility for moving the agenda forward. Progress has been further impeded by the general election in 2019 and ensuing change of Presidency, followed by

COVID-19, which diverted attention, energy and budget to more urgent matters of the pandemic.

Using GEAS to make the case for comprehensive sexuality education

One of the key ways in which GEAS data has contributed to the aim of building evidence to support the scale-up of comprehensive sexuality education (CSE) in Indonesia is through their inclusion in policy briefs and online policy dialogues. Explore4Action partners UGM and Rutgers WPF Indonesia used the GEAS data to develop policy briefs for five key government departments: the Ministries of Health, Education, and Women Empowerment and Child Protection, the National Population and Family Planning Board (BKKBN) and the National Development Planning Agency (BAPPENAS, which is responsible for national budgeting). Key entry points were identified in the policy frameworks of each department, relevant GEAS data that related to department priorities was highlighted, and tailored recommendations for each department followed. For the Ministry of Health, the data focused on mental health; for the Ministry of Education and Women Empowerment on gender attitudes. For BAPPENAS, data on adolescent issues and development was linked to achieving the Sustainable Development Goals. For BKKBN and the Ministry of Education, GEAS data highlighting adolescent sexual and reproductive health (SRH) issues and needs were presented, including SRH knowledge and communication; safety, violence and aggression; and future aspirations. The role for sexuality education to help address these issues was argued, followed by recommendations on how the departments can support its implementation and scale-up. The policy briefs are available in English at <https://rutgers.international/programmes/explore4action/explore4action-resources>.

Building on these policy briefs, Rutgers WPF Indonesia and Universitas Gadjja Mada (UGM) then organised a series of five policy dialogues targeted at different governmental departments. The policy dialogues aim to refocus government

attention on adolescent sexual and reproductive health issues amidst the COVID-19 pandemic, and to make a strong case for the implementation and scale-up of CSE in Indonesia. Each dialogue is moderated by a relevant expert, and includes a high-profile government representative, alongside an academic from UGM who presents the policy brief and relevant GEAS results, a youth representative and a representative of a relevant NGO. Considering restrictions imposed by the COVID-19 pandemic, the policy dialogues are taking the form of online webinars.



KEY ENTRY POINTS WERE IDENTIFIED IN THE POLICY FRAMEWORKS OF EACH GOVERNMENT DEPARTMENT, RELEVANT GEAS DATA THAT RELATED TO DEPARTMENT PRIORITIES WAS HIGHLIGHTED, AND TAILORED RECOMMENDATIONS FOR EACH DEPARTMENT FOLLOWED.

In October 2020, the first online policy dialogue was held with BKKBN, the National Population and Family Planning Board. The webinar was attended by 189 participants, including government representatives, academics, students and NGO stakeholders from all across Indonesia. The online format allowed for the engagement of a much broader range and larger number of direct participants than would have been possible had the event been held in person in Jakarta. The event was also streamed live on YouTube and is available for viewing online on the Rutgers WPF Indonesia YouTube channel. During the dialogue, the policy brief was presented by an academic from UGM, followed by responses from a government stakeholder, a youth representative and an NGO representative. Though currently only baseline data, the GEAS

data played a strong role in providing a robust academic basis for showing adolescent SRH issues and needs, and how these interlink with a lack of communication on sexuality, with gender norms, violence and aggression, and with mental health. The data opened the space for arguing the need to invest in SRH interventions for adolescents, in particular the role that sexuality education can play and that this has to start in early adolescence. While the government representative was bound by their department's position and no hard commitments were made, the online policy dialogue created space for academic, NGO and youth voices to be heard, and demonstrated support and pressure from multiple angles for the implementation of CSE.

Looking ahead

The policy dialogue with BKKBN was the first of five events to be held in October-December 2020. Following the five policy dialogues, a national workshop is planned where all five institutions will be invited to jointly discuss budgeting and strategy for the integration of CSE curricula in the national educational curricula, alongside UNFPA and other organisations who have worked on developing an Indonesian CSE module to promote collaboration and to build on previous efforts.

The policy briefs and dialogues are complemented by a range of other local and national influencing efforts, including working with youth advocates in local areas to support the interpretation of GEAS findings for local advocacy, collaborating with local government stakeholders to run budget workshops to identify funding options and opportunities for CSE, and collaborating with other networks at a national level.

In 2021, the second wave of GEAS data will generate evidence on the results of the CSE curriculum and how gender norms influence health and well-being trajectories for adolescents.

Evidence-based doctor-patient communication on intimate partner violence in medical education in Mozambique

BEATRIZ MANUEL (DEPARTMENT OF COMMUNITY HEALTH FACULTY OF MEDICINE, UNIVERSITY EDUARDO MONDLANE)

There is growing evidence that most medical doctors do not recognise the signs and symptoms of intimate partner violence or its impact on women's as well as men's health. It is considered by many as a social or cultural issue. A lack of skills, time constraints, discomfort with the subject, limited referral points, sharing the same cultural and gender norms of survivors, are some of the reasons why there is resistance among medical doctors to address intimate partner violence.

Intimate partner violence, a public health issue in Mozambique

Intimate partner violence is a public health issue that affects both women and men. The most recent data on intimate partner violence in Mozambique shows that 55% of women report being victims of intimate partner violence, compared to 25% of men. One out of three Mozambican women aged 15-49 report having been a survivor of physical violence since the age of 15, their husband or intimate partner being the perpetrator in 62% of cases. Concerning sexual violence, 12% of women report being a victim since the age of 15, and 50% of the reported cases of violence against women are related to sexual abuse. Sexual violence also affects many orphans and other vulnerable children, including boys.

A high prevalence of intimate partner violence against men is reported in the north of Mozambique, where there is a matriarchal culture: 28% of men report being a survivor of intimate partner violence and 20% report being a survivor during the last 12 months, according to a survey conducted in 2011 in one province in the north of Mozambique. Strong beliefs in the role of ancestors and spirits influence gender norms, practices and relationship dynamics. Where initiation rites prevail, domestic violence is used as part of the construction of masculinity, where the man is at the top of the hierarchy as the one who exercises the power of authority; the provider of goods and family decision maker.

Unskilled health professionals

Beatriz Manuel's PhD research, *Addressing Intimate Partner Violence: Implications for Medical Curricula in Mozambique*, included four sub-studies, two of which were a literature review about key concepts of intimate partner violence response training programmes in medical curricula, and a survey among 387 sixth-year medical students from five medical schools in Mozambique to understand their perceived mastery of knowledge, skills and attitudes related to intimate partner violence. The research showed that just a few medical schools in Mozambique address skills development on intimate partner violence, and even where it is included in the curriculum, it is not standardised. This results in doctors experiencing a lack of

appropriate skills to deal with intimate partner violence. Only 37% of the respondents mastered intimate violence knowledge, skills and attitudes.

Intimate violence survivors agree that the first thing doctors should know is that everyone can be a survivor and that it is not just about sexual assault. It is often seen that medical doctors have different beliefs, values and practices about medicine and health care than what patients may believe, value or practice related to their own illness.

Communicating effectively with patients requires complex skills to enable doctors to take accurate patient histories, consider the patients' perspectives, involve patients in the interview process and attend to their emotional well-being, and initiate a process of clinical reasoning. Mastery of communication competency is critical for medical students to assist patients. In general, little is known about medical students' comprehensive mastery of intimate partner violence curriculum contents and how this sensitive topic should be taught to acquire better doctor-patient communication skills. At the time when this research was conducted, no formal communication skills training related to intimate partner violence existed in the Mozambican setting for medical students.

The lack of training related to intimate partner violence leads to a lack of screening, a lack of confidence in dealing with survivors of intimate partner violence and, therefore, poor follow-up or intervention. It can even cause harm if doctors advocate leaving an abusive relationship while failing to provide survivors with a safety plan or to take into account the survivor's perspectives.

Communication skills curriculum

The final study involved 34 of all fourth-year medical students (59%) from one medical school in Mozambique to study the impact of an innovative intervention to develop critical intimate partner violence knowledge, skills and attitudes, supported by a patient communication script. The study was

complemented with analysis of student perceptions. Students reported that a simulation module on doctor-patient communication skills substantially helped them to gain the required attitudes to deal with intimate partner violence victims.

Through this research, medical schools started to recognise the importance of these competencies in their curricula. The research thus provided justification for developing a competency-based, interprofessional curriculum to improve communication skills on sensitive topics in medical education.

Our research also identified new content that would be appropriately incorporated into education and training to produce these competencies in medical students, as well as specific educational approaches that could be used in delivering this content.

Policy recommendations

- Integrate the following skills throughout the existing curricula for medical students:
 - Listening in a non-judgemental way and leaving out prejudice and bias (e.g. cultural norms on sexual and gender issues, discrimination, etc.)
 - Using appropriate communication styles when talking about sensitive health issues in a medical setting
 - Assessing the patient's and family's risks, intentions and expectations when making a decision
 - Conducting appropriate clinical inquiry
 - Documenting and keeping a record of what the patient says
- Set up an evaluation system for the curriculum based on advice of key stakeholders.
- Set up a platform to share experiences about inappropriate behaviour of medical staff around sensitive topics.

ANSER's doctoral school in Sexual and Reproductive Health and Rights (SRHR)

ELIN C. LARSSON (KAROLINSKA INSTITUTET)

KRISTIEN MICHIELSEN (INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GHENT UNIVERSITY)

In November 2020, four ANSER partners (Ghent University, Belgium; Karolinska Institutet, Sweden; Technical University of Kenya and NOVA National School of Public Health, Portugal), organised a doctoral school on global sexual and reproductive health. The course of 3 ECTS was taught fully online and 34 PhD students from all over the world participated.

The course built on the earlier experience of organizing a 1,5 ECTS doctoral school in Belgium and Sweden with physical and streamed classes for 20 participants.

The 2020 doctoral school was built on recorded online lectures and readings that were followed up with live discussions and seminars etc., held over Zoom. All four institutions contributed to the lectures. Approximately 40 students attended the doctoral school, 10 from each institution.

Except for lectures and seminars we also organised a high-level panel, on the topic 'Current SRHR challenges and opportunities – perspectives from different global actors'. Participants were Chandra Mouli (WHO), Marleen Temmerman (Aga Khan University, Kenya) and Caroline Kabiru (African Population and Health Research Center). Thanks to ANSER, we were able to provide the students with a unique learning experience, allowing them to meet lecturers and students from several academic institutions and from different parts of the world.

Meet our students:



ANNA

"I took the doctoral school in 2017 when I was about halfway into my PhD studies. The examination assignment 'Gaps in SRHR research' forced me to revisit my project's aims and reflect upon which gaps I was trying to fill with my research. Based on lectures and classroom discussions, I was able to see the broader implications of my PhD work related to SRHR. I really like the international exchange with Ghent University. I remember that there were some technical challenges for the course administrators when it came to the streamed lectures, but as I recall the students were very understanding and also fascinated by the possibilities of this new and modern way of conducting PhD courses."

Anna Nielsen, midwife and PhD, attended the doctoral school in 2017 and defended her thesis in 2019.



RITAH

"My name is Ritah Bakesiima, a PhD student in a joint degree programme between Makerere University and the Karolinska Institutet. I will be taking the doctoral school in November 2020, and I am keen to be a part of it. My research centres on adolescent sexual and reproductive health, so my expectations from this course are to learn more about adolescent SRH rights, the most appropriate methods of obtaining confidential SRH information/data from adolescents without making them feel uncomfortable, ethical issues involved in adolescent SRH research, and the way forward for SRH in poor resource settings or low- and middle-income countries. I believe that this course will equip me with the knowledge and skills I need to become a better SRH researcher."

Ritah Bakesiima, adolescent sexual and reproductive health researcher, who was asked about her expectations of the doctoral school in 2020.



KARIN

"The doctoral school was excellent! It really made the most of being held online, by focusing on the strength of having so many students from different contexts coming together and ensuring that we really interacted with each other once we were all online together. SRHR can be a complex and sensitive topic, so depending on one's specific area of research, it can sometimes be hard to find a supportive community. This course was a valuable opportunity to create that kind of community, especially one that is international and diverse in terms of research interests, professional backgrounds and experience (i.e. social work, epidemiology, medicine and sociology). It was also useful that the content was so comprehensive – we got to explore concepts such as SRHR and systems thinking, but also apply relevant skills, such as reviewing articles and policy processes, to our own work. All of this develops our knowledge, professionalises our skills, and expands our perspectives on SRHR, helping us to improve our research practices so that we can better contribute to ensuring SRHR for all."

Karin Båge, doctoral student, Global and Sexual Health Research Group, Department of Global Public Health Karolinska Institutet, attended the doctoral school in 2020.

**ORINA**

“The doctoral school presented quite insightful and diverse experiences, both academic and personal. It enriched and broadened my horizons on matters of SRHR, research methodologies, concepts, and their implication for policy and practices. The course presented a diverse perspective on redefining clinical and social science research by embracing the community, inclusivity and respect for human rights towards people’s health and survival, economic development and the general well-being of humanity. Despite the ravages brought about by the COVID-19 pandemic globally, the doctoral school was a great success as it presented a unique opportunity and platform where doctoral students from various parts of the world interacted freely with diverse research interests, experiences and unique challenges. This training has given me courage to continue on with my PhD journey and I feel more empowered to delve deep into this field of sexual and reproductive health and rights, until now a complex area, especially in Africa.”

Orina Ogato Anser-Tuk, PhD Candidate at the University of Nairobi, Kenya, attended the doctoral school in 2020.

**EUNICE, EMÍLIA & MÓNICA**

“By attending the doctoral school we wanted to strengthen our knowledge and skills on how to conduct research in sexual and reproductive health and rights. After ten days of intense reading, individual reflection, and group discussions, the communication and interaction between different cultures on the subject of the course was very interesting and necessary, as we learned people from different cultures have their own way of thinking according to their values and beliefs.

The course exceeded our expectations, due to the fact that most of the theoretical material was translated into practice in the group discussions. Each speaker selected the best methods to communicate, which motivated everyone to meticulously follow the course, even though it was taught online.”

Eunice Jethá, Emilia Goncalves and Mónica Frederico, PhD students at Ghent University, attended the doctoral school ‘Global Sexual and Reproductive Health and Rights: Methods, Concepts and Implications for Policy and Practice’ in 2020.

COUNTRIES WITH MORE GENDER EQUALITY HAVE BETTER ECONOMIC GROWTH. COMPANIES WITH MORE WOMEN LEADERS PERFORM BETTER. PEACE AGREEMENTS THAT INCLUDE WOMEN ARE MORE DURABLE. PARLIAMENTS WITH MORE WOMEN ENACT MORE LEGISLATION ON KEY SOCIAL ISSUES SUCH AS HEALTH, EDUCATION, ANTI-DISCRIMINATION AND CHILD SUPPORT. THE EVIDENCE IS CLEAR: EQUALITY FOR WOMEN MEANS PROGRESS FOR ALL.

BAN KI-MOON, FORMER SECRETARY-GENERAL OF THE UNITED NATIONS (2007-2016)

REDSEX, the Sexual and Reproductive Health Network in Cuenca, Ecuador

CARMEN ORTIZ (SENDAS)

BERNARDO VEGA (FACULTY OF MEDICAL SCIENCES, UNIVERSITY OF CUENCA)

MONSERRATH JERVES (FACULTY OF PHILOSOPHY, LETTERS AND EDUCATIONAL SCIENCES, UNIVERSITY OF CUENCA)

The Sexual and Reproductive Health Network of Cuenca (REDSEX) is making collective efforts to articulate different political and institutional, public and private views on sexual and reproductive health and rights (SRHR) of young men and women. Our main goals are putting SRHR on the political agenda through evidence-based research, informing people, raising awareness, and making SRHR accessible to everyone in Cuenca.

The fact that SRHR is now a topic on the political agenda in Cuenca is an important achievement, especially given the cultural context in which sexuality is still a taboo topic (because of the deep religious influence and the patriarchal society in Cuenca) and has always been considered something private, outside the reach of public policy. That is why we believe it is valuable to systematise the process that was carried out and to analyse the key elements of this achievement.¹

About REDSEX

The Sexual and Reproductive Health Network of Cuenca (*Red de Salud Sexual y Reproductiva*), or REDSEX, started at a key moment in the work on sexual and reproductive health and rights (SRHR) at the local and national level, when the National Constitution – made up of a lot of social movements – recognised the exercise of these rights as a condition of good living, including sexual rights as human rights. The defence of SRHR was in opposition to the church, the State, politics and anti-rights groups, as prejudices and taboos remained entrenched in their structures, making it difficult to fully exercise these rights. Ecuador is the third country in the region where adolescent pregnancies, a woman's right to decide, (emergency) contraception, sexual diversity and HIV/AIDS are not addressed or discussed as public agenda topics. Resources are scarce and decision-makers are afraid to work on these issues.

In this context, REDSEX was launched to respond to the need for strategic alliances and to strengthen cooperation within the SRHR framework. The network wanted to make SRHR challenges more visible and to place SRHR on the public agenda as a critical element for tackling poverty and inequalities.

Initially, REDSEX consisted of 15 – public and private – institutions. Firstly, the network intended to reduce teenage pregnancies and to eradicate gender violence and discrimination against LGBTI groups; secondly, it was our intention to ensure that the institutions involved fully complied with health care protocols in assisting victims of sexual violence. Subsequently, it was possible to put SRHR on the local public agenda and that of the academic world, integrating issues such as abortion and LGBTI rights.

A step-by-step process

Over the last two decades, REDSEX has been very successful in putting SRHR on the agenda of local politicians in Cuenca. These results were achieved through a step-by-step process. It started in 2012 by bringing together the different stakeholders involved, aligning their views and ideas, and having them work together in the REDSEX network. Once the network was set up, actions and proposals were integrated to change local public policies. The achievement of the proposed objectives required permanent social control and co-responsibility.

A joint fight for SRHR, showing the need for more sustainable collaboration to improve local politics (2000-2012)

In this initial phase, different stakeholders with significant motivation and interest in SRHR took action – individually and, eventually, collectively – to promote SRHR in Cuenca. In 2007, there was a proposal to modify the National Constitution, so the momentum was there to try and include SRHR in that Constitution. At this juncture, the participation of representatives from Cuenca was important, actively influencing the debate through the dissemination of objective information and the political claim for a rights and gender approach in the analysis and proposals for the National Constitution. Based on the activities carried out by each stakeholder in Cuenca, a network of contacts and inter-institutional relationships was woven, resulting in a willingness to work together.

The non-governmental organisation SENDAS took the lead. SENDAS can be considered a pioneer in Cuenca, as they have been actively promoting gender equality and SRHR for over 20 years. In 2007, they were joined by the University of Cuenca, more specifically the projects CERCA (Community-Embedded Reproductive Health Care for Adolescents) and HUMSEX (Promoting Sexual Health for Adolescents). Both projects are international and interdisciplinary collaborations with, among others, Ghent University and KU Leuven, respectively. Other important stakeholders in this phase were the local Health Council of Cuenca and the Ministry of Public Health.

Because of the shared objectives of these different stakeholders – generating common actions, inviting debate and raising awareness about SRHR – the time was right to join forces, especially given that the new penal code was also being discussed. All of these stakeholders wanted to place SRHR issues on the public agenda and to create more awareness among the population. Their actions required common efforts and resources to be sustainable in the long term, and thus the idea of institutionalising a network was born.

Building the REDSEX network (2012-2013)

Gradually, more local stakeholders, who had also promoted SRHR and had an interest in the development of SRHR policies, were approached, including members of the Economic and Social Inclusion Commission of the Municipality of Cuenca, representatives of educational institutions, NGOs, women's organisations and social organisations.

In addition, a coordinating team was formed, consisting of three representatives of different stakeholders: SENDAS (civil society), the University of Cuenca with the projects CERCA and HUMSEX (academia), and the Ministry of Public Health (national government). It was defined that the Cuenca Local Health Council would assume the Executive Secretariat.

¹ SENDAS. (2015). *Incidencia en la agenda local para la construcción de políticas públicas en derechos sexuales y derechos reproductivos en el Cantón Cuenca*.

Initially, common actions were identified to later propose the constitution of a legal framework that would allow the network to institutionalise these actions. In this context, SENDAS developed a proposal for a Municipal Ordinance that would guarantee the coordination, avoid double efforts and allow the achievement of ambitious goals for Cuenca, based on the sum of all institutional and organisational investments. The main goals of the Ordinance were the implementation of public policies aimed at the promotion, development and full experience of SRHR, as well as equal access to sexual and reproductive health care for the entire population of both urban and rural areas of Cuenca, with an emphasis on adolescents and young people.

It is important to emphasise that the approval of the Municipal Ordinance included a prior lobbying and advocacy process with members of the local council. At this time, the data and evidence generated by the organisations that made up the network were fundamental for capturing the attention of policymakers. While raising awareness among policymakers, it was also important to talk about non-controversial SRHR topics, in order not to polarise the discussion into moralistic positions that could generate resistance. Another key element in this process was the use of citizen participation mechanisms.

Finally, with the approval of the Ordinance, SRHR became a topic on the local political agenda, and an annual budget for the implementation of this regulation was allocated.

From paper to action (2013-2014)

In this phase, two strategies made it possible to sustain and operationalise the Municipal Ordinance and REDSEX. Firstly, a five-year plan was constructed to determine fundamental guidelines and to meet the specific goals of REDSEX. Secondly, the way in which the municipal funding would take place was specified. The management of government funds was quite a challenge due to the complexity of the processes, but specific agreements for the development of

the projects were signed. In turn, the institutions were to meet certain legal requirements, e.g. having legal status. Not all small stakeholders had this legal status, so SENDAS, being the NGO with the longest experience, acted as an umbrella for these projects. The University of Cuenca, meanwhile, was responsible for the research and the project budgeting.

Making a difference and setting an example (2014-2020)

During the last phase, the operationalisation and evaluation of the Ordinance, the main challenge was managing the budget in order to achieve the proposed goals. Because of the worrying indicators of sexual health among adolescents and sexual diversity groups, REDSEX has prioritised investments in edu-communication and promotion strategies for the prevention of adolescent pregnancies and maternal deaths, as well as in training and awareness strategies on SRHR, LGBTI rights and sexual violence.

So far, a significant budget has been successfully invested in these issues and good results have been achieved, especially in the prevention of adolescent pregnancies. Thanks to the support of the governmental departments of Education and Health, we were able to reach schools, colleges and even parents, thanks to a comprehensive community intervention.

The Ecuadorian State has still not designated a budget to carry out actions with respect to SRHR, but the Municipality in Cuenca has maintained or even increased the budget for SRHR promotion over recent years. This clearly shows how meaningful and effective the work of REDSEX is. Meanwhile, our experience of advocacy and work with respect to SRHR has also been adopted in six other Ecuadorian territories.

Lessons learned

- A network of SRHR stakeholders that can look at data collection and set out advocacy strategies together can stimulate strong SRHR policies. Together they can build evidence for the need of a legal framework and public investment in the issue.
- When proposals for public policies in SRHR arise from a collective action, they reflect the interests and needs of a wider group and are therefore more likely to have an impact and realise a transformation. Furthermore, greater stakeholder participation in decision-making processes will undoubtedly lead to a greater legitimacy of the construction of public policies.

- Political advocacy in SRHR requires a deep understanding of the policy process and context: What are the international frameworks related to the issue? What is the national legal framework? Is there political willingness? What are the political strategies, plans, programmes and policies promoted by the State? Etc.
- Advocacy processes in public policies related to SRHR do not only lead to legal change – or the guarantee of an established budget – but also to a stronger movement of organisations and institutions working on the issue.

REPRODUCTIVE FREEDOM IS CRITICAL TO A WHOLE RANGE OF ISSUES. IF WE CAN'T TAKE CHARGE OF THIS MOST PERSONAL ASPECT OF OUR LIVES, WE CAN'T TAKE CARE OF ANYTHING. IT SHOULD NOT BE SEEN AS A PRIVILEGE OR AS A BENEFIT, BUT A FUNDAMENTAL HUMAN RIGHT.

FAYE WATTLETON, REPRODUCTIVE RIGHTS ACTIVIST

The use of preventive HIV medication (PrEP) awaiting approval in Sub-Saharan Africa

SIMUKAI SHAMU (FOUNDATION FOR PROFESSIONAL DEVELOPMENT & UNIVERSITY OF WITWATERSRAND)

Sub-Saharan Africa (SSA) is experiencing a generalised HIV epidemic and has low levels of HIV testing, treatment and viral load suppression. Available data suggests that the region will not meet the UN's 90-90-90 targets unless more HIV preventive actions are taken. Pre-exposure prophylaxis (PrEP) for HIV has been identified as a new, safe and effective HIV prevention tool. It provides anti-HIV medication to HIV-negative people to stop them from becoming infected. The World Health Organization recommends its use for anyone at substantial HIV risk, as an additional method of prevention. Unfortunately, many Sub-Saharan African countries have not yet approved it and are therefore missing out on the opportunity to fight AIDS in the region.

The HIV epidemic in Sub-Saharan Africa

HIV remains a global public health burden, with unprecedented high incidence, prevalence and mortality regardless of gender or age. This constraint is highest in Sub-Saharan Africa. In 2017, 66% of the 5,000 new HIV infections per day were recorded in the region.

While the HIV incidence across the world is often highest in key populations, Sub-Saharan Africa is

experiencing a generalised epidemic with infections among young people and adults, male as well as female, and driven by heterosexual relationships.

The UN's 90-90-90 targets were introduced in 2014 to test, treat and suppress viral load in people living with HIV. It aims for 90% of all people living with HIV being aware of their status, 90% of all people with diagnosed HIV infection receiving sustained antiretroviral therapy, and of all those receiving antiretroviral therapy 90% having an undetectable viral load by 2020. Sub-Saharan African countries are particularly struggling to meet this target as their health systems are too weak to fully roll out treatment, which leads to a very slow uptake. For example, only 48% in Western and Central Africa knew their HIV status in 2017. Results for East and Southern Africa are slightly better, as three out of four know their status, but this still indicates a high number of people not having access to treatment.

What is PrEP?

Pre-exposure prophylaxis (PrEP) is a form of antiretroviral medication for HIV negative people. Research shows that the use of PrEP in conjunction with antiretroviral treatment for those already infected will significantly lower HIV infections among the population, as this medicine can help to keep the virus from establishing a permanent infection.

Strong and consistent evidence has shown that PrEP is highly efficacious in reducing HIV infections in high adherence situations among men who have sex with men as well as heterosexual men and women. Research also shows that PrEP can reduce new HIV infections among women in generalised epidemics by 30%. In Sub-Saharan Africa, individuals in serodiscordant relationships (where one partner is infected by HIV and the other is not), key population and adolescent girls and young women are especially likely to benefit from PrEP.

Therefore, as long as HIV vaccine trials are ongoing, the use of PrEP shows to be a very effective way to prevent HIV and can play a significant role in reversing the inability to meet the 90-90-90 UN targets.

Significant benefits

Research has shown that PrEP is safe for use and shows low incidence of acquiring HIV drug resistance. Its use is not associated with negative sexual risk behaviour, nor does it cause negative effects during pregnancy.

PrEP cannot prevent all sexually transmitted infections (STIs), as it was never developed to prevent other STIs except HIV. It should be part of a holistic approach, together with other preventive methods, such as regular HIV testing and condom use. However, PrEP does indirectly help prevent STIs, as PrEP users regularly visit health providers for HIV testing and experience a lower threshold to get information about STI prevention measures.

PrEP also gives its users a level of control over their bodies and health that is not generally achieved with condoms alone. Stigmatised key populations including men having sex with men, sex workers and less-empowered populations such as adolescent girls and young women may gain power over their bodies by experiencing full protection against HIV through the use of PrEP.

As HIV is sexually transmitted, it is most common among sexually active people in the reproductive age groups, many of whom still want to reproduce. Research found that PrEP can be used to protect pregnant women at risk of HIV or women planning to become pregnant. When it comes to using PrEP in the prevention of mother-to-child transmission, evidence from completed studies to date shows no increased negative child health outcomes at birth or soon after birth.

PrEP can be used while one is at high risk and be discontinued or suspended when risk levels subside. For example, if rolled out to the 15 to 25-year-old women and 24 to 35-year-old men in Sub-Saharan Africa who are most at risk, it can be discontinued when their partners' level of risk is lower or as users transit from adolescence and youth into adulthood.

Challenges

While the benefits and positive effects of PrEP are evident, we are also facing some concerns and challenges in its implementation.

First and foremost, a lot of scepticism remains, mainly because of a lack of knowledge. In 2015, following high-quality evidence, the WHO recommended the use of PrEP by all people at substantial risk of HIV infection. By June 2017, only 13 countries in Sub-Saharan Africa (global count = 49) had formally adopted the WHO's recommendation to put all people on HIV treatment, regardless of their viral load, while 12 countries in Sub-Saharan Africa had a policy on PrEP by June 2018. By 2017, 15 countries, including fewer than 10 from Sub-Saharan Africa, had approved Truvada® for PrEP.

Sub-Saharan African countries need to speed up their uptake of PrEP to ensure people at risk have access to this medication. One of the reasons for this slow uptake is the low understanding of PrEP by policymakers, health workers and the public. Studies show that only half of the policymakers and leaders in health care were well-informed.

A number of misconceptions also remain very persistent, for example the concern that people taking PrEP would engage more in increased risky behaviours such as multiple sexual partnerships, condomless sex, and not seeking health care as they feel protected while using PrEP. As mentioned above, research has shown the contrary.

PrEP protects against HIV infection when taken between seven and 21 days before risky intercourse. Raising awareness of this timing among its users is important to prevent them from engaging in sex before they have gained protection from the drug. Providing PrEP

information, education and communication to the general public and health workers is therefore required for PrEP roll-out.

Another challenge is the way in which PrEP use needs to be implemented in the health system. However, this challenge can easily be overcome by using the experience that was built up during the introduction of antiretroviral therapy in each country and setting up facility- and community-based HIV testing and counselling infrastructure as part of each country's health system. Each country should be prepared to distribute, market, create demand and supply, and manage PrEP.

AN AIDS-FREE GENERATION WOULD MEAN THAT VIRTUALLY NO CHILD IS BORN WITH HIV; THAT, AS THOSE CHILDREN GROW UP, THEIR RISK OF BECOMING INFECTED IS FAR LOWER THAN IT IS TODAY; AND THAT THOSE WHO BECOME INFECTED CAN ACCESS TREATMENT TO HELP PREVENT THEM FROM DEVELOPING AIDS AND FROM PASSING THE VIRUS ON TO OTHERS.

ANTHONY FAUCI, CHIEF MEDICAL ADVISOR TO PRESIDENT JOE BIDEN

Costs

PrEP has been found to cost less per averted HIV infections, quality/disability-adjusted life years, lives saved and also PrEP years per infections averted than some other HIV prevention methods used in the Southern African generalised epidemic.

Available evidence from systematic reviews shows that PrEP use in high-risk populations is a cost-effective addition to HIV prevention programmes. The exact level of cost-effectiveness of PrEP depends on a number of factors, including cost, the epidemic context, programme coverage and prioritisation strategies, participants' adherence to the drug regimen, and PrEP efficacy estimates. For example, in South Africa it is estimated that infections could be averted at a monthly cost of R264 (US\$ 17,4) per person. Models show a higher cost at the inception of the programme, but with time, and when more people take PrEP, these costs will come down. Cost calculations and implementation considerations should also factor in the dynamics of risk levels and the changing need for PrEP over a lifetime.

The marketing of the drug requires concerted efforts from politicians, stakeholders, health providers, leading behaviour change organisations and grassroots organisations, to meet people's concerns and to increase the demand and uptake of PrEP, which will in turn make PrEP more cost-effective. Forging relevant agreements with pharmaceuticals and the private sector could play a role in lowering drug costs and making PrEP available to populations in the fight against AIDS. Widespread use of the drug would make PrEP implementation affordable.

Policy recommendations

- Provide information, education and communication about PrEP safety, use, benefits and challenges to the general public and to health workers. Depending on what is appropriate for each country, this can be done in various ways, including social media (Facebook, Twitter, other online social

networking sites), traditional media outlets, roadshows at facilities and in community-based programmes.

- Ensure a good implementation in the health system by using successful experiences from the introduction of antiretroviral therapy, contraceptives and chronic care medicines which employ a broader mix of technologies to distribute products to all those who need them within their localities. This can focus on facility- and community-based HIV testing and counselling infrastructure.



PEOPLE AT RISK AND POLICYMAKERS HAVE TO MAKE A VERY RATIONAL CHOICE: WAITING UNTIL PEOPLE ARE INFECTED WITH HIV AND HAVE TO USE ANTI-RETROVIRAL DRUGS FOR THE REST OF THEIR LIVES, OR PREVENTING HIV WITH PREP AND KEEPING PEOPLE HIV NEGATIVE.

- Ensure the promotion and marketing of PrEP use as an HIV prevention tool together with other tools of choice to those at substantial risk.
- Define clear PrEP guidelines: Who should receive PrEP? How can PrEP be rolled out safely and effectively? How can PrEP clients be targeted successfully? How will the supply, distribution and implementation of PrEP be managed?
- Plan PrEP delivery models to ensure a strong and efficient supply in each setting or country.
- Plan, manage and sustain human resources and infrastructural requirements for PrEP distribution and sustainability.
- Develop role models and champions in PrEP use for the prevention of HIV in generalised epidemics in Sub-Saharan Africa.

I-SHARE, the International Sexual Health And Reproductive Health Survey during COVID-19

An interview with Gunta Lazdane — ANNEMIEK SEEUWS

The global COVID-19 pandemic has turned our world upside-down in 2020. Many restrictive social measures have been introduced to try to control the virus, but self-isolation, quarantine and cordon sanitaire measures may also have a profound influence on sexual and reproductive health. This is an aspect of the pandemic that has been given limited attention so far. The International Sexual Health And Reproductive Health Survey (I-SHARE) aims to combine online national surveys and global comparative analyses to assess the situation. The scope of the project is impressive, with over 30 countries taking part.

We talked about the project with Gunta Lazdane, Professor in Reproductive Health and Director of the Institute of Public Health at Riga Stradins University, an ANSER partner. Between 2003 and 2017, she was working at the WHO Regional Office for Europe as the Programme Manager for Sexual and Reproductive Health in the Division of Noncommunicable Diseases and Promoting Health through the Life-Course. She is coordinating the Latvian I-SHARE survey.

It could be said that the I-SHARE project is quite unique, as it is the first time such large-scale worldwide collaboration was set up during a time of crisis, especially without specific funding. Why did so many countries agree to participate nonetheless?

When we heard about ANSER's initiative to set up the I-SHARE survey we put ourselves forward immediately. We had already started some studies ourselves because a number of problems had been identified in other countries, e.g. reduced access to contraceptives, an increase in sexual violence etc., and we wanted to clarify the situation in Latvia. The geographical, economic and cultural situation differs in every country, as well as the level of lockdown. For example, Sweden and

Latvia are not that far apart, but the COVID-19 approach was totally different in both countries. I believe that is why so many countries were volunteering to collaborate on I-SHARE, even despite the fact not every team would receive funding for their work on it. The London School of Hygiene & Tropical Medicine and Ghent University developed the questionnaire, so individual ANSER members did not have to recruit any specific agencies to help them with that, which was a good thing. Everyone is using the same questionnaire, adapted of course to local specificities. For example, in Latvia we did not include questions on female genital mutilation because it's not really a problem we are facing here, compared to other countries.



Why did you and your team decide to join the survey?

Approximately two months after I-SHARE was already starting up there was a call from our National Research Programme (NRP) for a COVID-19 impact evaluation and the development of recommendations, in order to be able to better handle similar crisis situations in the future. Our small Latvian I-SHARE group – three medical doctors and three medical students – decided to apply. If we would not have been members of I-SHARE and ANSER I'm not sure we would have been brave enough to do so, or gotten the funding of the NRP.

I-SHARE in Latvia is a short project – six months – which speeds up the process. Besides that, we are part of a bigger project 'Impact of COVID-19 on health care system and public health in Latvia; ways in preparing health sector for future epidemics' and have the full support of Riga Stradins University. So yes, I am happy that we are part of I-SHARE, and that our young team members, young scientists who were really eager to participate, will receive some kind of remuneration for their work at the end of the project.

Did you face any challenges during the survey?

Latvia was among the first countries that started the survey. An important challenge was the development of the questionnaire, because in theory we have one official language, Latvian, but in practice quite a lot of people speak Russian too. Because sexual and reproductive health (SRH) is such a sensitive topic, especially sexual health, we really wanted to avoid any unnecessary political discussions so we included the option to answer the

questionnaire in Latvian or Russian. Of course, the London team had already done a lot of preparatory work, but still it took quite some time and work to translate the questionnaire – we really did not want to make any mistakes, because that may have led to a snowball effect. Our main objective was to reach as many respondents as possible.

Another challenge we faced was that we included qualitative research on top of the quantitative research, and it was a bit of a struggle to organise group discussions during the COVID-19 pandemic. We managed, but maybe in the future we would do things slightly different.

What is, in your opinion, the added value of networks such as ANSER in supporting this kind of research?

I think the academic background and the neutrality of ANSER are very important in this respect. Sexual health has not been defined by the UN, partly because there is so much diversity around the globe. So thanks to I-SHARE we can now write about sexual health more freely. The basic principle was not 'All countries *should* join the research' but 'If you *wish* so, if you are interested and ready to dedicate your free time to this study, you are welcome to participate'. I believe the topicality of the problem is a reason many countries were willing to participate.

ANSER focuses especially on the link between policy and research and emphasising the importance of those two parties listening to each other. That way, research can really make a difference for men and women out there. Is this also something you are working on, to ensure the results of I-SHARE are shared outside the academic network?

Yes, certainly. The academic level is actually only the third level we are working on. Of course we are developing research papers based on our national data, and we are looking forward to an international comparative data analysis of all participating countries, but we are also focusing on two other big groups: the public on the one hand, and the policymakers on the other hand.

As I-SHARE is an online survey, we had to explain to the public why it was so important for them to participate. Some critics were saying: "Come on, thousands of people are dying of COVID-19 and you want to talk about *sex*?" So we had to explain the importance of experience in SRH in emergency situations. As hospitals were getting full and many things had changed in society, you could argue that the COVID-19 crisis was close to a humanitarian situation.

Our goals were twofold: of course we needed the results, the answers to the survey in order to know how COVID-19 regulations and limitations had influenced people's lives, their access to contraceptives, their financial situation, how often they had sex and so on, but by inviting people to participate, by explaining why this was so important, we also wanted to ensure people understood the importance of SRHR.

We were very open about it, in order to reach as many people as possible.

For example, we used small postcards in Latvian and Russian to get people to participate. Our message was very accessible: "How did COVID-19 affect your sexual and reproductive health? If you are over 18 years old, please join us, it will only take 15 minutes of your time, you can use your computer, tablet, smartphone... to fill out the survey." We were also constantly monitoring the answers and when we noticed there was a lack of male participants we took action: I went to the national TV station to talk about I-SHARE and our younger colleagues worked through social media. Our researchers also wrote articles on SRHR topics for popular (women's) magazines, e.g. on COVID-19 and pregnancy, and some information from I-SHARE was already included in those articles. Riga Stradins University has a great PR team and the Latvian I-SHARE team had regular Zoom meetings, discussing ways in which to generate even more feedback and to actively engage the public. And of course this also works both ways: in the last week the survey was running I was on TV for a last call, and the producers asked me to come back when the survey was completed, to share the results with them and to give them some recommendations. We realised it was important to discuss results and to share recommendations, not only with experts but also with the public. Qualitative research included group discussions with mothers who had just delivered their babies, their partners, people living with HIV, and health care professionals who are providing maternal and emergency gynaecological care. But then we also had semi-structured interviews with policymakers, our third important group. We heard them and listened to their views and concerns. In the end we will submit reports to the Ministry of Education and Science, to the Ministry of Health and to the Ministry of Welfare.

Because of the large scope of I-SHARE there are a lot of partners involved from all around the globe. Has this collaboration given rise to new opportunities?

For one thing, COVID-19 has taught us some new communication skills. We have never used Zoom or Microsoft Teams on such a large scale before, so in a way COVID-19 has also created new connections.

I also want to mention an example of another collaboration as a result of our work on I-SHARE. We submitted an abstract for a conference on health and nutrition, because in the I-SHARE survey there is also a small chapter – just four or five questions – on nutrition. At the time when we submitted the abstract, there were only four countries that had finished the survey: Panama, Singapore, Argentina and Latvia. We immediately emailed them and they were quick to respond. Argentina let us know nutrition was not included in their survey, but Singapore and Panama agreed to submit a joint abstract for the conference. Our abstract was accepted and we hope to present the results in December. I am really looking forward to comparing the results on an international level. Some countries have limited access to alcohol during lockdown, whereas in Latvia the opposite happened: you can even order alcohol online now. It will be interesting to see the impact of these regulations, e.g. on the increase of violence, and I believe it can result in specific recommendations to really make a change that will impact lots of people's lives.

One of the Latvian I-SHARE team members is also a member of the International Federation of Gynaecology and Obstetrics (IFIGO) and a member of the scientific committee of their congress, which will be held in Australia next October. As I-SHARE

deals with women and very feminine questions, the results of I-SHARE in different countries and all the recommendations might be of interest to the conference, so we submitted a joint I-SHARE proposal for the congress as well. So hopefully the collaboration between teams and ANSER members will not stop when the survey ends.

What does the future look like?

The national part of the survey will be completed in January 2021, but after that we will still be part of I-SHARE internationally, and we are looking forward to appearing in high-level international publications. There is also a second wave of I-SHARE, including new countries who can learn from the first wave.

On the 27th of November we had a big webinar on I-SHARE in Latvia and we invited Kristien Michielsen from ANSER, to show our politicians that we are not alone in fighting for SHRH, that we are part of a bigger international movement.

If I-SHARE can prove that this approach and methodology lead to good results, and if people know how our results will impact their lives, how we can change lives and even save lives, maybe it will be easier to get proper funding in the future. In Latvia, SRHR is not a political priority at all. Maternal health, yes, but we are still fighting a lot of taboos concerning sexual health or the importance of family planning and contraception. That is why international support and joint research results can help. Your claim is much stronger if you are backed up by a worldwide network of people who affirm that your work is important and who support your research. I believe ANSER can really make a difference here as well.

**BIRTH IS NOT ONLY ABOUT MAKING BABIES.
BIRTH IS ABOUT MAKING MOTHERS,
STRONG, COMPETENT, CAPABLE MOTHERS
WHO TRUST THEMSELVES AND KNOW
THEIR INNER STRENGTH.**

BARBARA KATZ ROTHMAN, PROFESSOR OF SOCIOLOGY, CITY UNIVERSITY OF NEW YORK

Respectful maternity care – a joint exhibition between Ghent University Hospital and the Central Hospital of Maputo

ANNA GALLE (INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GENT UNIVERSITY)

PhD student Anna Galle set up a photo project about respectful maternity care in Mozambique, with the support of ANSER members Universidade Eduardo Mondloane and ICRH Mozambique. The photos were taken by local photographer Tina Krüger. With this exhibition they want to highlight the strength of women but also their right to a respectful birthing experience. The first part shows some unique stories of women and their families. The second part highlights women's rights, together with some good practices that were adopted in the Central Hospital of Maputo to guarantee these rights. In addition, two scientific publications about respectful maternity care were produced in collaboration with UEM and ICRH Mozambique.

Empowering women

In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families. They also represent a time of intense emotions and vulnerability. This photo project aims to show the experience of women who gave birth in the Central Hospital in Maputo, highlighting their

strength and positive experience they had. The Central Hospital of Maputo, where this project took place, became an example in terms of quality of maternity care. Women come from all over the country to give birth in this hospital because of its good reputation for respect and high quality of care.

This exhibition, which is currently on show in both Belgium and Mozambique, was part of a bigger project about respectful maternity care. This consisted of the training and sensitisation of health care providers, as well as conducting a prevalence study about the occurrence of disrespect and abuse in different facilities.



Fundamental human rights

For this photo project we followed 10 women from the moment they entered the hospital until the moment they left. We bonded with them and, with their full consent, took photos during their stay. Although they were all in pain, were often scared and sometimes felt vulnerable, all of them left the hospital with positive feelings and felt that their new baby made all their efforts worth it. We kept in touch with the women after the project and they all received their own pictures. Besides telling their stories, we also highlight the changes

and improvements in the hospital by including testimonies of the mothers of the new mothers, that had given birth in the hospital 20 years ago.

The final result of this project is a photo exhibition in the corridors of the hospital. The photos are accompanied by a list of the rights that women should have during labour and delivery. Through this exhibition we want to make both providers and patients aware of the right to a respectful birthing experience for every woman all over the world.



EVERY WOMAN HAS THE RIGHT



1.
to be free from harm and ill treatment.
.....
2.
to information, informed consent and refusal, and respect for her choices and preferences, including the right to her choice of companionship during maternity care, whenever possible.
.....
3.
to privacy and confidentiality.
.....
4.
to be treated with dignity and respect.
.....
5.
to equality, freedom from discrimination, and equitable care.
.....
6.
to healthcare and to the highest attainable level of health.
.....
7.
to liberty, autonomy, self-determination, and freedom from coercion.

Older adults: forgotten in research, policies and health care practices regarding sexual violence

ANNE NOBELS & INES KEYGNAERT (INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GHENT UNIVERSITY)

Older adults are often neglected in research, policies and practices – also in terms of sexual health and sexual violence. With the UN-MENAMAIS study, the first gender- and age-sensitive sexual violence prevalence study in Belgium, the authors want to raise awareness about this public health problem and to convince policymakers to take adequate measures.

Older adults: an overlooked group in society

Older adults are increasing in number worldwide. According to Eurostat, it is estimated that 30% of the European population will be 65 years or older by 2060. Despite this growing proportion of society, older adults are often overlooked in research, policies and health care practices, which could be seen as an expression of ageism. Ageism is the stereotypical, often negative, construction of the image of older adults, ageing and old age. Research shows that age-based discrimination and ageism are still widespread within research, policies and health care practices. This was confirmed during the first wave of the COVID-19 pandemic, in which older adults were misrepresented and undervalued in the public health discourse surrounding the pandemic. Amnesty International Belgium reported human rights

violations of older adults in nursing homes during the first months of the pandemic in Belgium. This negative treatment of older adults and the representation of older age may be internalised by older adults, which in turn contributes to a reluctance of older adults to seek medical and psychosocial help.

Sexual health and sexual violence in older adults

Since the 1990s, sexual violence has increasingly been considered a public health problem of major societal and judicial concern. The World Health Organization (WHO) defined it in 2015 as “every sexual act directed against a person’s will, by any person regardless of their relationship to the victim, in any setting”. In public health research regarding older adults, sexual violence is studied in the broader context of elder abuse and neglect, which the WHO defines as “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. Elder abuse and neglect comprise a broad range of abusive behaviours, including psychological abuse, financial abuse, physical abuse, sexual abuse and neglect. A recent meta-analysis by Yon and colleagues shows that one in six older adults worldwide seems to be affected by elder abuse and neglect, and 0.9% of older adults were sexually victimised in the past

year. However, only 16 of 52 included studies addressed sexual violence, indicating a lack of attention towards the topic in research. Moreover, we argue that sexual violence prevalence rates in older adults are likely to be underestimated because of methodological shortcomings in current studies.

Furthermore, we found that recent United Nations (UN) and WHO policy documents dealing with sexual and reproductive health, rights and ageing neither acknowledge sexual violence in older adults as a potential health risk that needs to be addressed nor mention older adults as a potential risk group for sexual violence. Nevertheless, all these policies emphasise the importance of providing information on sexual health to older adults, recognise a need for sexual health services directed towards older adults, and call for the elimination of all forms of elder abuse and neglect. In spite of the increased attention of policymakers towards sexual health in old age, in practice the sexual health needs of older adults remain mostly unmet. Research shows that health care workers tend not to address sexual health proactively when working with older adults, as they feel it is not a legitimate topic to discuss with this age group. Since they lack the language and skills to adequately address it, they are afraid of offending their patients. In addition, older adults are reluctant to seek (medical) help for sexual health problems since they presume sexual changes are normal at this older age.

Sexual neglect: a form of sexual violence?

It seems that scientists, policymakers, health care practitioners and even older adults themselves are responding to stereotypes of the ‘asexual older adult’, an ageist depiction that is often portrayed in the media and has become a wide societal image. In 2017, the CIUSS group of scientists, practitioners and policymakers in Quebec, Canada, developed the concept of ‘sexual neglect’, which they define as “a failure to provide privacy, failure to respect a person’s sexual orientation or gender identity, treating older

adults as asexual beings and/or preventing them from expressing their sexuality, etc.” Therefore, we believe that treating older adults as asexual beings could in itself be seen as an act of violence. Furthermore, the existence of sexual neglect can provide us with a greater understanding of why sexual violence is not taken into consideration in older adults. In a way, current researchers, policymakers and health care practitioners are guilty of ‘sexual neglect’ themselves, by ignoring older adults as a possible risk group for sexual victimisation and forgetting them in research, policies and practices regarding sexual violence. The inclusion of ‘sexual neglect’ into the definition of elder abuse and neglect, as was proposed by scientists, practitioners and policymakers from Quebec, could be a step towards the recognition of older adults as sexual beings, which in turn could help raise awareness of sexual victimisation in this older age group. Moreover, we argued in *The Lancet Global Health* that sexual neglect should be included in the WHO definition of sexual violence. Using this broad definition, including sexual harassment, sexual abuse without penetration, (attempted) rape and sexual neglect, could yield a more realistic picture of the magnitude and nature of sexual violence in later life. We assume that this in turn should lead to better and more tailored care for future victims and the development of preventive measures for the general public.

UN-MENAMAIS: the first gender- and age-sensitive sexual violence prevalence study in Belgium

Since 2017, we have been coordinating the UN-MENAMAIS study, which aims to achieve a better understanding of the mechanisms, nature, magnitude and impact of sexual violence in Belgium. It is the first study worldwide to research the prevalence and impact of sexual violence in older adults. In the first phase we interviewed 513 randomly selected adults of 70 years and older across Belgium. Our data shows that over 40% of our respondents had been sexually victimised during their life, and more

IT IS UNTHINKABLE TO ALLOW COMPLETE STRANGERS, WHETHER INDIVIDUALLY OR COLLECTIVELY AS STATE LEGISLATORS OR OTHERS IN GOVERNMENT, TO MAKE PERSONAL DECISIONS FOR SOMEONE ELSE.

SARAH WEDDINGTON, ATTORNEY, LAW PROFESSOR
AND FORMER MEMBER OF THE TEXAS HOUSE OF REPRESENTATIVES

than 8% had experienced at least one form of sexual violence in the past 12 months. The second phase of the UN-MENAMAS study is currently ongoing and concerns in-depth interviews with older victims on the long-term impact of sexual victimisation. The results of both phases will be used to formulate recommendations for future policies and practices and to provide sensitisation scripts. Based on our preliminary findings, we recommend that policymakers recognise older adults as a risk group for sexual victimisation in the national and regional action plans regarding (sexual) violence and elder abuse and neglect. To better detect signals, prevent, mitigate and respond to sexual victimisation in old age, professionals working with older adults urgently need capacity building through training, detection tools and care procedures. Finally, sensitisation of society in general is essential, emphasising the need for positive sexuality and respect of intimacy in older adults as well as the prevention of sexual victimisation and other forms of violence against older people.

Conclusion

Although recent research shows that people of 70 years and older are vulnerable to sexual victimisation, policies and health care practices regarding sexual violence in older adults are non-existent. Furthermore, by not including 'sexual neglect', current definitions of elder abuse and neglect and sexual violence do not grasp the complexity of sexual violence in older age. Not recognising older adults as a potential risk group for sexual violence may deprive older victims of adequate care. We call upon policymakers to include 'sexual neglect' in the definitions of elder abuse and neglect and sexual violence, and to acknowledge older adults as a risk group for sexual victimisation. This could lead to a greater awareness of this public health problem among researchers, health care professionals and the general public, and consequently to the development of preventive measures and more tailored care for older victims of sexual violence.

Working towards eradicating the medicalisation of female genital mutilation/cutting

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Female genital mutilation/cutting (FGM/C) comprises all procedures that involve the partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. Approximately 200 million women and girls globally are estimated to be survivors of FGM/C. The practice is deeply rooted in sociocultural norms and is considered harmful and a violation of human rights that should be eliminated in all forms.

The medicalisation of FGM/C is practiced in the belief that it is a harm-reduction strategy and as such its prevalence has increased in many countries. However, there is no empirical evidence that medicalisation reduces the negative health consequences associated with FGM/C. Several countries have already legislated to ban the medicalisation of FGM/C, with mixed outcomes and limited success in reducing the practice. Further work needs to be done to eradicate FGM/C, including the medicalisation of FGM/C by challenging the cultural and social factors that support it. With efforts towards the elimination of

FGM/C, and in particular its medicalisation, it is essential that a multi-pronged approach is taken when working on solutions, including at policy level. This should include human rights, health and legal perspectives.

What is female genital mutilation/cutting?

According to the World Health Organization (WHO), FGM/C comprises all procedures that involve the partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons.

Depending on tradition, FGM/C can be performed on girls and women at any stage of their life, including during childhood, adolescence and even at some point during their reproductive age. However, there is evidence that traditions are changing and that cutting is also taking place on infants and baby girls. But the majority of girls are cut between 8 and 12 years of age. It is estimated that over 200 million women alive today have been subjected to FGM/C and that over three million girls are at risk every year. FGM/C is mainly practised in Africa, the Middle East and Southeast Asia. Nevertheless, it is important to note that due to immigration from countries

where FGM/C is the cultural norm, it has become increasingly present in Europe, Australasia and North America, and thus has become an issue of global concern.

A closer look at the sociocultural reasons under which FGM/C is practised shows how they vary significantly from one region and ethnic group to another, but they are all deeply rooted in patriarchal traditions which are oppressive to women and girls. In general, the reasons for its perpetuation can include the following:

- Conforming to social norms, tradition and as a rite of passage to adulthood and womanhood

- Securing marriageability and controlling female sexuality
- Upholding cultural norms with respect to hygiene and aesthetics
- Believing the practice has religious foundations and merit

FGM/C is a culturally embedded practice, enforced by community sanctions, often involving the discrimination of girls and women who have not been subjected to FGM/C and ostracising them from their families and communities.

FGM/C is often carried out by traditional circumcisers or traditional birth attendants, who are highly respected in their communities. Yet, in

IS THE MEDICALISATION OF FGM/C A WAY TO REDUCE HARM OR A HUMAN RIGHTS ABUSE?

Medicalisation creates the impression that FGM/C can be performed safely and is condoned by respected medical professionals, reducing the motivation of parents to abandon the practice. This eventually could lead to the legitimisation and institutionalisation of FGM/C. It is believed that medicalisation of FGM/C will have a negative impact on the gains achieved in the campaigns to abandon the practice.

Whilst not empirically proven, medicalised FGM/C is believed to minimise (though, not avoid) some of the short-term physical consequences of FGM/C. However, FGM/C itself has no perceived health benefits, and women have to live with the effects of FGM/C for the rest of their lives. Moreover, some of the long-term effects, such as mental health implications, are poorly understood. Additionally, health professionals performing FGM/C in order to provide a safer setting for the procedure are ignoring the human rights issues associated with FGM/C, including the right to freedom from violence and discrimination, amongst others.

Medicalised FGM/C is often believed to involve less invasive forms of FGM/C and/or have less negative health consequences. If medicalised FGM/C is carried out in a sterile environment, by trained professionals and with anaesthetics, the acute complications can be minimised, although the opposite has also been documented. In Indonesia, for instance, there is anecdotal evidence that midwives are performing more invasive and painful forms of FGM/C than traditional practitioners.

REFLECTING A SOCIAL NORM AND USED TO JUSTIFY FINANCIAL GAIN

Health professionals who carry out medicalised FGM/C often share the same social norms and beliefs regarding FGM/C as the communities they are working in, and resisting the pressure and demand from the community to carry out the procedure might be challenging. This has been exemplified through a study in Nigeria, which showed that four out of five health professionals who performed FGM/C had also cut their own daughters. Additionally, another study from Sudan concluded that medicalisation is mainly fuelled by the demand from communities that medical professionals serve.

The capacity to make financial gains for both health professionals and the girls' families by performing FGM/C is also relevant, as FGM/C can bring extra income to the health care professional and ensure a higher bride price when the girl gets married. Health professionals' motivation is potentially reinforced by the fact that money obtained by performing FGM/C can become a source of income for themselves.

recent decades, communities have increasingly been turning to health professionals to perform FGM/C, in the belief that medicalisation reduces the health risks for their girls.

The World Health Organization (WHO) distinguishes four main categories of FGM/C:

- **Type I:** partial or total removal of the clitoris and/or the prepuce.
- **Type II:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **Type III:** narrowing of the vaginal orifice by creating a covering seal by cutting and re-positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). If performed after giving birth this form of FGM/C is known as reinfibulation.

- **Type IV:** all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

FGM/C does not have any health benefits. On the contrary, it results in many adverse health outcomes, and is the cause of many immediate health consequences such as death, pain and bleeding as well as long-term effects, including, but not limited to: urinary difficulties, fistula, menstrual problems, sexual dysfunction, fertility issues, and pregnancy-related complications, including stillbirths and mental health difficulties.

For the reasons presented above, FGM/C is internationally recognised as a form of sexual and gender-based violence and as such is a violation of women's human rights, constituting a severe form of discrimination against women and girls. All forms of FGM/C, including medicalised FGM/C,

are classified as a form of torture and an inhumane procedure that is prohibited by international law and conventions.

What is the medicalisation of female genital mutilation/cutting?

The WHO defines FGM/C medicalisation as those situations in which FGM/C is practised by any category of health professionals, whether in a public or a private clinic, at home or elsewhere, at any point in a woman's or girl's life.

Medicalisation of FGM/C is escalating in many countries despite the growing number of states legislating against the practice. It is estimated that around 16 million women between the ages of 15 and 49 living with FGM/C report having been cut by a medical professional. According to UNFPA, medicalisation rates of FGM/C are above 10% in 8 countries amongst girls aged under 14 years (Djibouti, Egypt, Guinea, Iraq, Kenya, Nigeria, Sudan and Yemen). Medicalisation of FGM/C

amongst girls aged under 14 years is particularly high in Egypt where 78% of FGM/C on this cohort was performed by a healthcare professional, 77% in Sudan and 31% in Guinea. In Indonesia 62% of girls under the age of 11 years living in urban areas have been subjected to medicalised FGM/C.

This increase in cases of medicalised FGM/C has been mainly attributed to the fact that the early campaigns against FGM/C were centred on stressing the negative health consequences of the practice, the so-called health approach to ending FGM/C. It is speculated that this approach has unintentionally led to the medicalisation of FGM/C as a means of reducing the harmful effects of FGM/C when performed by a health professional.

United Nations organisations, including the United Nations Population Fund (UNFPA) and the WHO, healthcare professional associations and civil society organisations, such as the END FGM European Network, have taken a clear stance against medicalisation and deemed the practice

WHEN IS FGM/C DEFINED AS A MEDICALISED FORM OF FGM/C?

Medicalisation is not always defined in the same way. It is sometimes considered to include less invasive types of FGM/C, such as pricking, promoting them as 'harm reduction' procedures and often documented in Africa as well as countries in the global North. There is also some discussion on whether the use of medical instruments, antibiotics and/or anaesthetics by traditional practitioners should be considered as a form of medicalised FGM/C. Data on this is notably lacking, and only anecdotal evidence is available.

Finally, it is also important to note the difficulty of proving medicalised FGM/C in a court of law. A good example of this is a court case in the UK in which a doctor was prosecuted, but not convicted, for the reinfibulation of a woman following the birth of her baby. He stated the operation was necessary to stop the woman from bleeding heavily.

CULTURAL RIGHTS VERSUS HUMAN RIGHTS?

Because FGM/C is strongly embedded in traditional and cultural norms it poses a serious challenge to the implementation of legislation that aims to protect the human rights of women and girls by criminalising FGM/C. This has been demonstrated in Kenya, where some communities claim that their cultural right to perform FGM/C takes precedence over the law banning FGM/C.

FGM/C is considered by many as a cultural right, which makes it resistant to any calls to respect the rights of women and girls, as the rights of females are considered subordinate to the cultural rights of the community in general. Using the argument of the protection of cultural and traditional rights, any legal framework aimed at ending FGM/C gets diluted. This underscores the importance of sensitising and creating awareness among FGM/C-practising communities about the human rights implications of the practice, rather than just relying on a legal approach.

unacceptable, highlighting the importance of stopping medicalisation if FGM/C is to be eradicated. However, despite strong consensus between global expert bodies, the rise in medicalisation rates shows that it is not a straightforward issue that can easily be resolved.

There are still ongoing debates around FGM/C and its medicalisation that stem from the fact that people want to comply with social norms supporting FGM/C, but want to do so safely. Likewise, health professionals do it because they are part of the community and share these same social norms, and/or for financial gain as health systems in some of these high-prevalence countries are very fragile.

Recommendations for ending the medicalisation of female genital mutilation/cutting

Considering the debates surrounding medicalised FGM/C, ANSER is putting forward the following policy recommendations:

- Implement existing human rights legislation to safeguard girls' and women's bodily integrity and protect their human rights. The UN Special Report on Torture (2008), the African Charter on Human and People's Rights (The Banjul Charter), the Protocol on the Rights of Women in Africa (Maputo Protocol), the African Charter on the Rights and Welfare of the Child, the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), and the European Convention for the Protection of Human Rights and Fundamental Freedoms, can be a basis to start from.
- Include FGM/C and the human rights violations of the practice, even if done by health professionals, in the curricula of

health professionals to create awareness of the practice and its consequences as well as to encourage adherence to FGM/C protocols, guidelines and legislation.

- Ensure health professionals are given the tools and training to untangle professional norms from their personal perceptions regarding FGM/C, to understand how performing FGM/C breaches their Hippocratic Oath and non-maleficence principle, and to uphold the 'do no harm' principle.

- Acknowledge health care providers as role models, respected members of their communities and strong agents of change for ending medicalised and traditional FGM/C, and support them to reach out to legal stakeholders, religious leaders, community leaders and the general public.
- Provide resources and financing to carry out research on the medicalisation of FGM/C. Generating evidence-based information will assist in guiding public policies and programmes that contribute to the ending of FGM/C and its medicalisation.

**FROM THE WOMAN WHO MUSTERS
THE COURAGE TO ASK HER HUSBAND
TO WEAR A CONDOM, COUNTER TO CULTURAL
PRESSURES, TO THE WOMAN IN PARLIAMENT
WHO DEMANDS ACCESS TO AFFORDABLE
REPRODUCTIVE HEALTH SERVICES
FOR WOMEN WHO NEED THEM MOST,
DARING KNOWS NO SCALE OR STATUS.**

—

PURNIMA MANE, PRESIDENT AND CEO OF PATHFINDER INTERNATIONAL

Summer School Ghent: welcoming SRHR students from all over the world

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**SOFIE THIELEMANS, DARA DE SCHUTTER, REMI MOERKERKE & LOUIS DE BACKER
(SUMMER SCHOOL, GHEENT UNIVERSITY)**

Summer School Ghent is a student-based project, founded in 2009 through Ghent University. We are a team of students who organise two summer schools, one about sexual and reproductive health and rights, and the other about health and globalisation. Each summer, we welcome students from all over the world for this 12-day educational programme, full of interesting lectures and workshops, taught by renowned international experts in the field. The courses cover topics such as family planning, gender, abortion, LGBTQ, human rights, sexual violence, health inequ(al)ities and many more.

As it is our goal to reach a very wide range of students from different countries, but also from different study majors, our participants include not only medical students, but also post-graduates and PhD students, from a wide range of faculties, such as medicine and health sciences, psychology, law and political and social sciences, as well as health care workers, lawyers etc. This mix of nationalities and educational backgrounds allows these participants to socialise with students from different cultures and discuss opinions concerning ethical issues and legal

frameworks. As well as an interesting educational programme, we also provide a social and cultural programme so that the participants can experience Belgian culture to its fullest in our beautiful city Ghent, while getting to know one another as well as our team members.

Partnership with ANSER

For several years now, we have had a partnership with ANSER. Thanks to ANSER and the continued guidance of professor Olivier Degomme, we have had the honour of welcoming numerous experts on the topic of sexual and reproductive health and rights to our summer school. The wide interdisciplinary character of the network is something we aim to reflect in our educational programme, and is often the greatest enrichment of our summer school that former participants look back on, as you can read more about further on. In addition to this guidance, ANSER has also supported us financially, for which we are immensely grateful. It allowed us to keep our summer school accessible for students from all different social backgrounds, and therefore enabled us to create a very interesting and diverse group of participants each year.

Our future plans

The world is ever changing, and so are we. Every year, our summer school team looks for new ways to improve our project. In these uncertain and challenging times, our focus lies on becoming

more flexible, thereby enabling us to anticipate all possible circumstances. We are therefore proud to inform you that next summer, for the first time, we will also be hosting an online version of our educational curriculum, which will be accessible to students from all over the world via webinars. Because accessibility remains one of the most important values of our summer school, we would also love to introduce and are slowly working towards developing a scholarship system, which would enable an even wider range of students to attend. And finally, we are looking for ways to engage in partnerships and join forces with other summer schools and interesting projects. If this year has taught us one thing, it would be that when we come together, we can reach new heights.

Meet our students:



Jeric

"I was just a second-year student when I decided to take a summer school abroad to broaden my knowledge, widen my perspective and, at the same time, have fun and de-stress from med school. During that time, a lot of quality universities abroad offered a summer school programme, each with different and interesting topics, but what made me choose the Ghent University initiative was the fact that it was the only one that satisfied all of my predefined objectives. After attending the summer school, I was appointed as the local officer for the Standing Committee on 'Sexual and Reproductive Health and Rights', a local member organisation of the Asian Medical Students' Association in the Philippines. There I was able to share what I had

learned during the summer school, and I had the opportunity to contribute to a solution for some of the prominent issues concerning this topic in our country.

Before I attended the summer school, my knowledge and opinions regarding sexuality were limited to following and respecting the LGBTQ+ movement. But having attended the summer school, I can now say that I am aware of a lot more factors to consider when talking about sexuality, and I realised that I need to educate myself more regarding this topic.

Sexuality is much more than the act of having intimate intercourse, it is more about sexual thoughts, feelings, behaviours, consent and cultural influences. We also need to be aware of its effect on mental health, especially when people are unsupported, misunderstood, or experience discrimination and inequality because of their preferences. When I look at my country, the Philippines, I am now more aware of the numerous issues regarding sexuality that need to be addressed. Before, I only saw the tip of the iceberg.

Attending this summer school has been one of the best decisions of my life. Not only was I able to fulfil my objectives, but the whole programme exceeded my expectations. I got to interact with participants from different countries, attend interesting lectures given by experts, and each of the topics was able to change me and make me more aware, have a more open mind, and a more adaptive and understanding perspective."

Jeric John C. Ildefonso, a medical student and now a clerk/intern at Saint Louis University-Hospital of the Sacred Heart, Baguio City, Benguet, Philippines, attended the summer school in 2019.

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Maja

"I first heard of the summer school in Ghent through a friend of mine who attended it the year before. She had such lovely things to say about her experience that I decided to see for myself. Although the students attending are different each year, the experience I had could be described as very similarly to hers, which only proves that the organisers of the summer school manage to keep the quality on point each year.

The summer school broadened my views on medicine. The lectures I attended during the summer school were much more related to the social aspects of medicine – medicine for people facing social inequality. We are all aware that some people require special recognition and attention in order to be able to live a life with the highest possible level of health. Although we might not always know how to provide the best appropriate health service for them, through learning about the specific needs of individuals (such as considering the language barriers and religious beliefs) we can give them the best treatment for them.

Another important aspect of the summer school was that the multicultural environment allowed me to unlearn the subconscious cultural unfamiliarity I am accustomed to because I live in a rather small country that is not a cultural melting pot. Each lesson included students talking about the situation in their home countries, which differed quite a bit from the experiences in my own environment. That was perhaps the most valuable knowledge I received during the summer school. Apart from knowledge, the summer school also provided connections. The fact that I met

some of the loveliest individuals has made me incredibly happy and pushes me to travel around the world to see them again."

Maja Osojnik, a Slovenian medical student, attended the summer school 'Health & Migration' (now: 'Health & Globalisation') in 2019.



Maria

"I had never participated in an interdisciplinary summer school before, so I felt this was a great chance to broaden my research perspectives and experience the fruitfulness of the interdisciplinary approach. I chose this summer school because it focused on the topic of my research interest – human reproduction. Each lecture was given by an expert/professor in the field, indicating the high quality of the information received. Also, the price was affordable for students compared to other summer schools in Europe, and Ghent is one of the most beautiful cities I've ever seen. After the summer school, I decided to continue working in the sphere of human reproduction and medicine. Now I am working on a PhD in health care in which I closely interact with professionals beyond social sciences."

Maria Denisova, a Russian sociology student, attended the summer school in 2019.

Linking research and policy: understanding the importance and relevance of the Centre for Adolescent Health Research

— VIOLA N. NYAKATO & ELIZABETH KEMIGISHA
(MBARARA UNIVERSITY OF SCIENCE AND TECHNOLOGY – MUST)

The Centre for Adolescent Health Research (ADHERE) is a collaborative multi-country interdisciplinary research initiative involving different institutions whose primary focus is young adolescent health research. Young adolescence (ages 10-14) is a critical developmental period, yet it is sorely neglected in research and policy. Young adolescents are at the beginning of major physical, cognitive, emotional and social changes that will set the course for a lifetime of health behaviours, but they have been largely an invisible group in global health research. The Centre for Adolescent Health Research aims to change this. It will bring together adolescent health experts to provide an enabling environment, and support capacity building for adolescent health research. The community will be engaged through a Community Advisory Board and Stakeholder Meetings for buy-in, cultural appropriateness and sustainability. The Centre will have a physical office at Mbarara University of Science and Technology but will also act as an inter-institutional hub for virtual engagement.

We talked about the relevance of setting up this Centre with DN, Assistant Commissioner for Adolescent Health and School Health from the Ministry of Health; HS, Commissioner for Career Guidance from the Ministry of Education and Sports; RM, Principal Social Development Officer in Charge of Family Affairs from the Ministry of Gender Labour and Social Development; and BM, Archdeacon of the All Saints Church in Mbarara City.

Why do you believe it is important to set up the Centre for Adolescent Health Research in Mbarara? What difference can it make?

DN, Assistant Commissioner for Adolescent Health: "I think the Centre is going to be a very good contribution to policy and everything that we do around adolescent health. We believe it's important to make decisions based on evidence and research, so we definitely want to support this project. We also know how dynamic adolescent issues can get. For example, last year we were not talking

about teenage pregnancies, but as an effect of COVID-19 we suddenly saw the numbers increasing."

HS, Commissioner for Career Guidance: "Indeed. There are so many changes around adolescent health, so many new things are coming up. The advantage of having a specialised research centre is that it will help us to understand emerging challenges among young people. I have recently heard of things I never imagined before: sex parties, extreme cases of cyber harassment, girls selling their virginity and so on..."

Another issue, and one that is often overlooked, is that of menstruation hygiene management. Our surveys indicate that it's a huge factor leading to school dropouts. I believe the Centre has an important role to play in tackling these challenges, in informing and supporting the young and maybe even their parents. I also think the Centre can help us to come up with innovations in terms of communication, because it's very important to use the right language to talk to adolescents. The Centre should be able to tell us which language we need to use when talking to adolescents, which type of people interact best with them – peers or adults? – or through which channels we can reach them best – their smartphones, the internet, the radio or TV, and so on. If policy is to work, then it must be based on evidence. And if we are to get evidence, then evidence must obviously be based on research. So if we are talking about evidence-based policy interventions, this Centre will definitely contribute to that.”

RM, Principal Social Development Officer in Charge of Family Affairs: “Our colleagues from the parenting and family unit are finding it very difficult that they don't have enough information or statistics to base their plans on, so I'm convinced the establishment of the Centre can help us in getting all the evidence and information we need. And it works both ways: we can also use the Centre to share our information with the public. For example, on the issue of menstruation hygiene, I would advise empowering the parents and ensuring that they help their adolescent children, because one word from a parent sticks much more than a word from any other person. So I agree with HS that we should also use the Centre to involve the parents.”

How should the Centre for Adolescent Health Research respond to community needs?

HS: “The community often shows us what they need, but we also know that there are restrictions and things they don't talk about when it comes to adolescent health. So if there's research going on thanks to this Centre, it can help us to dig deeper into some of the community issues that are not very easy for the community members to discuss. Often policies are implemented that we believe will help people, but just as often these programmes have failed. Whereas, when participants have been involved, when they were asked to identify their problems and to suggest possible solutions, policies have been much more successful. It is our role as policymakers to support you and your research to make this possible.”

BM, Archdeacon of the All Saints Church in Mbarara City: “I don't think the Centre should exclusively focus on issues of SRHR, but also include training for the community on communication, parenting, career guidance etc. We should aim to train children in such a way that they can, in turn, train their own children later on, in order to realise changes in the next generation. Today, parents have no time to talk to their children anymore, or only when it is too late. They often wait for a situation such as a teenage pregnancy and start to blame the child for what has occurred, but there is no initiative to provide the child with adequate knowledge and skills to prevent such a situation. We should encourage parents to communicate with their adolescents, especially in school holidays. I think the Centre might also play a role in this.”

Can you think of other relevant tasks or roles for the Centre?

HS: “I think capacity building is also very important. The capacity gap is always there. First of all in our schools, we rely on teachers, but they have not been trained in adolescent health, so they need to be supported in that. Let's take for example the situation we are in after COVID-19: lots of girls are returning to school pregnant, and we are saying: 'Let them continue their education', but these adolescents – both boys and girls – are overwhelmed by psycho-social challenges. A teacher who has been trained to teach chemistry and biology is unlikely to know what to do. We have already tried to empower them with respect to HIV, we have given them basic skills on counselling, but we need to do more. The same goes for health care workers. Somehow we keep assuming they already know everything about adolescent health, but they all have their own area of specialisation – if I'm a paediatrician I may not know much about HIV either.”

DN: “First of all I think we need to make adolescent health more prominent in our training. In the future I hope to see a bachelor in adolescent health, or at least some field of study related to young people's health. I know there have been suggestions to upgrade the curriculum in the paediatrics section to consider adolescent health as well. It would be good to standardise the curriculum with other universities, as this would help future practitioners to have some guidance on adolescent health. I also think it would be good to have specific adolescent health-oriented capacity building modules for health workers and people already in service.

Maybe at some point we will even have adolescent health nurses. But how do we get there? We need to have clear packages and clear training institutions.”

RM: “Another role of the Centre would be advocacy, I think. Let me give you an example: we are trying and struggling to develop a family policy, but we don't have statistics. Not even the Uganda Bureau of Statistics (UBOS) has these. We are trying to ensure that they call a household a 'family', but if there were research that explains what a family in Uganda is today, it would be a basis for us to justify why we are talking about a 'family'. I also think it's important to carry out independent research to show the real effects of our policies and programmes on families.”

What is, in your opinion, the added value of networks such as ANSER?

HS: “Networks are about benchmarking each other. We keep wondering what the others are doing, how they are doing it, what challenges they are facing etc. But it's also about knowledge sharing, because we have different sources of information, different funders and so on. So yes, networking is something we should continue thinking about as we proceed with this project.”

Integrating post-abortion family planning in China (INPAC)

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Around nine million induced abortions are conducted every year in China. This large number of abortions is primarily a result of incorrect, inconsistent or non-use of contraception. One third are repeat abortions. Unsafe and repeat abortions are associated with a high risk of injury, long-term physical and psychological morbidity and a heavy social-economic burden in the long term. Most abortions are performed in hospital settings where post-abortion family planning services are often lacking, and women are usually not referred to family planning clinics for counselling and services. Thus, there is great need for improved post-abortion family planning services in China. Three European partners worked in close collaboration with four Chinese partners to review current policies and develop new ones, focused on integrating post-abortion family planning services into existing abortion services in hospital settings in China.

Integrating post-abortion family planning services

The INPAC project looked at the effect of integrating post-abortion family planning services into existing abortion services in China on the number of unintended pregnancies and repeat abortions. The study included different interventions. In 2013, INPAC conducted a literature review of China's policy and practice of family planning and abortion, and a survey in 300 hospitals across the country. Between 2014 and 2016, INPAC compared three different types of services across 90 hospitals. In a first group, both service providers and users were informed/trained on abortion services, post-abortion counselling was offered, and free contraceptive methods were made available. A second group received exactly the same treatment as the first group, but, in addition, providers received incentives to offer post-abortion family planning services, and the partners of the women were invited to participate. The third group was a control group, who received normal abortion care without specific post-abortion family planning services.

The results showed a higher use of modern contraception, lower unintended pregnancies and fewer repeat abortions in the two intervention groups, compared to the control group.

Involving stakeholders

At the beginning of the project, a Policy Advisory Board was established that met regularly with the INPAC consortium, aimed at strengthening the relations between the researchers and the policymakers, and providing advice on how to translate study results into policy. The Advisory Board was involved throughout the entire research process: from development of the study design to implementation and evaluation. The members represented different political levels.

INPAC also conducted interviews with policy-makers and service providers to have a better understanding of their perception on the importance and implementation strategies of integrating post-abortion family planning services into the hospital abortion services. Their feedback on strengthening the capacities of abortion providers regarding post-abortion family planning services, and promoting long-term reversible contraceptive measures, have been taken into account in INPAC's recommendations.

Additionally, an online questionnaire was conducted among the 90 participating hospitals in 30 Chinese provinces. We wanted to hear their opinion on the feasibility of integrating post-abortion family planning services into the regular abortion services in their hospitals. The majority of the respondents (87%) expressed a willingness to continue providing post-abortion services after the INPAC project was completed. They also mentioned the necessity of additional funding (resources) to provide post-abortion family planning services in hospitals.

Key policy recommendations

- Integrate post-abortion family planning services into existing abortion services and information.
- Include contraceptive counselling and follow-up consultations for all women of reproductive age (including women that had an abortion) in all family planning policies and guidelines.

ABOUT INPAC

INPAC – **I**ntegrating **P**ost-**A**bstion family planning services into existing abortion services in hospital settings in **C**hina – was a collaborative research project funded by the European Union under the 7th Framework Programme (FP7) conducted from August 2012 to January 2017. The consortium consisted of seven groups led by the International Centre for Reproductive Health at Ghent University (ICRH/Ghent University, Belgium), working together with the Chinese Society for Family Planning – Chinese Medical Association (CMA-CSFP, China), Fudan University – School of Public Health (FU, China), the National Research Institute for Family Planning (NRIFP, China), Sichuan University (WCSUH, China), Aarhus University – Danish Epidemiology Science Centre (AU-DESC, Denmark), and Liverpool School of Tropical Medicine (LSTM, UK). We are thankful to all partners of the INPAC project for their support. We are also grateful to other Chinese ANSER members, Professors Feng Cheng, Xiaoying Zheng and Kun Tang, and Mr. Jun Zhang and Mrs. Ping Hong for their scientific advice.

- Implement the guidelines for maternal and child health care services at all policy levels throughout China.
- Increase funding for post-abortion family planning services.
- Strengthen capacities of providers regarding post-abortion family planning services.
- Include the promotion of long-acting reversible contraceptives in the services, especially post-abortion.
- Invest in prevention campaigns about abortion for unmarried young people.

Making a difference with research results

Policy changes

The INPAC recommendations have been applied at different levels. First they were implemented in the Chongqing province, where the local Health and Family Planning Commission developed guidelines for post-abortion family planning services and translated them into local regulations.

In August 2018, the National Health Commission of the People's Republic of China developed guidelines for post-abortion services, based on the INPAC recommendations, and advised their implementation throughout the whole country.

Societal benefits

Besides the health benefits, the integration of more effective post-abortion family planning services will also induce other societal benefits, for example empowering Chinese women to seek other types of reproductive health services as they are better informed. It also creates a neutral environment for women who seek abortion and shows the importance of preventive care, which could be a best practice for the reforms of the Chinese health care system in general.

Economic advantages

In China, an operation for induced abortion costs around 10,000 RMB (or 1,300 euro). During the INPAC intervention, repeat abortion rates were reduced by nearly 50%. Around 5,856 women took part in the study and approximately 2,928 of them were able to avoid an abortion. We can estimate that nearly 30 million RMB (or almost 4 million euro) has been saved. This figure could even be much higher if the interventions were implemented throughout the whole country, as the estimated annual abortion rate in China is around 9 million.



Sexual and gender-based violence among refugees, asylum seekers and undocumented migrants

CHARLOTTE NEVES DE OLIVEIRA (PHD INTERNATIONAL HEALTH, PUBLIC HEALTH CONSULTANT, NURSE/MEDICAL REFERENT FOR INGOS)

Worldwide sexual and gender-based violence (SGBV) is a major public health concern. Refugees, asylum seekers and undocumented migrants are especially vulnerable. In European asylum reception facilities, residents and professionals are exposed to both victimisation and perpetration. Research was needed to improve the definition of evidence-based preventive measures against sexual and gender-based violence in the European Union, and to identify the factors that can induce vulnerability to sexual and gender-based violence in residents and professionals living and working in European asylum reception facilities.

We used data collected in the scope of the European project 'Senperforto', coordinated by Ines Keygnaert, that aims to contribute to health protection and health promotion among young refugees, asylum seekers and undocumented migrants by preventing sexual and gender-based violence in asylum reception facilities. Senperforto included a knowledge, attitudes and practices study of residents and professionals living and working in asylum reception facilities in eight countries (Belgium, Greece, Hungary, Ireland, Malta, the Netherlands, Portugal and Spain). In total, 600 interviews were conducted with 398 residents and 202 professionals.

Key findings

Professionals reported a broader concept of sexual and gender-based violence than residents. The main difference was that professionals referred to physical violence as part of the sexual and gender-based violence conceptualisation – in line with the UNHCR definition in their 2003 Guidelines for preventing and responding to sexual and gender-based violence against refugees, returnees and internally displaced people. Considering the differences in conceptualisation among residents and professionals, their perception of a specific act of sexual and gender-based violence being violence was also different. Also significant was the fact that committing a sexual and gender-based violent act

Expanding knowledge on sexual and gender-based violence

Charlotte Neves de Oliveira's PhD research, jointly supervised by two ANSER members, aimed to expand the knowledge on sexual and gender-based violence – conceptualisation, reported cases, causes, preventive measures and predictive factors – in residents (refugees, asylum seekers and undocumented migrants) and professionals (services and health care providers) living and working in European asylum reception facilities.

was described as being equally violent whether afflicted upon a woman or a man. This is remarkable, as previous research by Montesanti and Thurston reported gender as a determinant with direct influence on the forms and consequences of violence.

We were able to highlight that older professionals tend to disagree that abuse, rape and trafficking are forms of violence, raising the question of their capacity to respond adequately to sexual and gender-based violence within European asylum reception facilities, and enhancing the need for sensitisation, training and a strict code of conduct. In our findings, participants reported 698 cases of sexual and gender-based violence (residents 328, professionals 370), comprising 1,110 acts of different types of violence. The main assumed causes were frustration and stress (residents 23.6%, professionals 37.6%), and differences related to cultural background (residents 19.3%, professionals 20.3%).

Respondents assumed acts of sexual and gender-based violence could be prevented by sensitising and raising awareness, and by improving the living conditions and communication between residents and professionals in asylum facilities. However, the majority of residents were not aware of the existence of preventive measures in the asylum facility or host country.

Living conditions especially were highlighted as an important feature for predicting sexual and gender-based violence victimisation. Appropriated sanitary facilities, accommodation types, the age of people with whom sanitary facilities are shared, the type of occupation, immigration status and age can influence victimisation considerably, for residents as well as professionals.

Policy recommendations

- Clearly define what is considered to be violent behaviour, and what is not, taking into account socio-economic differences.
- Enhance living and working conditions at asylum facilities to avoid incidences of violence (e.g. avoid non-related members sharing spaces, respect family culture and dynamics, ensure one sanitary facility per family, assure age balance within the facilities, and respect gender identities).
- Ensure gender-sensitive and equitable asylum procedures.
- Ensure residents and professionals have active voices in the development of asylum procedures.
- Improve tailored European policies and directives with respect to living and working conditions in reception facilities.
- Make training on existing policies and directives related to sexual and gender-based violence and how to implement them compulsory for all professionals working in European asylum reception facilities.



Charlotte

“During the five years of my PhD I've collaborated with my supervisors Professor Sónia Dias (NOVA University Lisbon) and Professor Ines Keygnaert (Ghent University). It was a great journey, full of lessons learned, and ended with a great outcome, my PhD degree. My research has benefitted from having access to data from two renowned institutions, and of course it also helped that both of my supervisors already knew each other thanks to previous ANSER collaborations.

Just after finishing my PhD I also had the opportunity to collaborate with Ines Keygnaert and Saar Baert on the organisation and implementation of the training programme for the medical team working on the pilot project on Sexual Assault Care Centers in Belgium. I believe a network such as ANSER can facilitate opportunities like this, connecting people from very different backgrounds – researchers, politicians and policymakers, professional caregivers, community members... – in order to ensure sexual and reproductive health and rights become accessible for everyone around the globe.”

**ETHICAL GLOBALIZATION IS POSSIBLE IF ONLY
WE CAN HOLD GOVERNMENTS AND BUSINESS
ACCOUNTABLE FOR RESPECTING HUMAN RIGHTS,
NOT JUST IN THE TRADITIONAL POLITICAL
AND LEGAL REALMS, BUT IN EVERYTHING
– HEALTH, EDUCATION AND THE OTHER SOCIAL
DETERMINANTS OF HEALTH.**

MARY ROBINSON, FORMER PRESIDENT OF IRELAND (1990-1997) AND UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS (1997-2002)

Sexting amongst children and teenagers: towards a policy that balances protection and autonomy

ARGYRO CHATZINIKOLAOU & EVA LIEVENS (LAW & TECHNOLOGY, FACULTY OF LAW AND CRIMINOLOGY, GHENT UNIVERSITY)

Children increasingly engage with digital technology to establish and maintain intimate relationships and develop their sexual identity. Sending self-generated sexually explicit photos via the internet and mobile apps, a phenomenon known as 'sexting', is one of the ways in which this exploration materialises. It is essential that clear and foreseeable national regulatory frameworks protect consensual sexual activities in which children are involved, on the one hand, and address coercive and nonconsensual acts on the other hand.

Sexting: legitimate youth behaviour or risky business?

On the one hand, sexting is associated with notions of risk and harm and has been attracting considerable public anxiety. Risks that may arise are, for instance, coercion to produce such pictures, further distribution of intimate images without the consent of the person who is pictured, and, subsequently, the inclusion thereof in the corpus of circulating child sexual abuse material.

On the other hand, sexual acts or expressions may constitute a part of children's legitimate exploration of their sexual identity and a way to

express their sexual individuality. In this sense, the production of sexually suggestive or explicit images by children may be conceived as falling within the scope of a child's freedom of expression and right to privacy (articles 13 and 16 of the United Nations Convention on the Rights of the Child; UNCRC). Research has found, for instance, that most sexting occurs within the context of a romantic relationship and can be considered a positive experience. According to recent findings, consensual sexting is becoming a more common practice among the youth, with prevalence rates increasing in recent years and as they age.

Given this tension, it is essential that the legal framework enables the legitimate exploration and expression of one's sexual identity, while aiming to minimise adverse consequences thereof. However, in the context of legislative instruments at different levels, sexting may fall under the concept of production, possession and/or dissemination of child sexual abuse material and may, therefore, be criminalised according to the existing legislation. When sexting occurs on a consensual basis among children, though, criminalisation could destabilise the cultivation of trust and establishment of control and privacy rights.

Three prerequisites: trust, control and privacy

Firstly, in the digital environment, the amplification of risks related to online behaviour, such as

the simplified (online) spreadability, persistence and visibility of content, intensify the need for the cultivation of trust within intimate (online) communications.

Secondly, control relates to the ability to self-determine one's sexual identity and (online) sexual representation. During adolescence, a highly developmental period of a person's life, experimenting with one's sexual identity through sexting presupposes and at the same time is expressed through the exercise of control over one's image. It is fundamental that (also) a young person under the age of 18 maintains the ability to decide on essential factors, such as the content which will be produced and exchanged, the person(s) who will have access to the sexual(ly) expressive or suggestive content, and the time and duration of the exchange and access. When reflecting on the exercise of control in the context of online sexual acts such as sexting, the concept of 'consent', which denotes the autonomy of individuals to have control over their lives, is essential. Providing consent, either explicitly or silently, for the creation and sharing of intimate (audio)visual material of oneself is an essential aspect of exercising control.

Thirdly, the potential violation of privacy does present a risk for individuals who engage in sexting, as online spatial boundaries seem to be blurred and the often unknown number of individuals who may gain access to a piece of information or image create the impression that digital spaces are inherently public. However, there is a wide consensus rejecting the assumption that everything digital is automatically public; individuals – children included – maintain the right to protect their personal information from being accessed or monitored in case they decide to share intimate imagery or texts of sexual content.

A legal perspective on sexting

From a legal perspective, trust, control and privacy as prerequisites for engaging in sexting, are safeguarded in a number of ways.

First and foremost, the exploration and expression of one's sexual identity fall within one's private sphere. On the basis of international human rights instruments, such as Article 16 UNCRC, Article 8 of the European Convention on Human Rights (ECHR) and Article 7 of the Charter of Fundamental Rights of the European Union (CFREU), children merit protection of their sexual development and expression as part of their established right to protection of private life. Although in certain circumstances and under strict conditions, certain restrictions may be imposed on an individual's right to privacy, an absolute restriction of the right of children to explore their sexual identity as part of their private life would constitute a violation of the right to privacy.

Secondly, images of a recognisable individual may be protected under the right to image, a personality right which attributes control rights to persons about whether and how their image can be taken and disseminated, and which can in many jurisdictions be enforced before a court, or under data protection legislation, as images may also constitute 'personal data'. In this respect, unlawful use of personal data may for instance be complained about to national Data Protection Authorities under the 2016 EU General Data Protection Regulation.

Thirdly, in national legal frameworks, specific legislation that criminalises the non-consensual dissemination of sexual images is being increasingly adopted. This type of legislation usually focuses on the further dissemination of such images where the pictured person has not consented to this or is unaware that the images are being distributed further, and labels this a criminal offence.

Yet, whereas the three above-mentioned rights and legislative instruments actually allow the enhancement and enforcement of trust, control and privacy in the context of sexting, other regulatory frameworks still exist that – at least from a theoretical point of view – consider (even consensual) sexting between children to be a

criminal offence under legislation that was originally adopted to criminalise child sexual abuse acts by adults.

In fact, analysis of the legal provisions regulating the production, possession and acquisition of child sexual abuse material across Europe, on the one hand, and the interpretation and implementation of these provisions by the respective Member States, on the other hand, reveal an emerging gap between theoretical criminalisation and non-implementation of the legislation in practice. For instance, the Member States of the Council of Europe are afforded the option to decriminalise the “production and/or possession of pornographic material involving children who have reached the age of sexual consent [as set by the national legislator] and where these images are produced and possessed by them with their consent and only for their own private use”, as stated in the Lanzarote Convention.

At the same time, the Member States of the European Union are, according to Directive 2011/93/EU on combating the sexual abuse and sexual exploitation of children and child pornography, afforded the discretion to decide whether the legislation on the production, possession or acquisition of child pornography applies “to the production, acquisition or possession of material involving children who have reached the age of sexual consent where that material is produced and possessed with their consent and only for the private use of the persons involved, in so far as the acts did not involve any abuse”. While only a few Council of Europe Member States have explicitly allowed for a relevant exemption in respect of consensual sexting between minors (for instance Austria, Cyprus, Germany and Liechtenstein), most Member States clarify that in practice children shall not be prosecuted. The findings of such divergence between theory and practice gives rise to legal uncertainty, both for citizens and law enforcement authorities, and calls for additional (legislative and policy) clarity.

Policy recommendations

- Roll out an evidence-based child rights impact assessment, as a basis to define policies on sexting that balance the need to protect children from exploitation or abuse with children's integrity and autonomy rights, in view of their best interests.
- Carefully consider exceptions to criminalisation of production and possession of sexual material involving children based on the age of sexual consent. These exceptions may not dissolve the legal uncertainty for those children that are younger but who do engage in sexting. The higher the age of sexual consent in a given country is, the wider the gap will be between the legal framework and the day-to-day reality and practice of sexting. Different ages for different types of sexual activities might be a solution, but this still does not alter the fact that young people develop at very different paces and that a set age will not always be in the best interests of every child of that age. Moreover, different age thresholds adopted across countries can lead to a fragmented approach as to the criminalisation (or not) of similar behaviour performed by children residing in different countries.
- Formulate uniform guidelines to deal with sexting cases in which children are involved, for instance in a circular addressed to police and prosecutors. This is even more important in the absence of an explicit legal decriminalisation of consensual sexting by children.
- Educate and cultivate awareness on the importance of consent as a fundamental element for legitimate online sexual exploration. Avoid blaming individuals who engage in sexting, rather blame those who breach the trust or engage in abusive behaviour.

This contribution is adapted from the authors' submission to the public consultation of the United Nations Committee on the Rights of the Child regarding its Draft General Comment on the rights of the child in the digital environment. These policy recommendations have also been presented to and discussed with the Council of Europe's Lanzarote Committee, the Belgian Federal Public Service of Justice and civil society organisations such as Sensoa.

WOMEN WILL HAVE ACHIEVED TRUE EQUALITY WHEN MEN SHARE WITH THEM THE RESPONSIBILITY OF BRINGING UP THE NEXT GENERATION.

RUTH BADER GINSBURG, FORMER ASSOCIATE JUSTICE OF THE SUPREME COURT OF THE UNITED STATES (1993-2020)

A sustainable partnership with the United Nations Population Fund (UNFPA)

An interview with Tamar Khomasuridze

— EMILIE PEETERS (ANSER SECRETARIAT & INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH, GHENT UNIVERSITY)

Tamar Khomasuridze is UNFPA Sexual and Reproductive Health Adviser for Eastern Europe and Central Asia, based in the UNFPA Eastern Europe and Central Asia Regional Office in Istanbul, Turkey. She is a medical doctor with more than 25 years of experience in the field of sexual and reproductive health, as a clinician, researcher, programme adviser and manager. She holds a PhD in reproductive health. She is currently responsible for providing strategic and technical support to the UNFPA sexual and reproductive health programmes in Eastern Europe and Central Asia.

Can you tell us how the collaboration between the UNFPA office in Eastern Europe and Central Asia and ANSER came about?

I already knew about ANSER when I was still head of the Georgian UNFPA office. I looked at the ANSER website quite regularly, because the information was very useful for my work. After joining the UNFPA Regional Office, I started working with ANSER while developing a regional SRH action plan for Europe, 'Leaving no one behind'. I had the chance to meet ANSER staff members at interregional, inter-agency or technical meetings. We started negotiations to become formal partners in 2015. The agenda of ANSER is very much based on the ICPD programme of action that was agreed upon in 1994 and which is the UNFPA mandate. We support countries in developing and implementing national policies and programmes to

accelerate the progress in universal access to sexual and reproductive health, so we couldn't have found a better partner than ANSER.

We've been working together for quite some time now. What is, in your opinion, the added value for UNFPA in working with a network like ANSER?

First of all I'd like to underline that ANSER is fully dedicated to the values and principles of UN and UNFPA in particular. When we talk about sexual and reproductive health and rights, there are a lot of similarities in our approaches, visions and objectives, which means a lot.

Since 2014, UNFPA Eastern Europe and Central Asia has been implementing a strategy of 'bridging science with policy'.



We have accelerated our work to reach even more regional and global partners with evidence for developing the impact-oriented policies in our countries, so we are happy to see the level of the support from ANSER in this regard. One of the key advantages of this cooperation that we see is the strong capacity of the ANSER team and their dedication to the mandate. ANSER's support really made a difference in the implementation of SRHR policies in countries in Eastern Europe and Central Asia, especially because ANSER knows the region very well. These countries can now benefit from access to top-level expertise and technical support, and they have access to documents, reports and bilateral cooperation opportunities. So from many perspectives this cooperation is very much valued by our regional office and the countries that became members of ANSER.

ANSER also developed a couple of monitoring tools for UNFPA to support national governments in implementing international development goals related to SRHR, such as the Sustainable Development Goals (SDGs), the outcome of the International Conference on Population and Development (ICPD) and regional SRHR plans. Why is it so important that these tools accompany policies in the countries in the region?

ANSER is our key partner for the ICPD regional review and global review as well. It is not only a theoretical cooperation, but as you mentioned, ANSER has developed very useful and necessary tools during recent years to meet the needs of the countries in developing SRHR policies and programmes.

First of all there's the quality assurance tool, which helps the countries to develop their national programmes and policies with respect to various sexual and reproductive

health and rights. This tool enables the countries to self-assess the quality of their programmes, strategies and policies and to enhance their quality in line with international standards that have been incorporated in the tool. The results are great: the countries have very good and up-to-date reference material to include in their national action plans and policies, and they can also use the tool to review their existing policies and to update them. The countries are cooperating with other ANSER members if they need technical support to enhance their policy frameworks.



ANSER'S SUPPORT REALLY MADE A DIFFERENCE IN THE IMPLEMENTATION OF SRHR POLICIES IN COUNTRIES IN EASTERN EUROPE AND CENTRAL ASIA, ESPECIALLY BECAUSE ANSER KNOWS THE REGION VERY WELL.

Then there is the SRHR programmes and strategies monitoring tool, which is the first monitoring tool ever to harmonise, align and integrate different monitoring mechanisms that exist on a global, regional and country level in the area of SRHR. In particular, the document provides very clear guidance on indicators that countries need to monitor their progress. The tool integrates and harmonises three important components for monitoring progress in the area of SRHR: ICPD, SDGs and SRHR regional action plan monitoring frameworks.

All countries using this tool are already incorporating these monitoring indicators in their national programmes, but this monitoring framework also automatically enables them to report on national programmes' progress in line with ICPD and SDG targets. I think this is a revolutionary step that we were able to take thanks to ANSER.

All countries we cover in the region of Eastern Europe and Central Asia found both tools very useful. Depending on their stage of policy development they applied different components of the tools or the entire tool to their processes. For example, Turkmenistan, which was in the process of initiating their national action programme development. Georgia, Moldova and Serbia are also countries that applied these tools very effectively during different stages of the development of national plans. Depending on the timeframe to develop or update their national policies, other countries in the region might also use these tools while developing, implementing or finalising their action plans.

You also decided to join I-SHARE, a large-scale research project on the impact of COVID-19 on SRHR, with quite an impressive number of member countries from your region. Why is it relevant for your region to take part in a global survey like I-SHARE?

We needed this data in each country we cover anyway, so as soon as we heard about the opportunity to participate in I-SHARE we immediately provided this information to all countries in the region. There are multiple reasons why it is valuable for any country to join the survey. First of all there is the capacity and reliability of ANSER as a network and an academic think tank. Of course, the comprehensive questionnaire and methodology you provided were

also very important. ANSER fully incorporated the feedback and the specificities of each country to make sure that all the diverse needs of the countries were addressed in one survey, so I believe that from many perspectives I-SHARE is very important and we look forward to receiving the data. Our region will now also be able to compare the results to those of other regions, in order to learn what are the threats, challenges and opportunities beyond our region. And of course the reliability of data, the level of analysis and the quality of report we expect from ANSER are also very important factors in terms of why we think this cooperation is important and why we participated in the survey.

We are now at the end of the first five years of ANSER and we're trying to refine and strengthen the structure of the network in view of the coming years. How do you see the future of ANSER? Do you have any advice for our network going forward?

As I already mentioned, ANSER is our key partner in ICPD regional and local events. We believe the commitment made by the countries is translated into actions and the technical support of ANSER and UNFPA is critical in this process. Immediately after the International Conference on Population and Development in 2019, ANSER kindly agreed to organise a special session with the Eastern Europe and Central Asia Regional Office and top-level experts participating to discuss the implementation strategies and challenges, and to agree on the way forward. Thanks to ANSER, I believe we have some good plans in place, on how to support the countries, strengthen their policies, accelerate their processes and, most importantly, translate their commitment into specific actions and results. I believe that in a next phase we'll collaborate even more successfully

with ANSER to meet the demand of our programme countries. The network can help them by providing technical expertise, high-quality reports and evidence, and also by building the knowledge of the national level, which is very much needed in each country. Also I'd like to underline the importance of capacity building among younger generations. The fact that ANSER has summer schools, internships, and also organises or supports other regional and global events builds a very strong network across countries. This can help them to become owners and drivers of their programmes and then I believe great things can be achieved. And last but not least, I believe that global and regional networking, which ANSER does so well, may bring even more members to the network. I would like to see all countries of

our regional office in an official partnership with ANSER and I hope their applications will be accepted because they are trying their best to meet the requirements. The UNFPA regional office will support them during the process from application to acceptance, counting of course on support from ANSER as well.

Because of the new agenda, new commitments and more countries joining ANSER, the network will need more financial resources to keep addressing the needs, and I believe the donors will support the efforts of ANSER to mobilise more resources, support more countries and address more challenges. ANSER has already achieved great results, but I am convinced that with a wider network and more resources, ANSER can do even more.

**IT IS BY STANDING UP FOR THE RIGHTS
OF GIRLS AND WOMEN THAT WE TRULY
MEASURE UP AS MEN.**

DESMOND TUTU, FORMER ARCHBISHOP AND ANTI-APARTHEID AND HUMAN RIGHTS ACTIVIST


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**THE ACADEMIC NETWORK FOR SEXUAL AND REPRODUCTIVE HEALTH
AND RIGHTS POLICY (ANSER) CELEBRATES ITS FIFTH BIRTHDAY IN 2021.**

From the start, we have considered it our duty to bridge the gap between research and policymaking, as we strongly believe sexual and reproductive health and rights (SRHR) policies should be based on scientific evidence.

In this publication you will find a glimpse of what we have achieved so far. May it inspire you to keep advocating sexual and reproductive health and rights worldwide.