Regional Framework for Reproductive Health in the Western Pacific
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ABBREVIATIONS

AIDS  acquired immunodeficiency syndrome
ANC  antenatal care
ART  antiretroviral therapy
CPR  contraceptive prevalence rate
GLBTI  gay, lesbian, bisexual, transgender and intersex
HIV  human immunodeficiency virus
HPV  human papillomavirus
ICPD  International Conference on Population and Development
IUD  intrauterine device
MDGs  Millennium Development Goals
MISP  minimum initial service package
MMR  maternal mortality ratio
MNH  maternal and newborn health
MVA  manual vacuum aspiration
NGO  nongovernmental organization
NMR  neonatal mortality rate
PMTCT  prevention of mother-to-child-transmission (of HIV)
STI  sexually transmitted infection
TFR  total fertility rate

Map of the Western Pacific Region
Significant efforts have been made in reproductive health since the International Conference on Population and Development in 1994 and the launch of the Global Reproductive Health Strategy in 2004. Although progress has been achieved in many components of reproductive health, it is still not enough to keep all Member States in the Western Pacific Region on track to achieve Millennium Development Goal 5, which calls for universal access to reproductive health. Moreover, reproductive health inequities have widened in many Member States in the last decade.

There are health systems, technical, social and cultural challenges in achieving universal access to reproductive health services. In 1995, WHO Regional Committee for the Western Pacific adopted a resolution urging Member States to review their policies, strategies and plans of action for improving reproductive health services. The Regional Office has been supporting Member States in achieving their objectives of universal access to reproductive health.

Recently, following the launch of the Global Strategy for Women’s and Children’s Health (2010), the need for a regional framework for reproductive health was emphasized. This framework would serve as a guide for country programmes in accelerating the achievement of universal access to reproductive health and reducing inequities among and within Member States.

It is important to integrate services among the five components of reproductive health and other relevant programmes, building upon the foundation of a strong health system. Well-managed integration increases effectiveness, efficiency and equity of service delivery. Thus, this Regional Framework for Reproductive Health in the Western Pacific Region has been developed in close consultation with Member States, in collaboration with the WHO divisions responsible for reproductive health and health systems development. It is anticipated that this framework will be useful for decision-makers, policy-makers and reproductive health programme managers in Member States to update policies and design strategies and programmes to achieve universal access to reproductive health.

Shin Young-soo, MD, Ph.D.
Regional Director
Convened by WHO and UNICEF, the International Conference on Primary Health Care met in 1978 in Alma-Ata, which is now Almaty in the Republic of Kazakhstan. The historic conference adopted a declaration calling for the development of primary health care throughout the world, particularly in developing countries.
1.1 INTERNATIONAL COMMITMENTS ON REPRODUCTIVE HEALTH

Globally, the goal of *Health for All* has been promoted since 1978 through the Alma Ata Declaration, and remains an aspirational goal for health development. In 1994, the Programme of Action of the International Conference on Population and Development (ICPD) gave directions for improving reproductive health, a concept that was agreed for the first time globally1 (see Annex 1). In 2000, the Millennium Development Goals (MDGs) were launched as a framework for reducing poverty, hunger and disease and for achieving a set of attainable targets by 2015. In keeping with the spirit of Alma Ata, the MDGs encourage countries to address eight health-related issues in an integrated manner to reduce inequity within and across countries. MDG 5 deals with improving maternal health through the achievement of universal access to reproductive health (Table 1.1).

**Table 1.1 Millennium Development Goal 5: Improve maternal health**

<table>
<thead>
<tr>
<th>Targets</th>
<th>Indicators for monitoring progress</th>
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</table>
| Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio | 5.1 Maternal mortality ratio  
5.2 Proportion of births attended by skilled health personnel |
| Target 5.B: Achieve, by 2015, universal access to reproductive health | 5.3 Contraceptive prevalence rate  
5.4 Adolescent birth rate  
5.5 Antenatal care coverage  
5.6 Unmet need for family planning |

Thirty years after the Alma Ata Declaration, WHO renewed its commitment to primary healthcare, outlining four areas of reform to support universal coverage of health care to improve health equity and social justice. A focus on service delivery marks the importance of health systems strengthening in delivering integrated and people-centred health services. It also recognizes the significance of healthy public policy and the critical role of intersectoral coordination and community participation. Giving special attention to health services for poor and marginalized groups is recognized as crucial in achieving universal coverage of healthcare, including reproductive healthcare.

Worldwide, governments have taken steps to achieve universal access to reproductive health. To augment these efforts, WHO launched the global *Reproductive Health Strategy* in 2004 to accelerate progress towards attainment of the international development goals and targets contained in the Programme of Action of the ICPD and ICPD+5 (Annex 1), as well as the achievement of targets set for MDG 5. The global *Reproductive Health Strategy* identified five core components of reproductive health for sustained and accelerated action, namely:

1. improving antenatal, delivery, postpartum and newborn care;
2. providing high-quality services for family planning, including infertility services;
3. eliminating unsafe abortion;
4. combating sexually transmitted infections; and
5. promoting sexual health.

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1 The Programme of Action of the ICPD in 1994 defined reproductive health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”. 

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The global strategy also proposed five key actions in building and strengthening country capacity to improve the broad context of reproductive health, particularly in achieving MDG 5 by 2015:

1. strengthening health systems capacity;
2. improving information for priority setting;
3. mobilizing political will;
4. creating supportive legislative and regulatory frameworks; and
5. strengthening monitoring, evaluation and accountability.

Reproductive health starts before and extends beyond the years of reproduction and is closely associated with nutrition, sociocultural factors, gender roles and protection of human rights, especially in regard to sexuality and personal relationships. With help from the ICPD, discussions shifted from addressing only a list of diseases or conditions to considering the reproductive health of the whole person—placing people firmly at the centre of development efforts, with a strong focus on equity and poverty reduction.

A review of the Programme of Action in 2009, *ICPD at 15*, recognized not only successes, but also gaps that needed to be addressed in order to achieve universal access to reproductive health at country and regional levels. In 2010, the United Nations Secretary-General addressed the investment gaps by launching the *Global Strategy for Women’s and Children’s Health*. The *Commission on Information and Accountability*, established in 2010, outlined an accountability framework that promotes better tracking of resources and results, particularly related to MDGs 4 and 5.

### 1.2 PURPOSE OF THE REPRODUCTIVE HEALTH FRAMEWORK

This framework aims to provide guidance for decision-makers and national programme managers in planning and designing reproductive health programmes. It aims to support the progressive integration of traditionally separate, vertical reproductive health programmes into a comprehensive overall country programme. Reproductive health programme integration is emphasized in order to improve effectiveness, efficiency and equity of services.

### 1.3 REPRODUCTIVE HEALTH IN THE WESTERN PACIFIC REGION

There is great geographic, demographic, sociocultural and economic diversity among and within the 37 countries and areas of the Western Pacific Region. For example, China has a population of over 1.3 billion, whereas some small Pacific island countries and areas have populations of fewer than 2000 (see Table 1.3 and Annex 2 for detailed demographic profiles).

<table>
<thead>
<tr>
<th>Population Size</th>
<th>Countries/Regions</th>
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<tbody>
<tr>
<td>&gt; 2 million population</td>
<td>Cambodia, China, Lao People’s Democratic Republic, Malaysia, Mongolia, Papua New Guinea, Philippines, Viet Nam</td>
</tr>
<tr>
<td>100 000 to 2 million</td>
<td>Fiji, Federated States of Micronesia, Samoa, Solomon Islands, Tonga, Vanuatu</td>
</tr>
<tr>
<td>&lt; 100 000 population</td>
<td>American Samoa, Cook Islands, Kiribati, Marshall Islands, Nauru, Niue, Palau, Pitcairn Islands, Tokelau, Tuvalu, Walls and Futuna</td>
</tr>
</tbody>
</table>

Reproductive health needs also vary considerably across and within the countries and areas of the Region (see Annex 3 for a detailed situational analysis). In the Western Pacific Region, significant efforts have been made to address the five core components of reproductive health in accordance with each country’s situation and needs. These efforts have met with different degrees of success, with significant advances in the quality and coverage of reproductive health services in some instances. However, in the context of widening health inequities within and across countries of the Western Pacific Region, a strategic framework was deemed necessary to accelerate the achievement of universal access to reproductive health by 2015 and beyond.
Maternal and newborn health

Most maternal deaths are preventable, whether from obstetric complications such as postpartum haemorrhage, eclampsia and sepsis or from indirect causes. A number of countries have succeeded in reducing maternal deaths. In 2010, the maternal mortality ratio (MMR) in the Western Pacific Region was 66% lower than in 1990; however, an estimated 12 000 women died due to maternal causes, with almost 76% of these deaths occurring in the three largest countries: China, the Philippines and Viet Nam (see Figure 1 in Annex 3). Globally, it is estimated that for every maternal death, 20 other women endure injury, infection and disability because of pregnancy and child birth. There is a need for more data on maternal morbidity in the Western Pacific Region, and on the intersection between noncommunicable diseases such as diabetes and maternal and newborn health.

Most neonatal deaths are a consequence of the poor health and nutritional status of the mother, coupled with inadequate care before, during and after delivery. In 2010, in the Western Pacific Region, the average neonatal mortality rate (NMR) was estimated at 11 deaths per 1000 live births. Cambodia, Kiribati, the Lao People’s Democratic Republic, Nauru and Papua New Guinea had the highest rates, but China, the Philippines and Viet Nam contributed the greatest overall numbers (see Figure 2 in Annex 3). Stillbirth rates were high in 2009, ranging from 14 to 18 deaths per 1000 total births in Cambodia, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and some Pacific island countries.

The proportion of deliveries assisted by a skilled birth attendant is low in the Lao People’s Democratic Republic (37%), Papua New Guinea (40%) and the Philippines (62%), while all other countries in the Western Pacific Region have achieved more than 65% coverage, and all countries except eight have achieved more than 90% coverage (Figure 3 in Annex 3). There is also considerable variability in access to skilled care at birth within countries, with inequities based on socioeconomic status, rural/urban location, and other determinants. Figure 4 in Annex 3 shows, for example, that the Lao People’s Democratic Republic and the Philippines have striking inequities in skilled birth care coverage, while Mongolia has been successful in achieving universal access.

In 2005–2010, more than 90% of pregnant women in China, Mongolia, the Philippines and most countries and areas of the Pacific visited an antenatal care clinic at least once, but only 37% did so in the Lao People’s Democratic Republic. However, coverage for at least four antenatal care visits is generally much lower in most countries, such as in Papua New Guinea (29%). Several countries were not able to provide data on the number of antenatal visits after the first one (Figure 5, Annex 3).

Anaemia affected an estimated 30.7% of pregnant women in the Western Pacific Region during the period 1993–2005. It continues to pose a challenge in improving maternal and newborn health.

Family planning and fertility rate

In 2005–2010, most of the Pacific island countries and areas had a contraceptive prevalence rate (CPR) of less than 45%. CPRs are also low in Papua New Guinea (36%) and the Lao People’s Democratic Republic (38%), the countries which also have high MMRs. However, these two countries have significantly increased their CPR in the past 10 years, while the Philippines has made only a small gain (Figure 7, Annex 3). In 2001–2010, the unmet need for family planning was reported to be highest in the Lao People’s Democratic Republic (27%), the Philippines (22%) and some Pacific island countries, and lowest in Viet Nam (4.8%), Mongolia (4.6%) and China (2.3%) (Figure 8, Annex 3).

The total fertility rate (TFR) was generally higher in countries with a low CPR, as in Papua New Guinea (4.0), the Philippines (3.2), the Lao People’s Democratic Republic (2.7), and Cambodia (2.6). Pacific island countries with small populations also have high TFRs, ranging from 2.7 to 4.2. Some countries in the Region have stabilized their population growth by maintaining a TFR of 2.1. China, Malaysia and Mongolia had the lowest adolescent fertility rates for the period 2000–2010, while the Lao People’s Democratic Republic, Papua New Guinea and the Philippines had the highest rates: 110, 70 and 53 births per 1000 girls aged
15–19 years, respectively. Many Pacific island countries, such as the Marshall Islands, the Federated States of Micronesia, Nauru and Niue also had adolescent fertility rates above 50 per 1000 (Figure 6, Annex 3).

**Unsafe abortion**

In 2008, about 790 000 women underwent unsafe abortion in the Western Pacific Region, with about 680 maternal deaths as a consequence. It was estimated that unsafe abortion was the cause of 5% of all maternal deaths in the Region. Unsafe abortion endangers women who live in places where abortion is highly restricted by law, or not otherwise easily accessible. In the Western Pacific Region, only Cambodia, China, Mongolia and Viet Nam have laws that permit abortion without restrictions. However, inadequate and poor quality services still lead to unsafe abortions in those countries (Table 1, Annex 3).

**Sexually transmitted infections**

Pacific island countries have a high prevalence of chlamydia infection, with rates ranging from 34% to 40% among people under 25 years age. Gonorrhoea prevalence is highest in Papua New Guinea (estimated at 3%). In China, Malaysia, the Philippines and Viet Nam, the estimated prevalence is 1% or less.

Syphilis remains a global health problem, with an estimated 12 million people infected each year, despite the existence of preventive measures and effective, relatively inexpensive treatment. A pregnant women infected with syphilis can transmit the infection to her fetus, causing congenital syphilis, with serious adverse outcomes for the newborn infant. Globally, an estimated 2 million pregnancies are affected by syphilis annually. About 25% of cases result in stillbirth or spontaneous abortion; another 25% result in low birth weight babies or serious infection. Some studies in the Western Pacific Region show seroprevalence of less than 1% among pregnant women in the Republic of Korea and Malaysia, and as high as 7% in Papua New Guinea.

There are serious long-term effects of chronic sexually transmitted infections (STIs), including pelvic inflammatory disease and infertility. Human papillomavirus (HPV) infection may cause cervical cancer. In 2005, HPV was diagnosed in more than 490 000 women and caused 250 000 deaths globally. In 11 countries in the Western Pacific Region, cervical cancer ranked either first or second as the leading cause of death from cancers among women. HIV continued to place a significant burden on some communities and on health-care services across the Western Pacific Region, with national prevalence being highest in Papua New Guinea (0.9% of adults) and Cambodia (0.5%), but the numbers of people living with HIV were greatest in China (740 000 people in 2009) and Viet Nam (280 000).

**Sexual health**

Sexual violence can be a determining factor in STIs, unwanted pregnancy, sexual dysfunction, and a range of other negative sexual outcomes. Sexual coercion at a young age can affect a person’s sexual behaviour and health later in life. A global multicountry study on women’s health and domestic violence found that in 10 of the 15 study settings—including Japan and Samoa—more than 5% of women reported their first sexual experience as being forced. Some settings reported more than 14%. The study also found that reports of lifetime prevalence of sexual violence by an intimate partner ranged from 6% to 59%. The proportion of ever-pregnant women being physically abused during at least one pregnancy exceeded 5% in 11 of the 15 study settings. These results highlight the interconnectedness of gender inequality, sexual health and other elements of reproductive health.

In the Western Pacific Region, country data is limited on the impact of a range of sexual health issues throughout life including infertility, menopause, prostate health and the sexual health of older people. Limited attention has also been paid to the sexual health of men, and of minority and marginalized groups, including persons with disability and gay, lesbian, bisexual, transgender and intersex (GLBTI) persons.
A father takes a moment to relax with his child in Ho Chi Minh City, Viet Nam, 2008.

AN INTEGRATED APPROACH TO REPRODUCTIVE HEALTH
Since the ICPD, there has been a movement towards developing a more holistic approach to reproductive health. Such an approach aims to link, modify and incorporate existing programmes to offer comprehensive reproductive health services that reach more women and men. Traditionally, reproductive health has been delivered through vertical programmes that deal with specific components. While these programmes have seen some great gains, opportunities tend to be missed by people who need more than one type of service. As such, these programmes push up financial and other costs for users, reducing access and health outcomes. The ICPD calls for population policies to be linked to a broader development agenda that incorporates poverty reduction and improvement in health and nutrition.

Reproductive health programmes in the Western Pacific Region tend to focus on married women, with few services offered for unmarried women, young women, older women, men, and disadvantaged and minority groups, such as persons with disability, GLBTI persons, migrants and indigenous communities. For example, policies to increase acceptance and use of contraception have mostly neglected the man’s role in family planning. Inadvertently projecting an image that reproductive health services are mainly for married women discourages other members of the community from using them, restricting access.

### 2.1 GUIDING PRINCIPLES

The five core components of reproductive health have guiding principles that are similar to those of the components of universal access to reproductive health. The guiding principles are not mutually exclusive—they rely on and augment each other. They assist decision-making in all aspects of health systems design and functioning to enable appropriate, efficient and accountable delivery of services to adequately meet population needs.

The guiding principles for reproductive health programmes in the Western Pacific Region, which are both implicit and explicit in the framework diagram in Section 3, include the following:

1. **Respect for human rights** for all members of society, as laid out in internationally-agreed instruments and global consensus declarations, without discrimination.
2. **Social and gender equality**, giving priority to poor and underserved populations because reproductive ill-health arises, in part, from poverty and gender inequality, and its burden is disproportionately borne by those from poorer and marginalized groups.
3. **Evidence-based interventions**, proven to be effective and beneficial to health, support the provision of good-quality health services.
4. **People-centred and integrated service delivery** involves treating people with respect and dignity—regardless of their social, cultural and economic status—and organizing services so that everyone can easily get comprehensive coverage of their needs at least cost to them. Integration also increases efficiency for the country’s health system.
5. **Cultural relevance and sensitive approaches**, or determining the most effective ways to challenge harmful cultural practices and strengthen positive ones, facilitates collaboration and mobilizes community involvement to improve reproductive health.
6. **Partnerships**: Many other programmes are related to various components of reproductive health and many stakeholders work in its broad areas. Partnerships with relevant programmes and stakeholders, including civil society and women’s groups, are necessary to optimize coordination in achieving desired reproductive health goals.
7. **Health systems strengthening based on primary health care and country context** brings together all of the above principles to ensure sustainability for achieving equity and universal access to integrated, comprehensive reproductive health interventions.
2.2 RATIONALE FOR INTEGRATING REPRODUCTIVE HEALTH SERVICES

Reproductive health services should be integrated to better meet population needs in a broader, more comprehensive manner and to improve access, efficiency, effectiveness and equity.

Meeting population needs

Vertical programmes for service delivery may be easier to administer; however, they do not assist users in identifying all of their reproductive health needs and in accessing services from separate providers. For example, a person who goes to a health-care provider for contraceptive advice does not have to go somewhere else to receive diagnosis and treatment of an existing STI. Similarly, when a pregnant woman or girl visits a health facility for antenatal care, she should also receive guidance on preparing for a safe delivery, healthy nutrition to prevent anaemia, and future family planning.

The challenge is not only to integrate and expand services, but also to reach populations with particular needs. Some people are faced with economic, social or cultural barriers that limit their access to services. Restricted access to essential services threatens health and exacerbates poverty, establishing a vicious downward spiral with poorer health outcomes.

Improve efficiency and effectiveness

Many vertical programmes work in areas that are closely interdependent. By progressively integrating their efforts, greater efficiency can be achieved. Users can have their needs met with fewer visits. And costs can be lowered, for both service providers and users, through the sharing of facilities and resources.

Well-managed integration will reduce the total number of health-care workers required, by reducing duplication of technical and administrative personnel used in separate vertical programmes. Providing adequate services with the existing cadre of health workers is crucial in countries with a very limited pool of human resources. Health workers will also be more confident and motivated when they are skilled to provide services that cater to the health needs of their clients.

2.3 CHALLENGES FOR INTEGRATING REPRODUCTIVE HEALTH SERVICES

The key challenges in integrating reproductive health services in low- and middle-income countries can be categorized as integration issues or as specific or technical challenges.

Integration issues

Integration of reproductive health services can occur on three levels: (1) policy-making and strategy development; (2) internal health systems planning; and (3) planning with partners. Challenges faced by the health system when integrating reproductive health services include the following:

• weak political will, leading to insufficient allocation of national and subnational budgets for key programmes;
• each component of reproductive health programmes may fall under different departments and units in the ministry of health, which may make the integration of reproductive health services even more challenging;
• inadequate collaboration within the ministry of health, and between the ministry of health and other sectoral stakeholders, including private providers, faith-based health services, nongovernmental partners, academia and professional societies;
• vertical and inflexible donor funding arrangements, and in some instances a lack of donor coordination;
• geographic, social and cultural barriers inhibiting support for reproductive health service delivery to poor, rural and marginalized groups;
• gender inequality and the low status and disempowerment of women, leading to a lack of prioritization of their reproductive and sexual health needs by households, communities and governments; and
• lack of access to services and information due to weak health systems that are characterized by poor
distribution of health facilities and human resources, poor organization, management and quality of
services; weak financing arrangements; and lack of medicines and commodities.

Specific challenges
The integration issues listed above impact on each of the five core components of reproductive health. In
addition, each of the core components has its own technical and health system challenges to effective and
equitable service delivery. Also, the health providers may not be prepared to have necessary knowledge
and skills for all components of reproductive health and its relevant programmes. These are outlined
in more detail in Section 4, along with an introduction to potential strategies for addressing them in a
comprehensive and integrated approach to reproductive health.
A Chinese woman walks with her grandson past a pavilion for family planning services in eastern China’s Shandong province, 2011.
The reproductive health framework aims to avoid or break the vicious cycle of ill-health and poverty by focusing on the principles of primary health care and addressing health system issues that are critical to enabling increased access to reproductive health services. The model shown in Figure 1 depicts aspects of a comprehensive, health systems approach to the integration of reproductive health services. The narrative under Figure 1 expands on priorities covered by these different aspects of an integrated approach, which are based on the guiding principles of the framework.

Reproductive health services, whether vertical or integrated, rely on health system capacity for effective implementation. The framework presented in this document is based on the principles of primary healthcare. Successful scaling-up of reproductive health integration will require an incremental approach with attention to all aspects of the health system in a balanced way. It is important to acknowledge that all system parts are interlinked, and any system is only as strong as its weakest part. Therefore, priorities and actions should address the weakest parts of the national health system, while taking a whole-of-system approach.

3.1 POLICY, LEGISLATION, LEADERSHIP AND MANAGEMENT

National assessment and planning
Reproductive health services planning should be based on a comprehensive situation analysis and should be in line with the overall national health strategic plan. As part of the situation analysis, an assessment of health system capacity and performance can examine the feasibility of integrating services, and can identify innovative approaches to service delivery or propose approaches tailored for the local context. In the Western Pacific Region, strategies are needed to support the delivery of reproductive health services in an environment of rapid social and economic change, as well as during disasters, times of conflict or other emergencies.

For planning to be robust, input must be solicited from all relevant stakeholders, especially those for whom existing reproductive health services are weak. Local health partners at all levels, including health planners, providers and practitioners, and NGOs, must also be involved. A phased or incremental approach to integrating services will be feasible in most countries. Sequencing the steps based on local health system capacity is an essential part of planning.

Political will and advocacy
Translating global or regional strategies for integrated reproductive health into country-specific plans for responding to national needs requires the involvement of all relevant stakeholders, with investment and commitment from all levels of government and from major development partners. To ensure the success of an integrated approach to reproductive health, advocacy may be required within the sector to develop commitment and support for a different way of working.

National policies and legislation
National policies and legislation related to reproductive health need to be enacted. However, they should be comprehensive, detailed and created in partnership with health and non-health partners to ensure that they are a core part of national development strategies. Any new policy or legislation needs to be aligned with existing national laws and development priorities, while respecting local religious, cultural and ethical values, and adhering to the universal principles of human rights and gender equality. Accountability mechanisms should be developed and strengthened to ensure that processes to integrate reproductive health services meet the expectations of communities, governments and partners.

3.2 IMPROVE DEMAND FOR REPRODUCTIVE HEALTH SERVICES

Identify vulnerable, poorly targeted populations and their health needs
The needs of target populations must be comprehensively analysed. Target groups include those who may not have been reached previously by reproductive health programmes, including: adolescents, men,
unmarried women and couples, persons with disability, GLBTI persons, sex workers, people who inject drugs, migrants, refugees and displaced persons, and older persons. Within any particular country, the needs of these groups may differ between urban and rural settings, or between areas or groups with different demographic and socioeconomic profiles.

**Communicate and conduct outreach to increase demand**

One of the most important steps in increasing demand for services is to develop appropriate communication and information strategies that include mass awareness campaigns, targeted outreach and/or peer-to-peer networks. Information strategies should be tailored to specific target populations, e.g. different strategies for youth or unmarried couples than for older, married couples. The rapid development of information and communication technologies across the Region opens up a range of new opportunities for information dissemination and mobile health approaches.
Reduce barriers to access

Financial barriers can be removed or reduced with policies that eliminate user fees, increase health insurance, and provide cash transfers or vouchers, and with strategies that tackle the indirect or opportunity costs of accessing care, such as transport costs and loss of income due to long waits. The transport sector can assist by improving public transport, which would make it easier for patients to reach health facilities. The education sector can assist by providing health education programmes (e.g. health, nutrition and sex education) and health care for students and local communities.

Reproductive health services should capitalize on the expansion of mobile phones, in terms of both numbers and coverage, thereby making it easier for service users to contact service providers, e.g. pregnant women should be able to contact midwives for advice or assistance during pregnancy and delivery. To ensure optimal use by those with reproductive health needs, services need to be culturally sensitive and user-friendly.

Address social and gender equity issues

Social and gender barriers often prevent women and girls from receiving good reproductive health services. Programmes that address these barriers need to form strong partnerships with non-health sectors to successfully integrate reproductive health. The education sector, for example, has a very important role to play. Educating girls has been proven to improve the health outcomes of women and their children. Gender-based violence also has a significant impact on reproductive health. It is important to get political commitments, backed by legal frameworks, to protect girls’ and women’s rights to health and education.

3.3 IMPROVE SUPPLY AND QUALITY OF REPRODUCTIVE HEALTH SERVICES

Provide and improve key services and referral

Each country ought to conduct a detailed assessment of the reproductive health needs of its population in order to identify an essential reproductive health services package (see Sections 4.1 to 4.5). The package of services may differ by province, by locale, e.g. urban or rural, and by demographic context. In-depth national and regional needs assessments will help to identify which services to offer at various levels and locations across the health system and how to improve the quality of services, especially at the primary care level.

Referral protocols, pathways and systems also need to be developed. This process includes establishing referral linkages and health service networks, as well as making provisions for rapid communication between facilities and ensuring access to emergency transport.

Increase availability of quality services

Increasing the availability of quality services by integrating and expanding the services offered at facilities is a core approach of this reproductive health framework. Delivering integrated services at the same facility and efficiently using the same equipment and systems will result in savings. The vertical reproductive health programmes will need to decide collectively what services can be integrated and what administrative aspects can be integrated at the various levels of management and service delivery. Detailed mapping of the locations, coverage and users of particular facilities will be required, along with analysis of who is not being reached or not using services. In addition to sufficient number of the health facilities, their location plays a large role in their use by the population. Access by road and public transport, as well as proximity to users and safety, will need to be considered when moving services or scaling up and planning new facilities.

Programme management

Managing an integrated programme requires steady and firm cooperation between various programmes and sectors. Highly competent managers are needed to ensure success at all levels. The impact of service integration will be most visible in health facilities. All health workers will need a clear understanding of their
roles and responsibilities within an integrated system. Managers will have to plan for and ensure the availability of the resources needed to deliver the expanded range of services under their responsibility. Integrated supportive supervision and reporting will also be needed, along with progressively integrated monitoring and evaluation. Procedures, protocols and guidelines should be developed with relevant stakeholders and distributed to all health providers.

3.4 IMPROVE AVAILABILITY AND QUALITY OF COMMODITIES

**Improve availability of commodities**

Providing a wider array of services at health facilities necessitates a revision of lists of essential medicines, technologies and commodities that need to be available at each level. These lists may differ by degree of integration and strength of referral mechanisms. To ensure continuous supply of generic drugs, access to functioning equipment and maintenance procedures at all facilities, countries will need to strengthen national policies and management systems, including those associated with drug procurement, distribution systems, storage facilities, costs to users, accountability for use and stock-outs, and strategies for avoiding fake or counterfeit products.

**Improve quality of commodities**

The quality and control of drugs and commodities have to be monitored at all points along the chain of production or procurement, distribution and use. For reproductive health services, the main concern is ensuring user-confidence in the quality of medications and technologies they use, and avoiding use of ineffective, fake, or counterfeit products.

3.5 HEALTH CARE FINANCING

**Costing and funding of services**

Promoting the integration of reproductive health services can be an effective strategy for increasing efficiency and sustainability, but it needs to be accompanied by governments and partners demonstrating their prioritization by increasing investment. Strategies to advocate for increased investment in reproductive health need to be developed. Careful costing of reproductive health services, e.g. by using the United Nations OneHealth costing tool, will be necessary to advocate for increased investment and to promote insurance or tax coverage and other mechanisms to reduce financial barriers.

**Mechanisms to reduce financial barriers to services**

It is important to identify clearly which services should be free at the point of care, and for whom. These services should be included in the insurance package or tax-funded service delivery. Mechanisms to reduce financial barriers to care need to be identified. Vouchers, conditional cash transfers, risk-pooling mechanisms, health equity funds and other innovative mechanisms should be considered where demand for services needs to be increased. Targeted mechanisms to reduce financial barriers for disadvantaged groups may also need to be considered, with frequent communication to target groups to ensure they understand their entitlements and how to access services.

3.6 HEALTH WORKFORCE

**Health workforce management and human resources**

Workforce distribution, density, skill-mix and competence should correlate closely with population location and needs. Integration of services should lessen the need for vertical programme staff; however, careful retraining and reallocation of existing or new health workers will be required to ensure motivation and efficiency. In some settings, more female health workers will be needed.

With the increasing array of services to be provided, the roles and responsibilities of health workers at different levels will need to be redefined and “task shifting” will need to be considered. Investment in the recruitment and resourcing of adequate numbers of health workers at different levels of the health system, especially those with midwifery skills, is required. Strategies to increase staff retention, including remuneration, housing allowance,
functional facilities, professional development and support, should be implemented. Ensuring the availability of male and female health workers at all levels of the health system is important. Adequacy of personnel for management and supervision is crucial. Supervisory roles need to be clearly defined and accompanied by adequate supervisory training and management support (see Section 3.3).

**Health workforce training**

The pace set for integration of reproductive health services will depend in part on health workforce pre-service training and competencies. Undoubtedly, in-service training packages will need to be merged to ensure service quality, while minimizing staff absence from the workplace. Training packages will need to cover clinical and non-technical skills, including: interpersonal skills, teamwork, role delineation, quality assurance and patient safety, counselling, informed choice, accountability, gender and human rights and outreach to underserved populations.

### 3.7 HEALTH INFORMATION AND RESEARCH

**Health information system**

Integration of services will require changes in data reporting and management. Health facilities should have to report to the higher administrative level only once to avoid overburdening staff. Clear protocols for reporting, storage and sharing of data among partners and programmes should be established, with the overall aim to reduce data collection workload and increase information use. If an integrated system for health information is already being implemented, then it can progressively absorb the remaining programmes that are still reporting vertically. Capacity to collect, analyse and use health information that is disaggregated by relevant social stratifiers, e.g. age, sex, income level, education, location and ethnicity, needs to be strengthened in order to monitor equity.

**Monitoring and evaluation**

Robust and efficient monitoring is crucial to check and verify coverage of services delivered, use of resources, service quality, user satisfaction, and cost of services. Evaluation is necessary to help assess the strengths and weaknesses of health system capacity and service integration. Using global and regional documents as guides, relevant stakeholders should agree on which core indicators to use and how to disaggregate them by relevant social stratifiers. A robust monitoring and evaluation framework is best developed in tandem with national planning.

**Research**

Implementation or operational research is needed to identify and document good practices in relation to integrated service delivery and to address key challenges in meeting reproductive health goals and component objectives. Efforts to plan and undertake research that is useful for evidence-based decision-making should be stepped up. Wide dissemination of research results and case studies, including through publication, would support efforts towards comprehensive, integrated reproductive health services throughout the Western Pacific Region.

### 3.8 PARTNERSHIPS

**Promote multisectoral action**

To improve health and equity overall, the health sector must work with non-health sectors, e.g. education, law and justice, social welfare, planning, transport and the private sector, to empower vulnerable populations, especially girls and women, and to address the social determinants of health. Attention should be paid to ensuring better collaboration within the health sector, and with and between development partners.

**Participation**

Greater support for the participation of civil society organizations, including women’s groups, professional organizations, faith-based organizations and NGOs, is needed to reach reproductive health goals and objectives. Strategies also need to be developed to increase the participation of men in all five components of reproductive health, and to increase participation of marginalized and disadvantaged groups in service design, delivery and evaluation.
**Table 3  Summary of the Framework for Integrating Components of Reproductive Health**

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Policy, legislation, leadership and management</strong></td>
<td></td>
</tr>
<tr>
<td>Assessment and planning</td>
<td>• Conduct systematic reviews of reproductive health needs at country level to prioritize responses.</td>
</tr>
<tr>
<td></td>
<td>• Identify innovative/tailored approaches, looking at models, to phase in integration.</td>
</tr>
<tr>
<td></td>
<td>• Develop and update national strategies and plans periodically.</td>
</tr>
<tr>
<td>Political will</td>
<td>• Hold multi-stakeholder discussions to foster commitment and ownership from all levels of government and from all partners and stakeholders.</td>
</tr>
<tr>
<td>National policies and legislation</td>
<td>• Create or update policies with health and non-health partners, based on national legal structures and international human rights.</td>
</tr>
<tr>
<td></td>
<td>• Develop and strengthen governance and accountability mechanisms.</td>
</tr>
<tr>
<td><strong>2. Improve demand for reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Identify target populations and health needs</td>
<td>• Identify members of expanded target populations including underserved groups, such as adolescents, men, unmarried people, persons with disability, and other socially marginalized groups, and identify their reproductive health needs.</td>
</tr>
<tr>
<td>Communications and outreach</td>
<td>• Identify and develop outreach and community information and awareness campaigns targeted at all vulnerable and underserved populations—this requires different approaches for different groups. Strengthen referral processes.</td>
</tr>
<tr>
<td>Reduce barriers to access</td>
<td>• Identify and address barriers to access, including social, educational and transport barriers.</td>
</tr>
<tr>
<td></td>
<td>• Address financial barriers with eliminated or lowered user fees, health insurance, cash transfers and vouchers; address indirect financial costs as well.</td>
</tr>
<tr>
<td></td>
<td>• Work with the transport sector to reduce transport barriers.</td>
</tr>
<tr>
<td></td>
<td>• Work with the education sector to improve access to services and to reduce discrimination.</td>
</tr>
<tr>
<td></td>
<td>• Develop user-friendly, culturally sensitive services.</td>
</tr>
<tr>
<td></td>
<td>• Work with men and community leaders to promote access to services.</td>
</tr>
<tr>
<td>Address social and gender equity issues</td>
<td>• Address gender and equity issues, involve men and boys, and empower women, girls and other vulnerable and underserved groups.</td>
</tr>
<tr>
<td><strong>3. Improve supply and quality of reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Increase availability of services</td>
<td>• Upgrade existing services to provide a wider range of services.</td>
</tr>
<tr>
<td></td>
<td>• Map services by need, increasing sites, as required.</td>
</tr>
<tr>
<td></td>
<td>• Identify which services are needed at the various health facility levels.</td>
</tr>
<tr>
<td>Provide and improve key services and referrals</td>
<td>• Identify necessary services and a minimum reproductive health package, which may differ by province, locale and demographic context; ensure quality of services.</td>
</tr>
<tr>
<td></td>
<td>• Identify and resource referral pathways, including referral to services outside the health sector and for emergency transport.</td>
</tr>
<tr>
<td>Programme management</td>
<td>• Develop strong management training guidelines and support for supervision.</td>
</tr>
<tr>
<td></td>
<td>• Develop clear, detailed guidelines for all health facility levels, from central to provincial and community level, and distribute to all stakeholders.</td>
</tr>
<tr>
<td></td>
<td>• Ensure strong reporting and referral protocols.</td>
</tr>
<tr>
<td></td>
<td>• Ensure strong operational linkages to monitoring and evaluation plans.</td>
</tr>
<tr>
<td><strong>4. Improve availability and quality of commodities</strong></td>
<td></td>
</tr>
<tr>
<td>Improve availability</td>
<td>• Revise lists of essential medicines and health products/technologies needed at each facility.</td>
</tr>
<tr>
<td></td>
<td>• Review national policies on essential drugs and equipment, procurement, national and local distribution systems, national and local storage facilities, maintenance, reporting use and stock-outs, monitoring and evaluation and management systems.</td>
</tr>
<tr>
<td>Improve quality</td>
<td>• Develop both internal and external quality assurance methods.</td>
</tr>
</tbody>
</table>
### Table 3  Summary of the Framework for Integrating Components of Reproductive Health (cont.)

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. Health care financing</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Costing and funding services | - Conduct accurate costing of services to help budget for national planning and insurance plans, and to advocate for increased investment in reproductive health.  
- Monitor commitments made to reproductive health against actual investment. |
| Mechanisms to reduce financial barriers | - Identify services that should be free at the point of care, and ensure they are included in the insurance package or tax-funded service delivery.  
- Consider vouchers, conditional cash transfers or other innovative mechanisms where demand for services need to be increased. |
| **6. Health workforce** | |
| Health workforce management and human resources | - Develop workforce management mechanisms to promote efficient use of personnel, prevent fatigue and boost morale.  
- Establish clear guidelines for role delineation and share them with all service providers.  
- Develop detailed supervisory guidelines and ensure support to supervisors.  
- Map current health facility staffing at different levels of the system, differentiating between rural and urban services, and by sex of health worker. |
| Health workforce training | - Develop an expanded services training package with a strong technical component to increase quality of care, plus a focus on related skills including interpersonal communication, accountability, counselling and informed choice.  
- Strengthen the awareness, capacity and skills of health sector staff in gender analysis and programming, and in human rights-based approaches.  
- Develop phased training to avoid overwhelming staff and to ensure information retention. |
| **7. Health information and research** | |
| Health information systems | - Develop one integrated health information system and avoid parallel reporting structures.  
- Ensure transparency of data collected, with relevant information being made available to the public and to key stakeholders. |
| Monitoring and evaluation | - Decide on core indicators.  
- Develop robust monitoring and evaluation and a reporting mechanism. |
| Research | - Conduct operational or implementation research to identify and document good practices in relation to the integration of components of reproductive health.  
- Disseminate findings of promising practices, e.g. through case studies.  
- Support gathering and analysis of data for evidence-based decision-making. |
| **8. Partnerships** | |
| Promote multisectoral action | - Work with non-health partners to empower vulnerable populations, especially girls and women, and to address social determinants of health.  
- Promote intrasectoral collaboration within the ministry of health. |
| Participation | - Ensure women's participation, women's empowerment and the accountability of governments and other duty-bearers.  
- Emphasize the role of civil society organizations and women's groups as key partners.  
- Develop strategies to increase men's participation in reproductive health initiatives. |
A young Hmong woman makes her way home with a baby on her back in mountainous Mu Cang Chai, in the province of Yen Bai, Viet Nam.
Of the five core components of reproductive health, improving maternal and newborn health, providing high-quality family-planning services and preventing unsafe abortion are most important in low- and middle-income countries in the Western Pacific Region. These components are related directly or indirectly to maternal survival, a necessity for achieving MDG 5, especially in countries with a high maternal mortality ratio. Family planning and unsafe abortion are culturally sensitive issues in some countries of the Region. More attention is necessary to advocate for human and reproductive rights, as well as gender equality. The two remaining components, combating sexually transmitted infections and promoting sexual health, affect both women and men in the Region. Unhealthy sexual behaviour is related to gender inequality. Annex 4 provides links to key publications on components of reproductive health.

4.1 MATERNAL AND NEWBORN HEALTH

Challenges

Integration issues

Maternal and newborn health is a cornerstone of most health programmes and a major focus of the MDGs. It is important to create mechanisms that can link services, administration, human resources and reporting in the area of maternal and newborn health with other relevant programmes. Managers and health providers at all service levels need to be informed of the importance of, and approaches to integration, and be given a chance to contribute. Clear role delineations, expectations and standards must inform all human resource decisions, and be communicated to all staff.

Specific challenges in maternal and newborn health

1. Skilled care for every birth

A dearth in human resources, especially those with midwifery skills, is the most common health system challenge in countries with a low proportion of deliveries assisted by a skilled birth attendant, such as in the Lao People’s Democratic Republic and Papua New Guinea. Managing the workforce for maternal and newborn health at primary care and first referral levels is a complex matter, which includes issues of production, placement, distribution of health workers, their supervision and management, working environments and motivation. Special attention should be paid to the level of midwifery skills at the primary care level, as well as the number and distribution of staff with those skills.

2. Gaps in the continuum of care

Continuity of care is needed before, during and after pregnancy, including childbirth, postpartum and neonatal periods. Continuity is also needed among community, primary care and referral levels. These continua of care are crucial in ensuring maternal and newborn health.

3. Life-saving services for mothers and their newborn infants

Women with obstetric complications and/or sick newborn infants often cannot access prompt referral services. Health providers at the primary care level may not have the skills or supplies to provide initial life-saving treatment before referral. Health facilities with the capacity to manage emergency obstetric cases and sick newborn infants may be difficult to reach, may be closed, and may have low quality of care. These factors threaten the lives of women with obstetric complications and their sick newborn infants and contribute to MMR and NMR.
Key interventions and actions

The goal of the reproductive health framework for improving maternal and newborn health is to accelerate the achievement of MDG 5 targets and other international development goals in low- and middle-income countries and address inequities within countries and areas of the Region.

The specific objectives are:

• to increase coverage and quality of maternal health services in order to achieve skilled care for every birth and improved pregnancy outcomes;
• to reduce inequities in maternal and newborn health through investment in partnerships between health and other relevant sectors, including the private sector; and
• to strengthen community actions for improving maternal and newborn health.

The following are some key interventions and actions to achieve these objectives.

Objective 1: Increase coverage and quality of maternal and newborn health services

Focus on ensuring access to a maternal and newborn health service package along the principles of continuum of care. Place special emphasis on achieving skilled care for every birth, including essential newborn care and immediate postnatal care, backed by adequate referral services to manage obstetric complications and newborn problems. Strengthen integrated services to promote health and address common health needs, including family planning, prevention and treatment of nutrition-related problems especially anaemia, prevention and treatment of malaria, HIV and other STIs, and management of diabetes, other noncommunicable diseases and mental health problems. With progressive integration, ensure availability of a wider range of services at more health facilities, paying special attention to the needs of underserved groups and areas.

Strengthen programme management, especially at the district level and below, to ensure efficient delivery of maternal and newborn health services, especially in the context of integrated reproductive health services. Focus on strengthening management functions that include strategic planning, distribution and use of human and other resources, quality assurance, scaling up services to reach more women, improved equity and monitoring service coverage. Conduct a human resources needs assessment and establish strategies to systematically address the issues of availability and quality of health workers.

Improve quality of care by implementing processes, e.g. maternal and perinatal death reviews, and setting up and monitoring the implementation of evidence-based standards. Ensure women-centred care for childbirth, emergency obstetric care and neonatal intensive care to respect women's sociocultural orientation and needs. Conduct strategic operational research to provide guidance in decision-making and programme planning for better maternal and neonatal health outcomes. In areas where women follow traditional practices, encourage good practices and discourage harmful ones. Strengthen the supportive involvement of men in maternal and newborn health to accelerate achievement of the objectives.

Objective 2: Address inequity issues in maternal and newborn health

Provide maternal and newborn health services to all clients, including those from disadvantaged groups and underserved areas, taking care to encourage the involvement of men. Adjust policies to increase demand, ensure access for disadvantaged and vulnerable groups, and promote gender equality and women's rights. Strengthen partnerships with NGOs, private health providers, and non-health sector partners, including civil society organizations and women's groups, to improve access for underserved groups and areas.

Develop mechanisms to address financial barriers to enable the poor and marginalized groups to access maternal and newborn health services free-of-charge, especially care during child birth, emergency obstetric care, essential newborn care, care for sick neonates and immediate postnatal care. Ensure accountability and monitor progress in the delivery of maternal and newborn health services, with special
attention to the needs of those from disadvantaged groups, such as poor and pregnant adolescents, persons with disability and persons from underserved areas. This should be done through the collection, analysis and use of information that is disaggregated by relevant social stratifiers to monitor equity.

**Objective 3: Strengthen community actions to improve maternal and newborn health**

Develop the capacity of women, families and communities in self-care at household level for mothers and their newborn infants, and other aspects of community-level care. Civil society organizations and women’s groups can play an active role in community actions, e.g. preparing women for childbirth, ensuring adequate nutrition for pregnant women in their community, educating mothers and their partners on postpartum family planning, helping mothers to obtain timely services for their newborn infants at health facilities, and supporting maternal mental health, particularly during the postpartum period.

Strengthen the capacity of any existing community health volunteers to ensure, among others, that target groups are registered and key events reported to health providers at primary care level. Strengthen communication and linkages with the formal health system to maximize the value of community health volunteers and ensure adequate backup care. Monitor and document community actions to improve maternal and newborn health.
### Table 4.1 Summary of Reproductive Health Framework for Maternal and Newborn Health (MNH)

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Policy, legislation, leadership and management</strong></td>
<td></td>
</tr>
<tr>
<td>Assessment and planning</td>
<td>• Conduct national-level review to assess MNH needs on the ground, priorities and areas where linkages to other programmes will be most effective and efficient.</td>
</tr>
<tr>
<td></td>
<td>• Strengthen integrated services to promote health and address common health problems.</td>
</tr>
<tr>
<td>Political will</td>
<td>• Conduct in-depth consultations with all stakeholders to ensure political buy-in.</td>
</tr>
<tr>
<td>National policies and legislation</td>
<td>• Ensure policies focus strongly on underserved and vulnerable populations, e.g. poorer communities, youth, unmarried women, persons with disability.</td>
</tr>
<tr>
<td></td>
<td>• Ensure policies address both referral pathways and emergency transport.</td>
</tr>
<tr>
<td></td>
<td>• Ensure policies focus on gender equality and women’s rights.</td>
</tr>
<tr>
<td><strong>2. Improve demand of reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Identify target populations</td>
<td>• Ensure target population captures all users, including poorer communities, youth, unmarried women, persons with disability, etc. and their specific health needs.</td>
</tr>
<tr>
<td>Communications and outreach</td>
<td>• Strengthen capacity of community health volunteers in delivering a message of integrated reproductive health services to increase awareness and demand.</td>
</tr>
<tr>
<td>Reduce barriers to access</td>
<td>• Develop user-friendly services that are welcoming to the disadvantaged groups.</td>
</tr>
<tr>
<td></td>
<td>• Decrease user fees for services.</td>
</tr>
<tr>
<td></td>
<td>• Increase access to transport in emergency situations.</td>
</tr>
<tr>
<td>Address social and gender equity</td>
<td>• Empower women and girls, and increase the supportive involvement of men and boys.</td>
</tr>
<tr>
<td></td>
<td>• Address stigma issues faced by adolescent and unmarried mothers.</td>
</tr>
<tr>
<td><strong>3. Improve supply and quality of reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Increase availability of services</td>
<td>• Increase number of sites and coverage by integrating with other reproductive health services, and by ensuring programmes are comprehensive – including a focus on nutrition, noncommunicable diseases and maternal mental health.</td>
</tr>
<tr>
<td></td>
<td>• Build partnerships with NGOs and private institutions that provide health services to disadvantaged and underserved areas.</td>
</tr>
<tr>
<td>Provide and improve key services and referrals</td>
<td>• Strengthen integration of all services with a focus on ensuring continuum and quality of care.</td>
</tr>
<tr>
<td></td>
<td>• Develop programmes to build capacity of women, families and communities in self-care at the household level for mothers and newborn infants, including a focus on nutrition, noncommunicable diseases and maternal mental health.</td>
</tr>
<tr>
<td></td>
<td>• Work with civil society and women’s groups to facilitate community actions to ensure birth preparedness for all pregnant women within their community.</td>
</tr>
<tr>
<td></td>
<td>• Develop strong referral systems to enable mothers and newborn infants to reach and obtain timely services at health facilities.</td>
</tr>
<tr>
<td></td>
<td>• Develop strong linkages and channels of communication between communities and health-care providers at community and primary care levels.</td>
</tr>
<tr>
<td>Programme management</td>
<td>• Strengthen programme management, especially at district level and below, focusing on: strategic planning, monitoring service coverage, quality of MNH services and implementation of strategic processes to increase equity.</td>
</tr>
<tr>
<td></td>
<td>• Improve quality of care by establishing processes for quality improvement, such as maternal death review, and by setting up and monitoring the implementation of evidence-based standards, including women-centred care, with a special attention on childbirth, emergency obstetric care and special care for sick newborn infants.</td>
</tr>
<tr>
<td></td>
<td>• Monitor and document the impact of community networks and programmes.</td>
</tr>
</tbody>
</table>
### Key areas | Key actions
--- | ---
#### 4. Improve availability and quality of commodities

**Improve availability**
- Ensure availability of essential medicines for maternal and newborn health and other related reproductive health services, such as oxytocin, magnesium sulphate, iron–folic acid tablet, as well as supplies and equipment, such as delivery kit for midwives.

**Improve quality**
- Develop a mechanism for supervision in monitoring stock-outs, quality and distribution of medicines, supplies and equipment for maternal and newborn health.

#### 5. Health care financing

**Costing and funding services**
- Improve collaboration with national board of planning, ministries of finance and internal affairs and development partners in areas such as programme planning and costing.

**Mechanisms to reduce financial barriers to access**
- Ensure adequate financing for maternal and newborn health as part of the integrated reproductive health approach.
- Develop transparent methods for accountability of service provision.

#### 6. Health workforce

**Workforce management and human resources**
- Systematically review availability and quality of health workforce at primary care level, especially those with midwifery skills to identify key gaps in quantity, quality and distribution.
- Identify areas of linkages with other relevant reproductive health services.

**Workforce training**
- Identify areas that need strengthening and plan for improving knowledge and skills both in pre- and in-service training, with particular focus on strengthening midwifery training.
- Work with other components of reproductive health to develop a comprehensive training manual covering all the stages of continuum of care.

#### 7. Health information and research

**Health information systems**
- Improve birth and maternal and newborn death reporting, including stillbirths, through registration of target groups and reporting of key community events.
- Integrate maternal and newborn death reporting and auditing into the national health information system, along with other maternal and neonatal health service coverage indicators.

**Monitoring and evaluation**
- Develop strong supervisory mechanisms for all levels.
- Monitor progress on the coverage and accountability of MNH services, with special attention paid to disadvantaged groups and their special needs, through the collection, analysis and use of information that is disaggregated by relevant social stratifiers.
- Monitor and document community actions.

**Research**
- Conduct strategic operational research in programming for better MNH outcomes.

#### 8. Partnerships

**Promote multisectoral action**
- Address MNH issues that need multisectoral action, e.g. early marriage, supportive working environment for midwives at village level, accurateness of maternal death reporting.
- Collaborate with other government sectors and private sector groups that provide MNH and other reproductive health services.

**Participation**
- Support the involvement of women’s groups in promoting community and self-care.
- Develop strategies to increase participation of men in maternal and newborn health.
- Develop strategies to increase participation of disadvantaged groups in the design and delivery of services.
4.2 FAMILY PLANNING

Challenges

Integration issues

Family planning is a component of reproductive health services that has strong natural links with the other four components: maternal and newborn health, preventing unsafe abortions, prevention and control of STIs including HIV, and promoting sexual health. The activities under this component are heavily dependent on commodities, counselling and outreach. These require service packages that emphasize quality of care and active listening to user needs and concerns as outlined below. Addressing infertility is an integral part of family-planning services.

Specific challenges in family planning

1. Limitations in targeting clients and weak communication strategies

Many countries provide family-planning services to only married couples, leaving unmarried people, often adolescents, without access to services. Information on family-planning options is often limited, making it difficult for the poor and marginalized, ethnic minorities, persons with disability and adolescents to know how to access services. Communication strategies for promoting family planning, and for addressing infertility, are often weak in countries with low contraceptive usage.

2. Limited contraceptive choice and counselling

Providing quality family-planning services is a challenge for countries that lack resources to expand contraceptive choice, provide counselling on the chosen method, prevent potential infections, treat any side-effects and ensure quality and client satisfaction.

3. Weak contraceptive security

Contraceptive security exists when every person is able to choose, obtain and use quality contraceptives for family planning without interruption in supply. Many low- and middle-income countries depend on external support to provide its citizens with a continuous supply of contraceptives. Contraceptive security requires commitment, good planning and monitoring, availability of necessary commodities, equipment and supplies at all levels.

4. Gender inequality and the role of men

Due to inequalities in gender relations, women often have less bargaining power in decisions related to family planning. Men may have limited knowledge of family-planning options and issues, and they may not give their partners permission to practise family planning because of cultural beliefs or the desire to have a son. However, men can play a positive role in birth spacing, postponing the first pregnancy, postpartum and post-abortion family planning, and addressing infertility. In areas with concentrated epidemics of STIs including HIV/AIDS, it is crucial for men to be proactive in the practice of dual protection to reduce unwanted pregnancies and to prevent the transmission of STIs.

Key interventions and actions

The goal of the reproductive health framework for strengthening family-planning services is to ensure universal access to family planning in low- and middle-income countries in the Western Pacific Region to assist them in reducing maternal mortality and in achieving their fertility goals.

The specific objectives are:

1. to increase coverage and improve quality of family-planning services, with special attention to the poor and marginalized groups, including adolescents;
2. to expand contraceptive choice and ensure family planning commodity security; and
3. to strengthen partnerships among key players, including public and private providers and the community, to reduce barriers and improve access to family-planning services.
The following are some key actions to achieve these objectives.

**Objective 1: Increase coverage and improve quality of family-planning services**

Develop a national policy on providing a wide range of contraceptive methods, including emergency contraception and condoms. Increase service providers’ capacity for providing intrauterine device (IUD) insertion, injectables and other modern methods of contraception at community and primary care level. Improve health staff’s capacity to counsel and guide users on selecting suitable contraceptive methods and following up to maintain continuity and to deal with any side-effects.

Implement a communication strategy advocating family planning. Ensure that information and services are accessible to the poor, disadvantaged and marginalized groups that have the highest unmet need, including adolescents, very young couples, unmarried young people, migrant workers, discordant HIV couples,2 sex workers and women who are HIV positive. Communicate regularly with these groups to ensure they understand their entitlements and how to access them. Women with special needs, such as those with disabilities, mental health issues, or substance abuse issues, need unique communication strategies. Address the needs of couples with infertility.

Address barriers to accessing family-planning services through service integration and expansion, channelling government subsidies to reduce contraceptive prices. Ensure the quality of follow-up care for women using any method of family planning, including managing side-effects and failure of contraceptive methods, and provision of postpartum and post-abortion family planning.

**Objective 2: Expand contraceptive choice and ensure commodity security**

Ensure a wide range of contraceptive methods at service delivery points: at least three modern methods at community and primary care levels, and six at referral level, including emergency contraception and condoms. Secure reliable sources for contraceptive commodities. Establish public–private partnerships for social marketing and distribution of contraceptives, i.e. using commercial outlets, such as pharmacies and shops to provide quality and affordable contraceptives.

Improve public-sector capacity for planning and monitoring family-planning commodities, including procurement, supply management, distribution and storage at national and local levels to ensure all clients’ needs are met without interruption. Integrate a well-functioning logistics and distribution system for contraceptives with the existing system to avoid stock-outs.

**Objective 3: Strengthen partnerships to improve access to family-planning services**

Assess the contraception needs of all people, including the underserved and marginalized groups. Identify social, cultural and religious barriers to universal access and advocate for policies and programmes to overcome them. Ensure male involvement in family planning, as a part of their reproductive health rights. Increase awareness of male contraceptive methods and establish services that are convenient and friendly for men to use. Increase efforts to empower women with the information and skills to negotiate family planning with their partners and, at the same time, encourage men to be responsive to their partner’s desire to use contraception.

Improve the knowledge of family planning among families and communities and demonstrate how family planning impacts their welfare. Involve community, religious, and faith-based organizations in advocating for family planning. Develop partnerships with NGOs to increase delivery of family-planning supplies and services at community level, especially for groups not served by the public sector, and strengthen referral pathways between relevant programmes, including HIV and youth-focused initiatives.

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2 A discordant couple is a pair of long-term sexual partners in which one has HIV infection and the other does not.
Table 4.2. Summary of the Reproductive Health Framework for Family Planning

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Policy, legislation, leadership and management</td>
<td></td>
</tr>
<tr>
<td>Assessment and planning</td>
<td>• Assess contraceptive needs for different target groups, especially disadvantaged groups, which should be the basis for planning of service delivery.</td>
</tr>
<tr>
<td>Political will</td>
<td>• Develop advocacy strategy for family planning.</td>
</tr>
<tr>
<td>National policies and legislation</td>
<td>• Develop a national policy on providing a wide range of contraceptive methods at facility, community and primary levels. Ensure at least six modern methods at facility level, including emergency contraception and condoms, and three at community and primary care levels.</td>
</tr>
<tr>
<td>2. Improve demand of reproductive health services</td>
<td></td>
</tr>
<tr>
<td>Identify target populations and their health needs</td>
<td>• Identify poor, disadvantaged and marginalized groups that have high unmet needs for family planning. • Ensure male involvement in family planning, including in addressing infertility. • Identify needs of couples and individuals, including underserved and marginalized groups, for contraception.</td>
</tr>
<tr>
<td>Communications and outreach</td>
<td>• Strengthen communication strategy for advocacy of family planning. • Ensure information and services are accessible to the poor, disadvantaged and marginalized groups that have high unmet needs for family planning, including adolescents, unmarried young people and people living with HIV. • Emphasize dual role of contraception, as appropriate. • Create awareness of and support for both male and female methods of contraception. • Improve family- and community-level knowledge of family planning and its importance for their welfare. • Develop focused programme for women with disabilities and/or with other health issues.</td>
</tr>
<tr>
<td>Reduce barriers to access</td>
<td>• Promote convenient access to services for men. • Decrease stigma and promote access for adolescents and unmarried people. • Use government subsidies to decrease costs of contraceptives. • Identify social, cultural and religious barriers to universal access to contraception and advocate for policies and programmes to overcome those barriers. • Involve community, religious leaders and faith-based organizations in advocating for family planning.</td>
</tr>
<tr>
<td>Address social and gender equity</td>
<td>• Empower women with information and skills to discuss family planning with their partners, and increase the supportive involvement of men and boys.</td>
</tr>
<tr>
<td>3. Improve supply and quality of reproductive health services</td>
<td></td>
</tr>
<tr>
<td>Increase availability of services</td>
<td>• Provide a wide range of contraceptive methods. • Increase number and range of sites where contraceptive methods are available, by developing partnerships with NGOs at the community level for delivery of family-planning services and commodities to marginalized groups not served by the public sector.</td>
</tr>
<tr>
<td>Provide and improve key services and referrals</td>
<td>• Ensure quality of and follow-up care for women using any method of family planning, including managing side-effects and failure of contraceptive methods and providing postpartum and post-abortion family planning. • Provide basic services for identifying infertility at primary care level and referral services, as appropriate.</td>
</tr>
<tr>
<td>Programme management</td>
<td>• Ensure monitoring of quality of family-planning services and availability of quality commodities or contraceptives.</td>
</tr>
</tbody>
</table>
## Key areas and Key actions

### 4. Improve availability and quality of commodities

**Improve availability**
- Ensure availability of a wide range of contraceptive methods at service delivery points: at least six modern methods at facility level and three at community and primary care level, including emergency contraception and condoms.
- Establish a reliable resource for contraceptive commodities, including routine government funds, supported by international donor agencies and NGOs.
- Establish public–private partnerships in social marketing and distribution of contraceptives; use commercial pharmacies and shops to provide quality and affordable contraceptives.
- Strengthen public-sector capacity for planning and monitoring of family planning commodities, as well as procurement, supply management, distribution and storage capacity of contraceptives at the national and local levels to ensure all clients’ needs are met.

**Improve quality**
- Integrate a well-functioning logistics and distribution system of contraceptives into the existing system to avoid stock-outs.

### 5. Health care financing

**Costing and funding services**
- Estimate the cost of each contraceptive method for planning purpose.
- Monitor commitments made to ensure security of contraceptive commodities against actual investment and performance in regard to commodity security.

**Reduce financial barriers**
- Provide free family planning in public health facilities or mechanisms for ensuring that poor couples get the services they need.

### 6. Health workforce

**Workforce management and human resources**
- Ensure health professionals who provide maternal health services also provide family-planning services, considering their close linkage.
- Delegate distribution of some methods of family planning through relevant channels in the community.
- Ensure male and female health providers are available to provide contraceptive and family planning advice and services.

**Workforce training**
- Increase capacity for providing modern methods of contraception, especially IUD insertion, injectables and other modern methods, at community and primary care levels.
- Improve service providers’ capacity in counselling users, in helping them select contraceptive methods and in addressing infertility.

### 7. Health information and research

**Health information systems**
- Include reporting and recording of family-planning services in the health information system—not as a stand-alone mechanism.
- Conduct analysis of data on contraceptive choices in a particular setting to inform planning and procurement.

**Monitoring and evaluation**
- Monitor coverage and quality of family-planning services, as well as commodity and contraceptive security.
- Evaluate the programme regularly, as appropriate.

**Research**
- Conduct analysis of local beliefs, understandings and attitudes in relation to family planning and different contraceptive methods.

### 8. Partnerships

**Promote multisectoral action**
- Collaborate among all key players to improve access and quality of services, including finding best ways to deliver family-planning services.

**Participation**
- Build partnerships not only with women’s groups, but also with men’s groups and community and religious leaders, to increase access to and uptake of family-planning services.
- Support women’s participation in the planning and evaluation of family planning and contraceptive services to ensure their perspectives are considered.
4.3 Preventing Unsafe Abortion

Challenges

Integration issues

Activities designed to improve service delivery for the prevention of unsafe abortion overlap strongly with other reproductive health components, especially family planning. However, the health system and integration issues are often further complicated by difficult societal, cultural and religious contexts. While these contexts sometimes limit integration opportunities, understanding them is essential for increasing access to services that reduce the consequences of unsafe abortion. Development of strong policies and laws that protect the human rights of women and girls is critical.

Specific challenges in preventing unsafe abortion

1. Limited information about abortion

Abortion is a very sensitive issue in many countries, making it difficult for health authorities to obtain information on abortion services and to develop a plan of action to address unsafe abortion. In all countries in the Western Pacific Region, more information is needed to know who seeks abortion, where and how, for what reasons, and with what health consequences.

2. Limited access to safe abortion and post-abortion care

In some countries, legal protection for safe abortion services does not exist, and post-abortion care is limited. In countries where abortion is legally permitted, women may still struggle to access safe abortion services because of the lack of quality services, costs and stigma. Sociocultural and gender-based issues, such as discrimination against women, are often the root cause of women being unable to obtain safe abortion services.

3. Repeated abortion

In some countries, repeated abortion is common among women who do not want more children but do not use contraceptives, either because they do not have access, or do not have power in the relationship, or do not want to use them. Women who are pregnant and seek repeated abortion services might be unaware of the negative long-term consequences, such as infection, infertility and sometimes death.

Key interventions and actions

The goal of the reproductive health framework for preventing unsafe abortion is to ensure universal access to pregnancy prevention services as well as safe abortion and/or comprehensive post-abortion care for women who need the service.

The specific objectives are:

• to prevent unwanted pregnancy as primary prevention for unsafe abortion;
• to improve access to and quality of safe abortion and/or comprehensive post-abortion care—according to the existing laws in countries—for women who need the service; and
• to strengthen partnerships among key players, including public–private partnerships in delivering the service and in reducing stigma.
The following are some key actions to achieve these objectives.

**Objective 1: Prevent unwanted pregnancy that leads to unsafe abortion**

The first step in preventing unsafe abortions is to prevent unwanted pregnancy by improving access to family planning information and services (see Section 4.2), especially among vulnerable groups such as adolescents, unmarried women, refugees, displaced persons, women with STIs including HIV, women with disabilities and victims of sexual abuse. Ensure that victims of sexual abuse and violence have access to emergency contraception. Prevent unwanted pregnancy and ensure every newborn infant is wanted and valued. Integrate family-planning counselling as a regular part of postpartum and post-abortion care. To reduce contraceptive failure rates improve commodity availability and quality of counselling on correct and consistent use of contraceptive methods, as well as availability of emergency contraception as backup for missed pills, condom failure or unprotected sex.

**Objective 2: Improve access to and quality of safe abortion and post-abortion care**

Ensure strong policies and legislation for preventing unsafe abortions. Information and advocacy are needed to inform policy-makers and society on the magnitude and consequences of unsafe abortion in order to foster informed discussion on laws, services. Clarify and communicate the existing national laws, norms and standards for safe abortion and/or post-abortion care to ensure that users and providers know their rights and obligations under the law. Review and revise the laws periodically to ensure they respond to women’s needs and realities.

In line with national law, expand or upgrade primary care services to provide safe abortion and/or post-abortion care, as well as services for rape and incest victims. Include infection prevention and pain management, and promote client-centred services that consider physical, social and psychological well-being. Use follow-up visits to offer counselling, to monitor complications, and to provide information on self-care at home, including recognizing complications.

Improve health providers’ capacity and ability to help prevent unsafe abortions. In line with existing law, allow mid-level providers, such as midwives, to provide high-quality menstrual regulation and/or post-abortion care using manual vacuum aspiration (MVA), as well as to provide medical abortion where applicable. Provide pre- and in-service training to relevant health providers on prevention of unsafe abortion, including provision of contraceptives and counselling, use of MVA and medical abortion. Monitor access to and quality of safe abortion care.

**Objective 3: Strengthen partnerships in delivering the service and reducing stigma**

Establish public–private partnerships for providing safe abortion and post-abortion care and expand them as appropriate. Collaborate with stakeholders and relevant institutions on how best to reduce stigma aimed at women who use the service, and on how to promote male involvement in preventing unwanted pregnancy and unsafe abortion.
Table 4.3 Summary of the Reproductive Health Framework for Preventing Unsafe Abortion

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Policy, legislation, leadership and management</strong></td>
<td></td>
</tr>
<tr>
<td>Assessment and planning</td>
<td>• Assess the current legal context and women’s needs in relation to abortion services, in order to inform decision-making and planning of the relevant services that can be offered in a particular national context.</td>
</tr>
<tr>
<td>Political will</td>
<td>• Inform policy-makers and society on the magnitude and consequences of unsafe abortion to promote informed discussion and review of laws, policies and services.</td>
</tr>
<tr>
<td>National policies and legislation</td>
<td>• Clarify national law, norms and standards for safe abortion and post-abortion care to ensure that clients and providers know their obligations and rights under the law.</td>
</tr>
<tr>
<td><strong>2. Improve demand of reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Identify target populations and their health needs</td>
<td>• Identify needs of vulnerable populations, such as adolescents, unmarried women, refugees, women with disability, displaced persons and women with STIs/HIV, in relation to preventing unwanted pregnancies and unsafe abortion.</td>
</tr>
<tr>
<td></td>
<td>• Ensure that victims of sexual abuse and violence have access to legal and health information as well as emergency contraception.</td>
</tr>
<tr>
<td></td>
<td>• Involve men in strategies and approaches for preventing unwanted pregnancy and unsafe abortion.</td>
</tr>
<tr>
<td>Communications and outreach</td>
<td>• Improve access to family-planning information and services, especially among vulnerable populations.</td>
</tr>
<tr>
<td></td>
<td>• Promote male involvement in preventing unsafe abortion.</td>
</tr>
<tr>
<td></td>
<td>• Ensure that clients and providers know their obligations and rights under the law.</td>
</tr>
<tr>
<td>Reduce barriers to access</td>
<td>• Ensure that services for preventing unsafe abortion are easy to access by everyone in the community, with special attention to disadvantaged and marginalized groups, and those with lower socioeconomic status.</td>
</tr>
<tr>
<td></td>
<td>• Use government subsidies to decrease costs of contraceptives.</td>
</tr>
<tr>
<td></td>
<td>• Reduce barriers to accessing post-abortion care.</td>
</tr>
<tr>
<td>Address social and gender equity</td>
<td>• Collaborate with stakeholders and relevant institutions on how best to empower women and reduce stigma for them in using safe abortion and post-abortion services, where appropriate.</td>
</tr>
<tr>
<td><strong>3. Improve supply and quality of reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Increase availability of services</td>
<td>• Establish public-private partnership for safe abortion and/or post-abortion care service delivery and expand as appropriate.</td>
</tr>
<tr>
<td>Provide and improve key services and referrals</td>
<td>• Improve quality of counselling on correct and consistent use of contraceptive methods to reduce failure rates and introduce emergency contraception as backup for missed pills, condom failure or unprotected sex.</td>
</tr>
<tr>
<td></td>
<td>• Ensure availability of provision of family-planning services, including emergency contraception to prevent unwanted pregnancy, and ensure every pregnancy is wanted.</td>
</tr>
<tr>
<td></td>
<td>• Ensure availability of family-planning counselling and services as a part of postpartum and post-abortion care.</td>
</tr>
<tr>
<td></td>
<td>• Expand and upgrade existing services at primary care level to provide safe abortion and/or post-abortion care, including services for rape and incest victims.</td>
</tr>
<tr>
<td></td>
<td>• Strengthen referral pathways for victims of sexual violence and abuse to ensure timely access to legal and health services, including emergency contraception.</td>
</tr>
<tr>
<td></td>
<td>• Allow and build the capacity of mid-level providers, e.g. midwives, to provide high-quality menstrual regulation, post-abortion care using manual vacuum aspiration (MVA) and medical abortion, when possible.</td>
</tr>
<tr>
<td></td>
<td>• Use follow-up visits after an abortion for to offer counselling, to monitor complications, and to provide information to women about self-care at home, including recognizing complications.</td>
</tr>
<tr>
<td>Programme management</td>
<td>• Upgrade clinical care for safe abortion and post-abortion care to include infection prevention, pain management and adequate supplies, as well as to promote client-centred services that consider physical, social and psychological well-being.</td>
</tr>
</tbody>
</table>
### 4. Improve availability and quality of commodities

**Improve availability**
- Ensure availability of contraceptives, including emergency contraception, and necessary supplies, equipment and medicines for managing complicated abortions.

**Improve quality**
- Ensure quality of commodities relevant for preventing unsafe abortion, including ensuring that emergency contraception is provided with information about its effective use.

### 5. Health care financing

**Costing and funding services**
- Calculate costs of services related to preventing unsafe abortion for better programme planning.

**Reduce financial barriers**
- Collaborate with NGOs working in the area of preventing unsafe abortion to improve access to services and to reduce costs, while waiting for expansion of coverage by government services or under health insurance schemes.

### 6. Health workforce

**Workforce management and human resources**
- Ensure that those providing maternal health and family-planning services have the necessary knowledge and skills to provide services for preventing unsafe abortion and for providing quality post-abortion care.

**Workforce training**
- Ensure that pre-service training of health providers includes key service elements for preventing unsafe abortion.

### 7. Health information and research

**Health information system**
- When possible, integrate reporting on abortion into the routine health information system, or consider surveys and research to guide decision-making and programme planning.
- Collaborate with the law and justice sector to enable data collection without compromising the safety or care of women seeking health services.

**Monitoring and evaluation**
- Monitor access to and quality of safe abortion and/or post-abortion care.
- Integrate evaluation of preventing unsafe abortion through the existing national surveys.

**Research**
- Research on who seeks abortion, where and how, for what reasons, and with what health consequences.
- Identify social, cultural and religious barriers to eliminating unsafe abortion and providing safe abortion and post abortion care; advocate for policies and programmes to overcome those barriers.

### 8. Partnerships

**Promote multisectoral action**
- Have cross-sectoral discussions on magnitude and consequences of unsafe abortions for society; advocate for multisectoral collaboration to increase women’s access to appropriate services.

**Participation**
- Create spaces for discussion of the realities and perspectives of women who have abortions to inform public discourse and decrease stigma surrounding abortion.
4.4 SEXUALLY TRANSMITTED INFECTIONS

Challenges

Integration issues

Prevention and management of sexually transmitted infection (STIs) should be linked to other components of reproductive health, e.g., antenatal care screening of syphilis and HIV for pregnant women, screening for STIs in family planning clinics, and promotion of dual protection to prevent pregnancy and transmission of STIs. Prevention of mother-to-child transmission of HIV and congenital syphilis needs strong engagement by maternal and newborn health and family-planning services. Currently, services for preventing and managing STIs are not always offered because of lack of skills, commodities, supplies and equipment where reproductive health services are provided.

Prevention of HIV infection involves activities by several nonhealth sectors, while HIV treatment requires long-term care and follow-up. Based on the geographic burden of HIV, identify the service levels at which HIV diagnosis and treatment can be provided or integrated with other reproductive health services. Not all levels of service delivery can be equipped to handle all HIV-related care and interventions. Health system-wide approaches to HIV prevention may not be financially viable in geographic areas with low HIV prevalence.

Specific challenges in prevention and control of STIs

1. Limited information on STIs in the Region

Limited data on STIs in the Western Pacific Region have been collected from routine reporting, making programme planning difficult. In most countries in the Region, fewer resources are available for gathering accurate STI data than for HIV surveillance, even though prevalence rates of other STIs are higher.

2. Most STIs are treatable but diagnosis is not always easy

STIs are difficult to diagnose, especially among women. The syndromic method of STI case management is useful for treating male clients but less so for women. In women, diagnosis often needs to be confirmed by laboratory testing, which is not always available at primary care level. Point-of-care tests to screen for STIs are available but are often not done, despite national policies on universal antenatal care screening.

3. Serious implications of asymptomatic STIs for women and their babies

The asymptomatic nature of some STIs can endanger women and their babies. This is often the case with syphilis, gonorrhoea, chlamydia and HIV infections. Often, diagnosis is made only after serious complications have occurred, such as infertility, ectopic pregnancy and newborn infections, e.g., congenital syphilis and ophthalmia neonatorum.

4. STI is a sensitive issue and women often do not have bargaining power to protect themselves

People who suffer from STIs are often stigmatized. Often, women do not have sufficient power to require their partners or their clients, where sex is sold, to use a condom. Also some women may not be able to ask their partners to get tested for STI/HIV.

5. Low priority given to prevention of STIs, except HIV

Attention given to the prevention of STIs is disproportionate to the burden of disease they cause. HIV infection has considerably lower prevalence in the Western Pacific Region than other STIs, but receives significantly more funding and attention.

6. Addressing the needs of special target groups

STI/HIV prevalence is often much higher in some groups of the population, such as adolescents, youth, sex workers, transgender people, men who have sex with men, people who inject drugs, migrants and refugees. These groups need special attention, and health workers need to present an accepting, nonjudgemental attitude in order to encourage use of services.
7. Limited capacities of primary care providers for STI/HIV diagnosis and treatment

Primary care health facilities in many low- and middle-income countries often do not have the capacity to treat STIs due to lack of skills, medicines and supplies. This necessitates clients to seek treatment from specialists, STI clinics and hospitals, with time, cost and transport barriers. People seeking STI treatment might also visit unregulated pharmacies and traditional healers, where services may be ineffective and potentially harmful.

Key interventions and actions

The goal of the reproductive health framework for preventing STIs, including HIV infection, is to ensure universal access to prevention and treatment services.

The specific objectives are:

- to promote prevention of STIs, including HIV infection;
- to improve access to and quality of services for prevention and control of STIs, including HIV infection; and
- to strengthen service linkages with other components of reproductive health.

The following are key actions for achieving these objectives.

Objective 1: Promote prevention of STIs, including HIV infection

STI prevention and control is an essential HIV prevention strategy. Targeted interventions for STI prevention among key affected populations are similar to those for HIV prevention. Raise awareness about STIs and HIV and increase access to information and services. Focus especially on at-risk adolescents and key affected populations, such as sex workers, men who have sex with men, transgender people and people who inject drugs.

Reduce the risk of STI/HIV transmission by promoting consistent and correct use of quality condoms and water-based lubricants, avoidance of multiple partners, and delay of first sexual activity. Provide information on ways to prevent STI/HIV infections, including: prevention of mother-to-child-transmission; syphilis and HIV screening for all pregnant women; and HIV testing and counselling for those at risk. Integrated services maximize potential for universal coverage, especially for mothers living with HIV. Increase men’s understanding about their role in the prevention of parent-to-child transmission of HIV and other STIs.

Support sex workers to practise safer sex, for their own health, and to ensure that transmission of STIs/HIV to their customers can be prevented. Provide regular outreach to sex workers and peer-based information and education on STI/HIV prevention, reproductive health services, including screening and treatment of asymptomatic infections, contraceptive counselling and provision of contraception and dual protection. Each key affected population may need specific prevention and treatment services, e.g. adolescent-friendly health services that include all components of reproductive health, among other services to promote overall health, nutrition and development of adolescents.

Objective 2: Improve access to and quality of services for STIs/HIV infection

Where feasible, integrate, expand and upgrade primary care services and ensure availability of relevant medicines and laboratory diagnosis to be able to provide syndromic case management and antenatal screening for syphilis. Provide pre- and in-service training on prevention and treatment of STIs/HIV for relevant health workers. Enable mid-level providers, such as midwives, to provide syndromic case management and use point-of-case tests for some STIs. Implement client consent sexual-contact tracing where necessary, in accordance with human rights principles. Provide user-friendly STI services including regular STI screening and case-finding programmes for adolescents and vulnerable populations.

Provide counselling on STI prevention and treatment as well as condom use, and promote screening for congenital syphilis. Diagnose and treat appropriately all genital ulcers with syndromic case management.
Test all women who have spontaneous abortion or stillbirth for syphilis. Improve the delivery of information and services for men on prevention and control of STIs/HIV, including adjusting their roles when part of a discordant couple. Strengthen information gathering, monitoring and evaluation of STIs/HIV for better planning and interventions. To reach people living with HIV, extend family-planning services to facilities that provide antiretroviral therapy (ART).

**Objective 3: Strengthen linkages with other components of reproductive health**

Reproductive health services across the five core components are important entry points for eliminating mother-to-child transmission of HIV and congenital syphilis. Test pregnant women for STIs/HIV and ensure uninfected pregnant women remain uninfected. Increase awareness of health workers on preventing mother-to-child transmission of HIV; providing paediatric ART; preventing STIs among adolescents/young people; and protecting/supporting children affected by HIV/AIDS.

Another important service linkage is related to the prevention of cervical cancer, which is triggered by infection of human papillomavirus (HPV) through sexual transmission. Establish and strengthen a system for early detection and treatment of cervical cancer. Use various approaches for cervical cancer screening, e.g. Pap smear, visual inspection with acetic acid, and HPV DNA testing at different levels of service. Ensure referral for treatment for women who test positive. Consider introduction of HPV vaccination for young adolescent girls.
Table 4.4 Summary of the Reproductive Health Framework for Preventing STIs including HIV

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Policy, legislation, leadership and management</strong></td>
<td></td>
</tr>
<tr>
<td>Assessment and planning</td>
<td>• Conduct surveys to assess magnitude of STI burden.</td>
</tr>
<tr>
<td></td>
<td>• Improve quality of STI testing to strengthen STI surveillance for advocacy and programming.</td>
</tr>
<tr>
<td>Political will</td>
<td>• Advocate for increased support for programmes focusing on elimination of mother-to-child transmission of HIV and congenital syphilis.</td>
</tr>
<tr>
<td>National policies and legislation</td>
<td>• Develop policy to allow mid-level providers, e.g. midwives, to provide syndromic case management and point-of-care testing.</td>
</tr>
<tr>
<td><strong>2. Improve demand of reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Identify target populations and their health needs</td>
<td>• Ensure pregnant women remain uninfected, and provide counselling on STI prevention and treatment, condom use, partner notification and treatment.</td>
</tr>
<tr>
<td></td>
<td>• Improve the delivery of information and services for men on prevention and control of STIs/HIV, including strengthening their role in preventing parent-to-child transmission of HIV and congenital syphilis and in HIV prevention within serodiscordant couples.</td>
</tr>
<tr>
<td>Communications and outreach</td>
<td>• Integrate STI health-seeking behaviour messages into HIV prevention interventions.</td>
</tr>
<tr>
<td></td>
<td>• Raise awareness about STIs/HIV and increase access to information and services, with special attention paid to vulnerable adolescents and key affected populations, and promote use of condoms, avoidance of multiple partners and the delay of sexual activity.</td>
</tr>
<tr>
<td></td>
<td>• Integrate STI/HIV prevention services within maternal health, family planning and adolescent health services; provide information on STI/HIV infection, including PMTCT, to all pregnant women, and promote HIV testing and counselling, especially to those who are at risk.</td>
</tr>
<tr>
<td>Reduce barriers to access</td>
<td>• Ensure friendly and quality STI services for adolescents and key affected populations.</td>
</tr>
<tr>
<td></td>
<td>• Strengthen functional referral mechanisms between reproductive health and STI/HIV services.</td>
</tr>
<tr>
<td>Address social and gender equity</td>
<td>• Empower women, including adolescent girls, to negotiate safe sex with their partners, and increase the supportive involvement of men and boys in STI/HIV prevention.</td>
</tr>
<tr>
<td><strong>3. Improve supply and quality of reproductive health services</strong></td>
<td></td>
</tr>
<tr>
<td>Increase availability of services</td>
<td>• Provide family planning, abortion and post-abortion counselling services within STI services for sex workers and other key affected populations.</td>
</tr>
<tr>
<td></td>
<td>• Expand and upgrade existing services at primary care level to provide at least syndromic case management and ensure availability of relevant medicines.</td>
</tr>
<tr>
<td></td>
<td>• Allow mid-level providers, such as midwives, to provide syndromic case management.</td>
</tr>
<tr>
<td></td>
<td>• Promote dual protection for pregnancy and STI/HIV prevention.</td>
</tr>
<tr>
<td></td>
<td>• Provide hormonal counselling services for transgender people.</td>
</tr>
<tr>
<td>Provide and improve key services and referrals</td>
<td>• Ensure quality of care, including screening for congenital syphilis and HIV testing and counselling early in pregnancy during antenatal care visits, with a special attention to those who are at risk.</td>
</tr>
<tr>
<td></td>
<td>• Ensure universal precautions are carried out at all times and levels of care, especially when dealing with mothers living with HIV.</td>
</tr>
<tr>
<td></td>
<td>• Effectively manage STIs, including genital ulcers, by using syndromic case management, especially for men at primary care level, or by laboratory-based diagnosis and treatment, where available.</td>
</tr>
<tr>
<td></td>
<td>• Ensure that all pregnant women who test positive for syphilis or those with spontaneous abortion and stillbirth, and their sexual partners, are adequately treated—or at least given single-dose treatment—and counselled at the point of care.</td>
</tr>
<tr>
<td></td>
<td>• Address the needs of sex workers and other key affected populations, promote condom use for dual protection, and address their other reproductive health needs, including options for handling unwanted pregnancies and provision of maternal health services.</td>
</tr>
<tr>
<td>Key areas</td>
<td>Key actions</td>
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</tr>
<tr>
<td>Ensure access to ART for prophylaxis or for therapy for pregnant women with HIV, involvement of men to reduce the risk of parent-to-child transmission of HIV and syphilis, counselling and provision of family-planning services for people living with HIV and advice on infant feeding and nutrition.</td>
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</tr>
<tr>
<td>Treat all infants born to HIV- and/or syphilis-infected mothers and ensure follow-up treatment for both mothers and their sexual partners and infants.</td>
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</tr>
<tr>
<td>Ensure primary and secondary prevention and management of cervical cancer.</td>
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</tr>
<tr>
<td>Programme management</td>
<td>Ensure regular communication and planning among maternal and child health, family planning and STI/HIV programmes and address integration of procurement and supply management.</td>
</tr>
<tr>
<td>4. Improve availability and quality of commodities</td>
<td>• Ensure availability of condoms, STI medicines and ART, and monitor distribution process, including stock-outs.</td>
</tr>
<tr>
<td>Improve availability</td>
<td>• Regularly monitor quality and storage of commodities, as appropriate.</td>
</tr>
<tr>
<td>Improve quality</td>
<td></td>
</tr>
<tr>
<td>5. Health care financing</td>
<td>• Estimate cost of key services for better planning.</td>
</tr>
<tr>
<td>Costing and funding services</td>
<td>• Ensure services can be accessed by key affected populations by reducing financial barriers.</td>
</tr>
<tr>
<td>Reduce financial barriers</td>
<td></td>
</tr>
<tr>
<td>6. Health workforce</td>
<td>• Assign health providers at primary care level with appropriate tasks to ensure proximity of services to the clients, including ensuring health providers with skills in syndromic management of STIs and STI/HIV testing, including point-of-care testing.</td>
</tr>
<tr>
<td>Workforce management and human resources</td>
<td>• Equip health providers at primary care level with necessary commodities.</td>
</tr>
<tr>
<td>Workforce training</td>
<td>• Provide pre- and in-service training for relevant health providers on prevention and treatment of STIs/HIV, and building skills for working with young people and other key affected populations.</td>
</tr>
<tr>
<td>7. Health information and research</td>
<td>• Facilitate sexual-contact tracing where necessary and provide appropriate services.</td>
</tr>
<tr>
<td>Health information systems</td>
<td>• Strengthen health information system, monitoring and evaluation of STI/HIV programmes for better planning and interventions.</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>• Prioritize collection and analysis of STI data to guide programme planning and evaluation.</td>
</tr>
<tr>
<td>Research</td>
<td>• Monitor progress in prevention and control of STIs/HIV.</td>
</tr>
<tr>
<td></td>
<td>• Evaluate programme for further improvement in service delivery and reaching specific target groups.</td>
</tr>
<tr>
<td>8. Partnerships</td>
<td>• Priorities collection and analysis of STI data (through commissioned studies where necessary) to enable program planning and evaluation.</td>
</tr>
<tr>
<td>Promote multisectoral action</td>
<td>• Conduct research to determine the accuracy of STI diagnostic approaches, e.g. point-of-care testing.</td>
</tr>
<tr>
<td>Participation</td>
<td>• Conduct research to increase understanding of local knowledge and treatment-seeking behaviours in relation to STIs.</td>
</tr>
<tr>
<td></td>
<td>• Ensure multisectoral involvement, e.g. community-based organizations, NGOs, social services, police, etc.</td>
</tr>
<tr>
<td></td>
<td>• Develop strategies to increase the participation of key affected populations in the design, delivery and evaluation of STI/HIV programmes</td>
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</tbody>
</table>
4.5 Sexual Health

Challenges

Integration issues

Sexual health—as a state of well-being across the life cycle—encompasses much more than what can be included in a health approach. While shifting to integrated reproductive health services, there may be a tendency to focus on clinical or more purely health-oriented aspects of sexual health and overlook others. To support sexual health for all ages and population groups, the health sector must work strongly across sectoral lines, from policy-setting to interaction with communities, ensuring information, education and services for all, including older people, persons with disability and sexual minorities. The health sector also has a crucial role to play in identifying and preventing gender-based violence.

There are limited data in the Western Pacific Region on the impact of a range of sexual health issues important throughout the life cycle, including infertility, menopause and the sexual health of older people. Limited attention has been paid to the sexual health of men, minorities and marginalized groups, including persons with disability and GLBTI persons.

Specific challenges in sexual health

1. Addressing risky and harmful sexual behaviour

Multiple sexual partners, sexual coercion, early onset of sexual activity, gender-based and sexual violence by intimate partners, lack of respect between men and women, and trafficking of women and girls are common practices in countries of the Western Pacific Region. These risky and harmful practices, which are supported by deeply entrenched gender norms in countries across the Region, undermine sexual health and can lead to unwanted pregnancy and transmission of STI/HIV.

2. Limited information and services related to adolescent sexual health

Many STI/HIV cases occur among adolescents and youth, with young people’s vulnerability being increased by their level of sexual activity, their limited knowledge, and gender norms that disempower young women. Furthermore, access to sexual and other reproductive health services and information is often very limited for young people, especially if they are unmarried.

3. Sexual violence is an issue in the Western Pacific Region

Sexual and gender-based violence, including rape by an intimate partner and violence by clients of female, male and transgender sex workers, are common in many countries of the Western Pacific Region. Such violence is even more frequent during conflicts or emergency situations.

4. Limited promotion of healthy sexuality

In many countries in the Western Pacific Region, socially conservative attitudes, as well as religious and cultural norms, limit the discussion of sex and sexuality. Social and technological changes have increased access to and the use of pornography, in the absence of a counter-narrative about healthy sexuality and respectful relationships between men and women.

Key interventions and actions

The goal of the reproductive health framework for promoting sexual health is universal access to information and services for sexual health.

The specific objectives are:

- to promote healthy sexual behaviours for all ages and population groups;
- to improve access to and quality of services for promoting sexual health, with special attention to adolescents and young people, including those who are unmarried, older people, persons with disability, GLBTI persons, etc.; and
- to prevent sexual and gender-based violence, including during times of conflict or emergency situations.

The following are key actions for achieving these objectives.
Objective 1: Promote healthy sexual behaviours

Promote sexual health through a variety of information and media channels. Create an environment where healthy sexual behaviours are the norm, e.g. by developing programmes that nurture respectful, equal and equitable relationships between boys and girls. Provide accurate and targeted information on healthy and responsible sexual behaviour. Promote messages to delay age of onset of sexual activity, marriage and first pregnancy. Promote practices of safer sex with regular and casual partners, including consistent and correct use of condoms when dealing with sex workers. Promote healthy sexual behaviours for gay, lesbian, bisexual and transgender persons through targeted communication strategies and by ensuring access to commodities such as condoms and lubricants. Cater to the needs of older people and persons with disability.

Objective 2: Improve access to and quality of services with attention to adolescents

Use multiple avenues to promote awareness and behaviour change communication interventions for young people. Involve adolescent and young people in the design and monitoring of reproductive health services that target them, including development of in-school and out-of-school programmes to provide sexual and reproductive health education, including education on life skills; healthy sexuality; delaying age of sexual activity, marriage and first pregnancy; and the risks associated with unsafe abortion, STIs and teenage pregnancy. Develop community-based initiatives to provide sexual and other reproductive health services to meet the needs of out-of-school young people and other vulnerable groups. Improve quality of care, and ensure privacy and confidentiality whenever dealing with clients.

Promote policy and legislative frameworks that support young people’s right to access to contraceptives, regardless of their marriage status. Engage the private sector, NGOs and civil society organizations to develop networks to ensure availability of services in venues where young people can easily access them. Improve relationships between the health, education and other sectors to develop comprehensive programmes for adolescents and youth, and monitor and evaluate their impact. Ensure that everyone, including persons with disability, sexual minorities, GLBTI persons, and people with sexual health vulnerabilities, such as sex workers and people who inject drugs, have equitable access to comprehensive sexual and other reproductive health services.

Objective 3: Prevent sexual and gender-based violence

Prevent and appropriately respond to sexual and gender-based violence that requires the development and implementation of laws and policies that protect the rights of women, girls and persons with disability. Foster a culture of “zero-tolerance” with regards to violence in communities. Strengthen health and other sector policies, increase health workers’ knowledge and skills on gender, develop legal and normative frameworks and protocols for screening, and improve the management and referral of cases of sexual violence across all components of reproductive health services and other social services. Ensure that victims of sexual violence have timely access to emergency contraception and ART prophylaxis, and where possible access to safe abortion services, counselling, legal advice, and safe accommodation.

Set up special courts for sexual and gender-based violence, and assign heavy penalties for those found guilty of sexual violence. This needs to be accompanied by training of police and court officials. Develop database, tracking and reporting systems within health and other social services on violence against women and girls.

Develop health and social services’ capacity to recognize and provide specialized care, including physical and mental care and reproductive health services to women/girls and men/boys who are victims of gender-based violence and sexual abuse. Institutionalize the response to sexual violence in pre-service training curricula for health professionals, health workers, teachers, social workers, youth workers and other key professionals. Strengthen partnerships and collaboration with relevant sectors to expand the availability of services and referral pathways and to help provide a full range of services and assistance to women, girls and disadvantaged groups. For example, increased collaboration between police and health workers in health facilities can enable early diagnosis and treatment of injuries and other health conditions, and early reporting of violence. This might also help reduce violence towards sex workers.

Implement a minimum initial service package (MISP) for reproductive health in crisis situations to prevent sexual violence. Prevent and manage the consequences of sexual violence for refugees in camps or for persons made homeless by natural disasters, including careful site planning of camps, setting up health services for medical treatment of victims, raising awareness of the importance of early referral of victims to health services, and coordinating the response between health, community, security and protection services.
Table 4.5 Summary of the Reproductive Health Framework for Promoting Sexual Health

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Policy, legislation, leadership and management</strong></td>
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</table>
| Assessment and planning | • Assess the overall situation on sexual health and develop programmes for specific target groups.  
• Assess sexual health needs of young people, of gay, lesbian, bisexual, transgender, intersex (GLBTI) persons and of other vulnerable persons to be used as a basis for programme planning. |
| Political will | • Advocate for setting up programmes that nurture respectful relationships between boys and girls through formal and informal channels.  
• Advocate for setting up of special courts for sexual and gender-based violence and heavy penalty for those found guilty of sexual violence, as well as training of police and court officials. |
| National policies and legislation | • Strengthen health sector policy, legal and normative frameworks and protocols for screening, managing and referring cases of sexual violence across all reproductive health services.  
• Promote supportive policy and legislative frameworks to support young people’s right to access contraceptives, regardless of their marital status.  
• Promote legislation and enforcement of laws and regulations to protect the rights of women, girls, persons with disability, and minority persons from sexual and gender-based violence and foster a culture of “zero-tolerance”. |
| **2. Improve demand of reproductive health services** | |
| Identify target populations and their health needs | • Identify target populations, including youth, men, victims of gender-based violence, GLBTI persons, communities in conflict, refugees and displaced persons, and their sexual health needs. |
| Communications and outreach | • Provide accurate information on healthy/responsible sexual behaviour through various channels.  
• Establish programmes that nurture respectful relationships between boys and girls through formal and informal channels and create environments with healthy sexual behaviours as the norm, while encouraging respect for people with a range of sexual orientations and gender identities.  
• Provide education on sexual and other reproductive health components for adolescents and young people, in- and out-of-school, including on life skills, delaying age of sexual activity, marriage and first pregnancy, and the risks associated with unsafe abortions, STIs/HIV and teenage pregnancy.  
• Promote media and behaviour change communication interventions for young people. |
| Reduce barriers to access | • Increase involvement of young people, persons with disability, and GLBTI persons in the design and monitoring of sexual and other reproductive health services targeting them. |
| Address social and gender equity | • Address discrimination and ensure information and services are available to different groups based on social status, sex, education, ethnicity, sexual orientation and gender identity status.  
• Strengthen gender awareness and skills of providers and other stakeholders.  
• Involve civil society and women’s groups and increase women’s empowerment. |
| **3. Improve supply and quality of reproductive health services** | |
| Increase availability of services | • Facilitate community-based initiatives to provide sexual and other reproductive health services to meet the needs of out-of-school young people and other vulnerable groups.  
• Engage the private sector, NGOs and civil society organizations to develop networks to ensure availability of services in venues where young people can easily access them. |
| Provide and improve key services and referrals | • Provide quality and specialized care, including physical/mental care and reproductive health services to women/girls and men/boys who are victims of gender-based violence and sexual abuse.  
• Provide minimum initial service package (MISP) for reproductive health during conflict/emergency/crisis situations.  
• Prevent and manage the consequences of sexual violence in refugee camps: careful camp site planning, set up medical treatment of victims, raise awareness for early referral of victims to health services and coordinate the response between health, community, security and protection services. |
<table>
<thead>
<tr>
<th>Key areas</th>
<th>Key actions</th>
</tr>
</thead>
</table>
| Programme management                          | • Improve quality of care, including ensuring privacy and confidentiality in providing information and services to clients.  
• Institutionalize response to sexual violence in pre-service training curricula for health professionals. |
| 4. Improve availability and quality of commodities |                                                                                                                                             |
| Improve availability                          | • Ensure availability of commodities related to promoting sexual health, such as condoms, other modern contraceptives and relevant educational materials. |
| Improve quality                               | • Ensure quality of the above commodities.                                                                                                                                                            |
| 5. Health care financing                      |                                                                                                                                             |
| Costing and funding services                  | • Estimate costs of key interventions in promoting sexual health.                                                                                                                                     |
| Reduce financial barriers                    | • Ensure that the poor can access services related to sexual health by reducing financial barriers.                                                                                                     |
| 6. Health workforce                           |                                                                                                                                             |
| Workforce management and human resources      | • Ensure that health providers providing reproductive health services have sufficient knowledge and ability to provide necessary information on sexual health and ensure availability of male and female health providers at primary care level. |
| Workforce training                            | • Provide training on sexual health, gender equality and referral pathways in responding to gender-based violence for health workers, teachers, social workers, youth and other key professional.                |
| 7. Health information and research            |                                                                                                                                             |
| Health information systems                    | • Develop database, tracking and reporting systems within health and other social services on violence against women and only vulnerable groups, e.g. GLBTI persons and persons with disability. |
| Monitoring and evaluation                     | • Use data from various components of the reproductive health programme to understand sexual health problems and monitor progress.                                                                   |
| Research                                      | • Conduct research to analyse the impact of issues, e.g. ageing and sexual health, infertility and reproductive tract cancers, as well as to identify effective health response to gender-based violence. |
| 8. Partnerships                               |                                                                                                                                             |
| Promote multisectoral action                  | • Promote delayed age of sexual activity, marriage and first pregnancy through collaboration with other government sectors and private sector groups.  
• Improve the relationship between the health, education and other sectors to develop comprehensive programmes for young people, and to monitor and evaluate their impact.  
• Strengthen partnerships and collaboration with relevant sectors to provide a full range of services and assistance to women, girls and disadvantaged groups, including law and justice, social services, education and NGOs, to strengthen prevention of and responses to gender-based violence. |
| Participation                                 | • Ensure participation of women and others who have experienced gender-based violence in the development of effective responses to it across the Western Pacific Region. |
Comprehensive abortion care training at the National Maternal and Child Health Centre, Cambodia.

5 IMPLEMENTATION OF REPRODUCTIVE HEALTH FRAMEWORK
In order to achieve universal coverage to reproductive health services, it is necessary for each country to identify key challenges, set priorities and formulate strategies for accelerated action. As detailed in Annex 3, countries and areas in the Western Pacific Region have very diverse reproductive health situations. This reproductive health framework can be used as a guide when conducting consultative processes that involve all stakeholders. While each core component of reproductive health has its special features, it is important to progress towards the delivery of integrated reproductive health services in order to improve effectiveness, efficiency and equity.

5.1 GROUPING OF COUNTRIES AND AREAS IN THE WESTERN PACIFIC REGION

Low- and middle-income countries and areas in the Region can be categorized as follows:

1. Countries with relatively small population but a high burden of reproductive health challenges, including a high MMR, a low CPR and a low to medium proportion of deliveries attended by skilled health personnel. These countries, namely Cambodia, the Lao People’s Democratic Republic and Papua New Guinea, contribute to approximately 20% of maternal deaths in the Region.

2. Countries with a large population that have achieved a low MMR, a medium to high CPR and a medium to high proportion of deliveries attended by skilled health personnel. China, the Philippines and Viet Nam contribute more than 70% of maternal deaths in the Region.

3. Pacific island countries and areas that tend to have very small populations and a high proportion of deliveries attended by skilled attendants, but also high total and adolescent fertility rates, and low CPRs. Violence against women and STI prevalence are also often high in these countries.

The above categorization is useful for understanding the overall contexts and needs in improving specific components of reproductive health in the Region; however, each country is unique. Planning at country level must be based on country needs and situation, such as the capacity of health systems, social and cultural backgrounds, norms and value systems, and collaboration among health and other relevant sectors and stakeholders. It is important to note that despite the diversities, each country needs to implement the basic principles of human rights and address inequities by meeting the needs of the poor, disadvantaged and marginalized groups.

5.2 DESIGNING REPRODUCTIVE HEALTH PROGRAMME IN COUNTRIES

Almost all countries and areas face challenges in integrating reproductive health services, not only among the five components, but also with other relevant programmes. Integration can occur in different ways. The most common practice in the Western Pacific Region is to integrate family-planning services with maternal and child health services, delivered by the same health providers and at the same service points; however, oftentimes these two components are provided on different days of a week. Such service delivery arrangements may result in missed opportunities, causing inefficiencies for the user as well as the provider. However, this type of issue can be easily addressed. More difficult challenges occur when health providers do not have the skills or mandates, and facilities do not have the means to deliver an integrated range of services. Actions at policy and management levels are necessary to address these system and organizational issues.

All countries and areas in the Region face challenges in quality of care, but they are often different in nature. For example, in the Lao People’s Democratic Republic, coverage of skilled care at birth is below 40% and quality of care at childbirth does not meet the standard for safe delivery at the primary care level. In China, on the other hand, coverage of skilled care at birth is more than 90%, but the rate of Caesarean sections is more than 25%, which clearly suggests that decisions to do a C-section are not always based on valid medical criteria. Such medicalization of normal delivery puts women at unnecessary risk; therefore, it is also an issue of quality of care.

The following are possible ways of designing reproductive health programmes for each category of countries and areas in the Western Pacific Region.
1. Countries with a high burden of reproductive health challenges

Focus should be placed on improving access to a small set of key reproductive health services. When resources are limited, integration of services should be carried out in a phased manner. When MMR is high and maternal health service coverage is low, it is necessary to focus at least on maternal and newborn health and family planning. Availability of adequate human resources with the right skills at primary care level, as well as necessary medicines, supplies and equipment are critical issues. Referral back-up and its linkage with primary care level need strengthening. Improving quality of care by implementing systematic supportive supervision would ensure better performance of service delivery. Gradually, as resources become available, and the health system is strengthened, the range of integrated services can be widened to cover more components of reproductive health and other relevant health services.

2. Countries with large population that contribute the majority of maternal deaths in the Region

The maternal mortality rate is an important indicator that reflects the overall performance of health systems. China and Viet Nam have almost reached universal access to skilled care at birth and family planning, as well as a low MMR. Although the Philippines has not achieved that level, its MMR is below 100 per 100 000 live births. It is because of the size of their populations that these three countries contributed approximately 76% of maternal deaths in the Region in 2010.

In these countries, especially in China and Viet Nam, it is important to address inequities among provinces or geographic areas, ethnic minorities and other disadvantaged and marginalized communities. A focus on quality of care is also important with the aim to address specific issues, such as high level of C-section rate, managing low birth weight and premature babies, congenital anomalies and stillbirths. These countries may also be ready to expand integration of reproductive health services and other relevant health services. For the Philippines, with some poorer indicators, the suggested focus might be more closely related to those for countries in Category 1.

3. Pacific island countries and areas

Most Pacific island countries and areas have very good service coverage for maternal and newborn health services, but they also have high TFRs, low CPRs, and often a high prevalence of violence against women. STIs are prevalent in some countries and areas, and the adolescent fertility rate is also high. In many cases, these factors are interrelated, and responses need to be based on understanding the underlying causes and linkages. Quality of care is a major issue that needs special attention in Pacific island countries. Considering the small size of populations and accessibility of health facilities, it may be feasible to widely integrate reproductive health services at a reasonably fast pace.

The approaches outlined above are for consideration only, and design of reproductive health programmes should be based on each country’s situation and needs. This process needs stakeholder involvement to ensure ownership, smooth planning and coordinated implementation, as well as programme monitoring and evaluation.
Danica Camacho, the Philippines symbolic seven billionth baby, lies on her mother Camille in a Manila hospital on 31 October 2011. The newborn was counted as part of the United Nations population projection campaign.

6 MONITORING AND EVALUATION
In order to monitor and evaluate progress, especially on equity, it is necessary to collect, analyse and use information that is disaggregated by relevant social stratifiers or indicators of social exclusion, such as urban/rural residence, socioeconomic status, age and ethnicity. Routine reporting, periodic surveys, including of gender-based violence against women, surveillance systems or sample surveys can be the main sources of information. As committed at the global level and following the launch of the Global Strategy for Women’s and Children’s Health, the monitoring mechanism is to be strengthened to ensure accountability in use of resources and results achieved.

Monitoring and evaluation should include analysis of reproductive health services in terms of policies, organizational structure and linkages with other programmes, and efficiency of service delivery mechanisms, in addition to output, coverage and impact indicators. Evaluation should identify how programme elements contribute to the overall goal and targets of MDG 5 and other international development goals for reproductive health. (See Annex 1)

**6.1 MONITORING**

Regular monitoring of reproductive health services is important for decision-makers to measure progress towards universal coverage and to identify problems that need to be addressed to improve programme implementation. Once a national strategy is adopted, appropriate indicators should be identified for measuring access to and quality of services, community attitudes and behaviours, and reproductive health outcomes. A monitoring framework should be included in the implementation plan; however, it is important to keep it as simple as possible. Table 6 provides some examples of key indicators for monitoring reproductive health programmes.

Each country and area in the Western Pacific Region needs to decide on a set of core indicators, as minimal as possible, relevant for its own situation and priorities. It is necessary to have baseline values for core indicators and repeat measurements on a yearly or regular basis. Data collected on key indicators should be disaggregated by relevant social stratifiers to enable analysis and tracking of health inequities. Such analysis is important for the design and modification of policies and implementation of strategies.

The monitoring system should build on existing and planned national monitoring tools. Coordination and collaboration with programmes that have well-developed monitoring systems would be vital as some indicators are common to several programmes. Every effort should be made to integrate the monitoring systems to reduce overlap and discrepancies. The capacity for collection and use of relevant data, analysis and dissemination should be increased at the local, district, province and national levels to improve decision-making and policy implementation.

**6.2 EVALUATION**

In order to evaluate the success of the implementation of reproductive health framework with respect to these principles and components, it is necessary to collect, analyse and use information that is disaggregated by the relevant social stratifiers, such as urban/rural residence, socioeconomic status and ethnicity. Periodic surveys conducted at least every five years may be necessary to carry out such analysis.

Surveys should also be used to monitor the indicators chosen, as many core indicators can only be accurately measured through surveys. Large-scale population-based surveys, such as demographic and health surveys, reproductive health surveys, and multiple-indicator cluster surveys have the capacity to calculate progress towards the MDGs and other indicators, including maternal mortality ratio, proportion of deliveries assisted by a skilled health personnel, antenatal care, unmet need for family planning, and adolescent fertility rate.

Surveys should be complemented by programme reviews that identify best practices, as well as constraints and ways to overcome them. Evaluation should focus on the attainment of MDG 5, international development goals for reproductive health and other specific national health development goals and objectives. The results of any evaluation undertaken should be made available to the public and used for policy formulation, decision-making, health planning and readjusting priorities and interventions of reproductive health programmes.
Table 6  Possible indicators for reproductive health programmes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Type of measure</th>
<th>Source of data</th>
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<tbody>
<tr>
<td><strong>Maternal and newborn health</strong></td>
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<td></td>
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<tr>
<td><strong>Core indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Coverage of women who attended antenatal care at least one and four times</td>
<td>Percentage</td>
<td>Health information system (HIS), survey</td>
</tr>
<tr>
<td>2. Proportion of deliveries attended by skilled health personnel</td>
<td>Percentage</td>
<td>HIS, survey</td>
</tr>
<tr>
<td>3. Coverage of postnatal care for mothers and newborn infants</td>
<td>Percentage</td>
<td>HIS, survey</td>
</tr>
<tr>
<td>4. Maternal mortality ratio (per 100 000 live births)</td>
<td>Ratio</td>
<td>Survey, civil registration</td>
</tr>
<tr>
<td><strong>Optional indicators</strong></td>
<td></td>
<td></td>
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<tr>
<td>5. Number of facilities (per 500 000 population) providing comprehensive emergency obstetric care</td>
<td>Ratio</td>
<td>HIS, survey</td>
</tr>
<tr>
<td>6. Proportion of births taking place in a health facility</td>
<td>Percentage</td>
<td>HIS, survey</td>
</tr>
<tr>
<td>7. Neonatal mortality rate (per 1000 live births)</td>
<td>Rate</td>
<td>HIS, survey, civil registration</td>
</tr>
<tr>
<td>8. Low birth weight rate (birth weight less than 2500 g)</td>
<td>Percentage</td>
<td>Survey, HIS</td>
</tr>
<tr>
<td>9. Prevalence of anaemia in pregnant women</td>
<td>Percentage</td>
<td>Survey, HIS</td>
</tr>
<tr>
<td>10. Prevalence of malaria in pregnant women in endemic areas</td>
<td>Percentage</td>
<td>Survey, HIS</td>
</tr>
<tr>
<td>11. Caesarean section rate</td>
<td>Percentage</td>
<td>Survey, HIS</td>
</tr>
<tr>
<td>12. Case fatality rate of selected obstetric complications</td>
<td>Percentage</td>
<td>Survey, HIS</td>
</tr>
<tr>
<td><strong>Family planning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Core indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Contraceptive prevalence rate (CPR)</td>
<td>Percentage</td>
<td>Survey</td>
</tr>
<tr>
<td>14. Unmet need for family planning (percentage of women at risk of pregnancy—currently married or in union who are fecund—who desire to postpone childbearing, but are not currently using a contraceptive method)</td>
<td>Percentage</td>
<td>Survey</td>
</tr>
<tr>
<td><strong>Optional indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Percentage of primary health care facilities providing at least three methods of modern contraceptives</td>
<td>Percentage</td>
<td>HIS</td>
</tr>
<tr>
<td>16. Contraceptive prevalence by method</td>
<td>Percentage</td>
<td>Survey</td>
</tr>
<tr>
<td>17. Total fertility rate and age-specific fertility rate</td>
<td>Rate</td>
<td>Survey, HIS, civil registration</td>
</tr>
<tr>
<td>Indicator</td>
<td>Type of measure</td>
<td>Source of data</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Preventing unsafe abortion</strong></td>
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<td>18. Abortion rate (number of induced abortions per 1000 women of reproductive age)</td>
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<td>21. Percentage of service delivery points using vacuum aspiration or medical termination for procedures by gestational age</td>
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<td>22. Condom use at last high-risk sex</td>
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<td>23. Proportion of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS</td>
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<td>24. Percentage of service delivery points offering voluntary counselling and testing</td>
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<td>25. Percentage of service delivery points in highly endemic HIV areas that provide prevention of mother-to-child transmission services and screening for syphilis</td>
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<td>26. Percentage of health facilities offering routine screening for cervical cancers</td>
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<td>27. Incidence of uterine cervical cancer (per 100 000 women)</td>
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<td>28. Proportion of women between the ages of 30–49 screened for cervical cancer at least once</td>
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<td>29. Adolescent birth rate (per 1000 girls aged 15–19 years)</td>
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<td>30. Number of service delivery points having staff trained to provide appropriate services for victims of sexual violence</td>
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<td>31. Percentage of men and women who have experienced coercive or forced sex (includes rape, date rape) and domestic violence</td>
<td>Percentage</td>
<td>Survey</td>
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Reproductive health through the life cycle, China, 2001.

REFERENCES AND ANNEXES
REFERENCES


### ANNEX 1: INTERNATIONALLY-AGREED QUANTITATIVE GOALS RELATED TO REPRODUCTIVE HEALTH

<table>
<thead>
<tr>
<th><strong>International Conference on Population and Development (ICPD), 1994</strong></th>
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<tr>
<td><strong>Reproductive health</strong></td>
</tr>
<tr>
<td>“All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015.” (Paragraph 7.6)</td>
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<tr>
<td><strong>Family planning</strong></td>
</tr>
<tr>
<td>“All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services which are not against the law.” (Paragraph 7.16).</td>
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<tr>
<td><strong>Maternal mortality</strong></td>
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<tr>
<td>“Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality ratio below 100 per 100 000 live births and by the year 2015 a maternal mortality ratio below 60 per 100 000 live births. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality ratio below 125 per 100 000 live births and by 2015 a maternal mortality ratio below 75 per 100 000 live births.” (Paragraph 8.21).</td>
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<table>
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<tr>
<th><strong>Key actions for the further implementation of the Programme of Action of the Internal Conference on Population and Development (ICPD+5), 1999</strong></th>
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<tr>
<td><strong>Reproductive health services</strong></td>
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<tr>
<td>“Governments should strive to ensure that by 2015 all primary health care and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases; and barrier methods such as male and female condoms and microbicides if available to prevent infection. By 2005, 60% of such facilities should be able to offer this range of services and by 2010, 80% of them should be able to offer such services.” (Paragraph 53)</td>
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<td><strong>Family planning</strong></td>
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<td>“... countries were urged to attempt to close the gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families by at least 50 per cent by 2005, by 75% by 2010 and 100% by 2050.” (Paragraph 58)</td>
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<td><strong>Maternal mortality</strong></td>
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<td>“... countries should use the proportion of births assisted by skilled attendants as a benchmark indicator. By 2005, where maternal mortality ratio is very high, at least 40% of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50% and by 2015, at least 60%.” (Paragraph 64)</td>
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<td><strong>HIV/AIDS</strong></td>
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<td>“... by 2005, ensure that at least 90%, and by 2010 at least 95% of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2010 prevalence in this age group is reduced globally, by 25% in the most affected countries and that by 2010 prevalence in this age group is reduced globally by 25%.” (Paragraph 70).</td>
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## ANNEX 2: DEMOGRAPHIC PROFILES OF COUNTRIES AND AREAS IN THE WESTERN PACIFIC REGION

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Data source: The State of World Population 2010, UNFPA
ANNEX 3: DETAILED SITUATION ANALYSIS ON REPRODUCTIVE HEALTH IN THE WESTERN PACIFIC REGION

Reproductive health needs vary considerably across and within the countries and areas in the Western Pacific Region. Efforts have been made to improve all five core components of reproductive health in accordance with each country’s situation and needs. Some countries have poor reproductive health indicators and are making less progress. Other countries with large populations, particularly China, the Philippines and Viet Nam, account for very high proportions of overall morbidity and mortality in the Region, even though their indicators are quite good. Further, inequity of various forms is an issue within countries, as well as across countries. The graphs presented in this section use the three letter international codes for each country as presented in Annex 2.

Maternal and newborn health

Millennium Development Goal (MDG) 5 calls for the maternal mortality ratio (MMR) to be reduced by three quarters by 2015, with 1990 as the baseline. One of the international development goals from ICPD+5 has targeted 90% of births attended by skilled health personnel globally and at least 60% in countries with a high MMR by 2015. The continuum of care before and during pregnancy, childbirth, postpartum and neonatal is a crucial factor for ensuring maternal and neonatal health.

Maternal mortality

It is recognized that high maternal mortality is a reflection of women’s subordinate or low social status, as well as the low priority accorded to women’s health. Limited access to health services causes, among other things, delays in reaching health facilities when complication arises. Poor health and nutritional status of pregnant women may also be a reflection of unequal treatment received by women at household level. Women sometimes die because of obstetric complications and from diseases such as malaria that are aggravated by pregnancy. Obstetric complications include postpartum haemorrhage, eclampsia, sepsis, obstructed labour and complications from unsafe abortion. Worldwide, more than 70% of maternal deaths are due to these causes.

Most maternal deaths are preventable, yet 287 000 women worldwide died in 2010 because of maternal causes. Of these, an estimated 12 000 deaths occurred in the Western Pacific Region, a reduction of 66% from the 1990 level. Almost 92% of maternal deaths in the Region occur in six countries: Cambodia, China, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and Viet Nam (Figure 1).

The Lao People’s Democratic Republic, Papua New Guinea and Cambodia have high MMRs, at 470, 230 and 206 per 100 000 live births, respectively, in 2010. Despite these high rates, these three countries contributed only 16% of maternal deaths in the Region. China, the Philippines and Viet Nam reduced their MMRs to 37, 99 and 59 per 100 000 live births, respectively; however, in terms of numbers of maternal deaths, they contribute 76% of maternal deaths in the Region—simply because of their large populations. However, there is uneven progress within these countries. For example, in China, there are huge provincial differences, while in Viet Nam, a disproportionately high MMR is encountered among ethnic minority groups.

One pervasive result of high maternal mortality is high neonatal mortality and stillbirths. Most neonatal deaths are a consequence of poor health and nutritional status of the mother coupled with inadequate care before, during and after delivery. Stillbirth rates are high (14 to 18 per 1000 total births in 2009) in Cambodia, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines, and some Pacific Island countries.

Anaemia was estimated to affect 30.7% of pregnant women in the Western Pacific Region during the period of 1993-2005. It affects women’s health, survival, productivity and income, as well as the health and survival of their offspring. Iron and folate supplementation before and during pregnancy could reduce
anaemia by 50% in some countries in Western Pacific Region. Maternal undernutrition and anaemia are contributing factors for low birth weight babies, besides other issues, such as maternal infections and obstetric complications.

In 2010, the average neonatal mortality rate (NMR) was estimated to be 11 deaths per 1000 live births in the Western Pacific Region. Figure 2 shows NMR in the Region, with Papua New Guinea, Cambodia, the Lao People’s Democratic Republic having the highest rates (21-23 per 1000 live births) in 2010. Nauru and Kiribati also have similar rates. However, China, the Philippines and Viet Nam contributed the greatest number of neonatal deaths in the Western Pacific Region. Three major causes of neonatal deaths in 2010 were pre-term birth complications (28%), birth asphyxia (26%) and neonatal sepsis (6%); other causes were congenital abnormalities (9%) and other unspecified conditions (32%). Most causes of neonatal deaths can be prevented.
and managed with affordable and effective evidence-based technologies and interventions, which often are inaccessible or underutilized by pregnant women.

**Service coverage**

The proportion of deliveries assisted by skilled health personnel/birth attendant is an important indicator for maternal health, as childbirth is a critical period for both mother and her newborn infant. These rates are low in the Lao People’s Democratic Republic (37%), Papua New Guinea (40%) and the Philippines (62%), as reflected in Figure 3, while all but eight countries in the Region have achieved more than 90%.

Skilled care at birth shows the most significant inequities among health services. Figure 4 illustrates these inequities in select countries by disaggregating data by the mother’s place of residence, wealth quintile and education level. The most striking inequities can be seen in the Lao People’s Democratic Republic, while Mongolia has been successful in achieving universal access to skilled care at birth.

In China, Mongolia, the Philippines, and most Pacific island countries and areas, coverage for one visit of antenatal care was higher than 90% in 2005–2010, but only 37% in the Lao People’s Democratic Republic (Figure 5). However, coverage for at least four antenatal care visits is generally much lower, especially in Papua New Guinea (29%). This drop in coverage reflects a lack of continuity in provision of antenatal care, which limits opportunities for providing education on maternal and neonatal health care and birth preparedness, and improving maternal health status.

**Figure 4. Health inequities in proportion of births attended by skilled health personnel (%)**

Adolescent pregnancy

Adolescent pregnancy exposes girls to a greater risk of maternal mortality, as they are at least twice as likely to die during pregnancy or childbirth than women in their twenties. Maternal deaths among adolescent girls are further influenced by age, marital status, social class, education, urban or rural setting and whether pregnancy is wanted or unwanted. The younger the age, the lower the social class and educational level, the higher is the risk of adolescent maternal death.

Pregnancy outside marriage can be more dangerous than pregnancy within marriage if the adolescent girl lacks family support and does not have access to reproductive health services. Such pregnancies may end with an unsafe abortion or obstetric complications and poor pregnancy outcomes, such as maternal morbidity, stillbirths, low birth weight and sick babies.

Figure 5. Antenatal care coverage (%) for at least 1 and 4 visits, 2005–2011

China, Malaysia and Mongolia had the lowest adolescent fertility rates for 2000 to 2010, while the Lao People’s Democratic Republic, Papua New Guinea and the Philippines had the highest rates: 110, 70 and 53 per 1000 girls aged 15–19 years (Figure 6). Pacific island countries, such as the Marshall Islands, the Federated States of Micronesia, Nauru and Niue also have rates higher than 50 adolescent pregnancies per 1000 girls.

Family planning

Family planning enables women to regulate their fertility, thereby reducing maternal deaths caused by unsafe abortion and the burden of having too many children that are too closely spaced. Around 25%–40% of maternal deaths could be eliminated if unplanned pregnancies were prevented. When the use of contraceptives is low in a country, the total fertility rate—average number of children per woman during her lifetime—is often high. Some countries in the Region have maintained stable population growth by reaching a total fertility rate of 2.1–2.2.

Contraceptive prevalence rate and total fertility rate

Contraceptive prevalence rates (CPR) are usually low in countries with a high MMR, as was the case in Papua New Guinea (36%) and the Lao People’s Democratic Republic (38%) in 2005–2010 (Figure 7). These two countries have significantly increased their CPR in the past 10 years, while the Philippines has made only a small gain. Most of the Pacific island countries/areas have a CPR of less than 45%.
The total fertility rate (TFR) in countries with a low CPR is usually high, as was the case in Papua New Guinea (4.0), the Philippines (3.2), the Lao People’s Democratic Republic (2.7), Cambodia (2.6) and Pacific island countries with small populations (ranging from 2.7 to 4.2). Most of the countries with a high TFR often have limited choice of contraceptive methods.

**Unmet need for family planning**

Many couples want to limit or space their pregnancies and yet do not use contraception. They are said to have an unmet need for family planning, as reflected in Figure 8. The unmet need for family planning was high in the Lao People’s Democratic Republic (27%), the Philippines (22%) and some Pacific island countries, but was comparatively low in Viet Nam (4.8%), Mongolia (4.6%) and China (2.3%).

The high rates of unmet need for family planning reflect low accessibility to family planning information and services and poor quality of care. Other reasons include lack of necessary knowledge on family planning, limited contraceptive choice, fear of side-effects of contraceptive methods, and social and cultural issues, such as women’s unequal bargaining power in decision-making related to family planning and the high cost of contraception in some countries.

**Unsafe abortion**

Unmet need for family planning for any reason may result in unintended pregnancies. These pregnancies may also be unwanted, which may lead to induced abortion. Such a procedure is often assisted by persons lacking the necessary skills or conducted in an environment lacking the minimal medical standards. Complications may arise and lead to maternal deaths.

Approximately 790 000 women underwent unsafe abortions in the Western Pacific Region, resulting in about 680 maternal deaths in 2008. It was estimated that unsafe abortion comprised 5% of the total number of maternal deaths in the Region. These numbers may grossly underestimate the problem, and data are very limited because unsafe abortions are often concealed.
Many countries do allow abortions, but indications for legal abortion vary from country to country. A country’s status could be described as follows: abortion is permitted (1) to save a woman’s life; (2) to preserve physical health; (3) to preserve mental health; (4) on socioeconomic grounds; and (5) without restrictions as to reasons. The standing of countries in the Region with regard to abortion laws is presented in Table 1. Only Cambodia, China, Mongolia and Viet Nam have laws that permit abortion without restrictions. However, adequate and safe services are sometimes lacking, leading to unsafe abortions.
Many providers are wary about providing this service because they lack training on safe abortion services; they have concerns about stigma and/or they fear that they may be breaking the law. In 2005, about 8% of women aged 15–44 years old in Cambodia reported having undergone at least one abortion. About 12% of these abortions were conducted at home, and 13% were helped by either a traditional birth attendant or relatives and friends. Another study in 2008 found that, although the law permits abortion on demand up to 12 weeks of pregnancy, 40% of providers from public hospitals believed that elective abortions were not permitted legally. In some countries, repeated abortions are common and seen by women as another method of family planning.

**Sexually transmitted infections**

The most serious and long-term consequences of untreated sexually transmitted infections (STIs) tend to affect women and newborn infants. In women, STIs are often asymptomatic which, if left untreated, could result in complications, such as pelvic inflammatory disease, infertility, chronic pelvic pain, tubo-ovarian abscesses and ectopic pregnancy. STIs are also associated with particular types of cancers, such as cervical cancer caused by chronic infection of the human papillomavirus. Untreated STIs in pregnant women can lead to infertility, spontaneous abortion and stillbirth, as well as low birth weight, gonococcal eye infections and congenital syphilis in newborn infants. Trichomoniasis infection, with an estimated prevalence of 4.9% among women in the Region in 2005, often causes habitual spontaneous abortion. In men, STIs can spread from the urethra to the epididymis, causing urethral stricture and infertility.

*Chlamydia trachomatis* and *Neisseria gonorrhoeae*. Pacific island countries and areas have a high prevalence of certain STIs, especially chlamydia and syphilis. Estimates of chlamydia infection show relatively high rates in Fiji and Samoa among women presenting for antenatal care, especially among young people (under 25 years of age), where prevalence is between 34% and 40%. In Australia, chlamydia infection was the most common STI notified, and the third highest for all notifiable diseases. Estimates of the chlamydia infection prevalence in the Region were 4.8% among women and 3.4% among men in 2005, while for gonorrhoeae 1.4% and 0.5% respectively. The highest estimated prevalence rates (3% or more) are found in Cambodia and Papua New Guinea. In China, Malaysia, the Philippines and Viet Nam, the prevalence was estimated to be 1% or below.

**Syphilis.** Syphilis remains a global health problem with an estimated 12 million persons infected each year, despite the existence of preventive measures, such as the use of condoms and effective and relatively inexpensive treatment options. Pregnant women who are infected with syphilis can transmit the infection to their fetus, causing congenital syphilis, with serious adverse outcomes for the neonate. Currently, some countries in the Region are committed to eliminate congenital syphilis and paediatric HIV by 2015–2020.

Globally, an estimated two million pregnancies are affected by syphilis annually. Approximately 25% of these pregnancies end in stillbirth or spontaneous abortion. Another 25% result in low birth weight babies or serious infection, both of which are associated with an increased risk of perinatal death. In the absence of active surveillance, it is difficult to assess accurately the annual number of pregnant women with syphilis. Estimates of the syphilis prevalence in the Region were 0.27% among women and 0.26% among men in 2005. Some studies in the Region show seroprevalence of less than 1% among pregnant women in the Republic of Korea and Malaysia and as high as 7% in Papua New Guinea.

**Human papillomavirus** infection causes cervical cancer, which was diagnosed in more than 490,000 women and caused 250,000 deaths globally in 2005. About 80% of all cervical cancer cases occur in developing countries where programmes for screening and treatment are seriously deficient or lacking. Globally, cancer of the cervix is the second most common cancer in women. In 11 countries in the Region, cervical cancer ranks either first or second as the leading cause of deaths from cancers among women.

**HIV/AIDS.** In 2007, there were 33.2 million adults and children living with HIV worldwide. Of those, nearly half, 15.4 million, were women. The main transmission routes for HIV infection in the Region are injecting
### Table 1: Countries by category of abortion law

<table>
<thead>
<tr>
<th>Country</th>
<th>Category of abortion law</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permitted to save a woman’s life or prohibited altogether</td>
</tr>
<tr>
<td>Brunei Darussalam</td>
<td>✓</td>
</tr>
<tr>
<td>Kiribati</td>
<td>✓</td>
</tr>
<tr>
<td>Lao People’s Democratic Republic</td>
<td>✓</td>
</tr>
<tr>
<td>Micronesia, Federated States of</td>
<td>✓</td>
</tr>
<tr>
<td>Palau</td>
<td>✓</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>✓</td>
</tr>
<tr>
<td>Philippines, The</td>
<td>✓</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>✓</td>
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<tr>
<td>Tonga</td>
<td>✓</td>
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<tr>
<td>Tuvalu</td>
<td>✓</td>
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<tr>
<td>Republic of Korea</td>
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<tr>
<td>Vanuatu</td>
<td>✓</td>
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<tr>
<td>Malaysia</td>
<td>✓</td>
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<tr>
<td>Nauru</td>
<td>✓</td>
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<tr>
<td>New Zealand</td>
<td>✓</td>
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<tr>
<td>Samoa</td>
<td>✓</td>
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<tr>
<td>Hong Kong (SAR)</td>
<td>✓</td>
</tr>
<tr>
<td>Australia</td>
<td>✓</td>
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<tr>
<td>Fiji</td>
<td>✓</td>
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<tr>
<td>Japan</td>
<td>✓</td>
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<tr>
<td>Cambodia</td>
<td>✓</td>
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<tr>
<td>China</td>
<td>✓</td>
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<tr>
<td>Mongolia</td>
<td>✓</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>✓</td>
</tr>
</tbody>
</table>

Source: WHO, Outline of a regional strategy on preventing unsafe abortion in the WHO Western Pacific Region, Report on a WHO WPRO inter-country meeting on preventing unsafe abortions held on December 2008, Kuala Lumpur, Malaysia, 2008
drug use, unprotected commercial sex, and men having sex with men. In many countries, women with new HIV infections represent a growing proportion of persons living with HIV/AIDS. This has been seen as increasing feminization of the HIV epidemic.

It is estimated that more than 10% of new HIV infections each year are caused by mother-to-child transmission of the virus. The transmission can occur during pregnancy, labour or through breastfeeding. Services to prevent mother-to-child transmission of HIV are important entry points for HIV/AIDS prevention, treatment, counselling, information and care services for women, their children and families. Many countries in the Region have made attempts to integrate prevention of such HIV transmission and screening for congenital syphilis into antenatal care services. However, it is estimated that only about 1 in 10 pregnant women with HIV in Asia and the Pacific are offered such services.

**Sexual health**

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality and is not merely the absence of disease, dysfunction or infirmity. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Adolescents have received more attention than other age groups because of young people’s vulnerability regarding sexual matters and high prevalence of premarital sexual activity. Young, unmarried adolescents are often denied reproductive health services, whether by law or by the attitudes of health personnel, parents and others. They are denied counselling and services for preventing pregnancy and STIs and for negotiating sex. Thus, they often engage in unprotected sex and unsafe sex.

Adolescents also often lack resources to access services, and lack mobility in some situations where socioeconomic and cultural barriers exist. Where services do exist, they are often ill-equipped to deal with issues related to adolescent sexual and reproductive health. Moreover, the most vulnerable adolescents are hard to reach, such as those not in school and those who are impoverished. Adolescents need services not only from the formal health sector but also from schools, outreach programmes and other sources, often through nongovernmental organizations (NGOs), for information and life skills coaching on sexual and reproductive health.

Sexual violence can be an important factor in unwanted pregnancy, acquiring STIs and sexual dysfunction. Sexual coercion at a young age affects sexual behaviour of girls later in life, leading to an increased likelihood of having multiple sexual partners and feeling less empowered to use a condom. A multicountry study undertaken by WHO on women’s health and domestic violence found that more than 5% of women in 10 out of 15 settings—including Japan and Samoa—reported their first sexual experience as forced. Some settings reported more than 14%. The study also found that the range of lifetime prevalence of sexual violence by an intimate partner was 6%–59%, but mostly 10%–50%. The proportion of ever-regnant women physically abused during at least one pregnancy exceeded 5% in 11 of the 15 settings. These findings highlight the interconnectedness of gender inequality and sexual health and other elements of reproductive health.
ANNEX 4: WEBSITES FOR GUIDELINES AND TOOLS ON REPRODUCTIVE HEALTH

A. Maternal and Neonatal Health


http://www.who.int/reproductive-health/publications/pcpnc/pcpnc.pdf

http://www.who.int/reproductive-health/impac/mcpc.pdf


http://whqlibdoc.who.int/publications/2006/9241593679_eng.pdf


annex 4


15. WHO. Department of Making Pregnancy Safer, 2007. Monitoring and evaluation of maternal and newborn health and services at the district level.


B. Family Planning


http://www.who.int/reproductive-health/publications/dmt/index.htm


http://www.cambridge.org/uk/catalogue/catalogue.asp?isbn=9780521774741


C. Preventing Unsafe Abortion


2. WHO. Department of Reproductive Health and Research, 2006. Frequently asked clinical questions about medical abortion.

3. WHO. Department of Reproductive Health and Research, 2008. Mid-level health-care providers are a safe alternative to doctors for first-trimester abortions in developing countries: Social science research policy briefs.
   http://www.who.int/reproductive-health/hrp/policy_briefs/midlevel_hcproviders.pdf


D. Sexually Transmitted Infections


E. Resources: Guidelines and Tools on Sexual Health


4. UNESCO. International technical guidance on sexuality education: an evidence-informed approach for schools, teachers and health educators. Volumes I and II.
   http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

   http://www.popcouncil.org/publications/books/2010_ItsAllOne.asp


F. Monitoring and Evaluation of Reproductive Health Programme


4. WHO. Department of Reproductive Health and Research, 2011. Universal access to reproductive health: accelerated actions to enhance progress on Millennium Development Goal 5 through advancing Target 5B.


G. Integrating Reproductive Health Services


3. Family Health International. Delivering reproductive health promises through integrated services. 

   http://info.worldbank.org/etools/docs/library/122031/bangkokCD/BangkokMarch05/Week2/4Thursday/S3EntryPoints/DeliveringRHservices.pdf

   http://www.pathfind.org/site/DocServer/Tanz_case_study_FINAL.pdf?docID=5161