Asia Pacific Alliance

FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

AN INFORMATION KIT ON MDG 5, SEXUAL AND REPRODUCTIVE HEALTH AND SUPPLIES AND THE FUNDING GAP IN ASIA AND THE PACIFIC

5

IMPROVE MATERNAL HEALTH

Investing in Sexual and Reproductive Health Saves Women's Lives

The Millennium Development Goals (MDGs) are eight goals agreed upon by United Nations (UN) member states in 2000, set to be achieved by 2015. It is a framework for development that is meant to reduce poverty, save lives and provide people the opportunity to benefit from the global economy. The eight MDGs have 21 targets and a series of measurable indicators for each target. This information kit is dedicated to MDG 5: Improving Maternal Health with a focus on **MDG 5b: Universal Access to Reproductive Health in Asia and the Pacific.**

Millennium Development Goal 5:
Improve Maternal Health

Target 5a	**Reduce the maternal mortality ratio by three quarters between 1990 and 2015**
Indicators	■ Maternal mortality ratio ■ Proportion of births attended by skilled health personnel
Target 5b	**Achieve universal access to reproductive health by 2015**
Indicators	■ Contraceptive prevalence rate ■ Adolescent birth rate ■ Antenatal care coverage ■ Unmet need for family planning

"When Girls and Women Win, Everyone Wins."

— WOMEN DELIVER

REPRODUCTIVE HEALTH is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. — INTERNATIONAL CONFERENCE FOR POPULATION AND DEVELOPMENT (ICPD), 1994

Target 5b is off-target!

The MDG Report 2010 findings on MDG 5 include:

- Inequalities in care during pregnancy are striking.
- Only one in three rural women in developing regions receives the recommended care during pregnancy.
- Progress has stalled in reducing the number of teenage pregnancies, putting more young mothers at risk.
- Poverty and lack of education perpetuate high adolescent birth rates.
- Progress in expanding the use of contraceptives by women has slowed.
- Use of contraception is lowest among the poorest women and those with no education.
- **Inadequate funding for family planning is a major failure in fulfilling commitments to improving women's reproductive health!** [1]

Direct benefits of meeting the need for maternal health and family planning

- Globally, maternal deaths would reduce by more than two-thirds from 356,000 to 105,000. In South Central and Southeast Asia, it would drop by 75%, from 130,000 to 30,000. [2]
- Unintended pregnancies around the world would reduce by more than two thirds, from 75 million in 2008 to 22 million per year. In South Central and Southeast Asia, it would drop by 74%, from 32.2 million to 8.5 million.
- Unsafe abortions, a leading cause of maternal mortality, would decline by three quarters from 20 million to 5.5 million. In South Central and Southeast Asia, it would drop from 10.3 million to 2.7 million (assuming no change in abortion laws).
- Worldwide, deaths from unsafe abortion would drop by more than four-fifths, from 46,000 to 8,000.
- The total number of women needing medical care for complications of unsafe procedures around the world would decline from 8.5 million to 2 million.
- Sustained investment in sexual and reproductive health and rights (SRHR) is critical for strengthening health systems and improving the lives of women and their families. [3]
- Financing reproductive health, particularly family planning, directly impacts economic growth and poverty reduction. [4] Targeted policies and adequately funded interventions are required to ensure that the poorest and most marginalised women are able to freely decide the timing and spacing of their pregnancies. Despite the great need and demand for family planning services and supplies, funding for SRHR has remained stagnant and actually declined for family planning. [5]

[1] UN. 2010. The Millennium Development Goals Report. http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%20201006l5%20-.pdf.

[2] South Central Asia includes Afghanistan, Bangladesh, Bhutan, India, Iran, Kazakhstan, Kyrgyzstan, Maldives, Nepal, Pakistan, Sri Lanka, Tajikistan, Turkmenistan, and Uzbekistan. Southeast Asia includes Brunei, Burma, Cambodia, East Timor, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand and Vietnam.

[3] The Guttmacher Institute. 2010. Facts on Investing in Family Planning and Maternal and Newborn Health. http://www.guttmacher.org/pubs/FB-AIU-summary.pdf.

[4] UNFPA. 2010. Investing in Reproductive Health and Rights to Achieve MDG5 and Accelerate Sustainable Development. http://www.unfpa.org/public/cache/offonce/news/pid/5484.

[5] Ibid.

MDG 5 and 5b in Asia and the Pacific

The region is still far from achieving MDG 5, particularly 5b

"The MDGs, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning."

— FORMER UN SECRETARY GENERAL KOFI A. ANNAN (1997–2006)

Maternal Mortality

About 356,000 women die each year due to complications during pregnancy and childbirth worldwide. [6] Forty-four percent of all maternal deaths occur in Asia and the Pacific. Asia-Pacific countries with the highest maternal deaths are Nepal, Lao PDR, Bangladesh, Cambodia, Pakistan, Papua New Guinea, Indonesia, Timor-Leste and Myanmar.

Proportion of deliveries attended by trained health personnel

Only 65.4% of women in Asia on average give birth with professional assistance.

Antenatal care visits

The majority of the women in Lao PDR (65%) and Nepal (56%) never visit an antenatal clinic during their pregnancy. For countries with very high maternal mortality, including Bangladesh, Cambodia and Pakistan, 8 out of every 10 women visit an antenatal clinic less than four times during their pregnancy.

Unmet Need

Among all the people in the world with an unmet need for family planning services, 55% live in the Asia-Pacific region. The countries with the most critical unmet need in the region include Lao PDR (40%), Tonga (34%) and 25% for Cambodia, Pakistan and Nepal.

Contraceptive prevalence rates

In South Central and Southeast Asia, only 47% of married women use modern contraceptives, even if more women want to avoid becoming pregnant. [7] In the Pacific Islands, the contraceptive prevalence rate (CPR) remains below average for developing countries and even lower in terms of the use of modern methods. In Papua New Guinea, Pakistan and Samoa only 20–23% of the women use any modern method of contraception. Fiji, Solomon Islands, Tonga and Tuvalu have no available data on CPR modern methods.

Adolescent birth rates

A significant proportion of maternal deaths in Asia occur among adolescents and young women. An important cause of these deaths is unsafe abortion. The lack of comprehensive sexuality education and sexual and reproductive health (SRH) services for young people increases unprotected sex among unmarried adolescents and exposes them to the risk of unwanted pregnancies leading to unsafe abortion. Incorrect use of contraceptives is a prime cause of method failure among young people. Those who are knowledgeable in using birth control methods still cannot access them due to a lack of youth friendly services and cultural barriers. Teenage birth rates are very high in Bangladesh, Lao, Nepal, Vanuatu and the Solomon Islands.

HIV prevalence

Sexual and reproductive health and HIV are inextricably linked, often sharing contributing factors such as gender inequality, limited access to information, poverty, social marginalisation and stigma. The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. In 2007 alone, 4.9 million people living with HIV were recorded in Asia and the Pacific. Approximately 300,000 people in the region died from AIDS-related illnesses in the same year.

Gender equality and women's empowerment

Gender power relations in society can prevent women and girls from accessing sexual and reproductive health services and information. Women in Asia and the Pacific region suffer from some of the world's lowest rates of employment, political representation, property ownership and participation.

What is…?

Maternal mortality or maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. [8]

Unmet need refers to women and couples who do not want another birth within the next two years or ever, but are not using a method of contraception.

Contraceptive prevalence rate is the percentage of women between the ages of 15–49 who are practising, or whose sexual partners are practising, any form of contraception.

Adolescent birth rate measures the annual number of births among 15 to 19 years old per 1,000 women in that age group.

Unless otherwise indicated, information in this section is based on findings published by APA in Making SRHR Count: Asia Pacific Resource Flows Project 2010 *by Maria Bordallo Gil. The report is a desk review of resource flows for SRHR in 21 countries in Asia and the Pacific. These countries are listed in the Development Assistance Committee list of official development assistance (ODA) recipients and where APA members and bilateral donors have programmatic focus. The full report is available at www.asiapacificalliance.org.*

[6] The Guttmacher Institute. 2010. Facts on Investing in Family Planning and Maternal and Newborn Health. http://www.guttmacher.org/pubs/FB-AIU-summary.pdf.

[7] The Guttmacher Institute. 2010. Facts on Investing in Family Planning and Maternal and Newborn Health in South Central and Southeast Asia. http://www.guttmacher.org/pubs/FB-AIU-Asia.pdf.

[8] WHO. 2011. Health Statistics and Health Information Systems. http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html.

SAVE WOMEN'S LIVES NOW!

Simultaneous investment in modern family planning and maternal and newborn health services would save more lives and would cost less than investing in maternal and newborn health services alone. [9]

Insufficient Funds

Aid for family planning as a proportion of total aid to health declined sharply between 2000 and 2008, from 8.2% to 3.2%. Aid to reproductive health services has fluctuated between 8.1% and 8.5%. To date, external funding has not yet returned to its 2000 level.

	NEED	AVAILABLE IN 2007	GAP IN 2010
TOTAL ESTIMATE	US$ 23 billion by 2010 US$ 25 billion by 2015	US$12 billion Total allocation (national + donors)	**US$11 billion**
1/3 FROM EXTERNAL DONORS	US$7.7 billion in 2010 US$8.33 billion in 2015	US$0.97 billion (ODA)	**US$6.73 billion**

HOW MUCH IS NEEDED?	Total allocations to population and SRHR needed in this region are **US$23 billion for 2010 and US$25 billion for 2015** according to the 2010 UN Commission for Population and Development revised estimates. The ICPD Programme of Action stipulated that one-third of this amount is expected to come from external donors, which means **US$7.7 billion in 2010 and US$8.33 billion by 2015**.
HOW MUCH IS AVAILABLE?	Total national and international SRHR funds in the region in 2007 were approximately **US$12 billion**. Of this amount, official development assistance (ODA) totalled **US$0.97 billion** in 2007, or 7.8%. The difference of more than US$11 billion were mobilised nationally, of which an estimated **70% were out-of-pocket expenditures**, or money paid directly by the patients or their families.
THE GAP IN 2010	The funding gap for 2010 in this region is about **US$6.73 billion**.
REGIONAL DONORS CONTRIBUTION	Bilateral funding for SRHR in the Asia-Pacific region has traditionally been the purview of Australia, Japan and New Zealand. These regional donors' total contributions to sexual and reproductive health in Asia and the Pacific accounted for approximately **US$65 million** or **6.6% of all the donor disbursements in the region**. In 2010, donors stepped up their commitments to achieving the MDGs in various international fora. Most notable for Asia Pacific are the commitments of Japan and Australia. The data here does not include these commitments, as they had still not been disbursed or reported in 2010.

Multilateral funding in Asia and the Pacific comes primarily from the World Bank and the Asian Development Bank (ADB). Since 2006, there has been a decline in World Bank spending and support for reproductive health and HIV/AIDS. With its 2010 Reproductive Health Action Plan, the World Bank might again scale up its interest in SRHR issues. ADB spending on these same areas represented less than 1% of its total spending from 2003 to 2006.

Four emerging donors—Republic of Korea, Thailand, China and India—have begun to increase SRHR contributions to the region. Their share of support remains significantly lower than Australia, Japan and New Zealand.

"Inadequate funding for family planning is a major failure in fulfilling commitments to improving women's reproductive health."

— MDG REPORT 2010

Reporting and monitoring systems and resource flow tracking is poor. There are critical gaps in information on SRHR and gender indicators are most often not available.

Recommendations to enhance financial resource flows in Asia and the Pacific

- Donors in the region should channel more funds to SRHR in Asia and the Pacific:
  - Increase total ODA, including increasing share of ODA/GNI (at least to meet the donor average of 0.47%) [10]
  - Increase share of ODA to the health sector
  - Increase share of ODA to SRHR (to meet donors' average of 7.19%)
  - Increase the portion of such funds through NGOs
- **Donors need to multiply their ODA almost 8 times in order to meet the MDG commitments.**
- Multilateral donors need to ensure that their policy matches their financial commitments.
- Donor and recipient governments need to enhance their reporting and funding tracking systems to reflect as accurately as possible the amount and precedence of provided and received funds for SRHR, including national utilisation and allocation of these funds.

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[9] The Guttmacher Institute. 2010. Facts on Investing in Family Planning and Maternal and Newborn Health. http://www.guttmacher.org/pubs/FB-AIU-summary.pdf.

[10] ODA/GNI refers to the U.S. dollar amount of official development aid as a percentage of donors' gross national income.

Photos by Rose Koenders and from APA Image library.

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ABOUT APA: The Asia Pacific Alliance for Sexual and Reproductive Health and Rights (APA) works to ensure everyone's right to health is fully achieved through the promotion and inclusion of SRHR in development agendas.

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Reproductive Health Supplies in Asia and the Pacific

5

IMPROVE MATERNAL HEALTH

Achievement of MDG 5, particularly 5b, is directly linked to availability and accessibility of reproductive health (RH) services, in particular, supplies. Shortages in RH supplies can lead to: unplanned pregnancies; unsafe abortions; unplanned family size and unspaced births; exacerbated poverty; maternal, infant and child mortality and morbidity; transmission of HIV and other sexually transmitted infections (STIs) and gender-based violence.

In the last decade, a Global Call was launched to advocate for a reliable supply and appropriate mix of quality, safe and affordable contraceptives, as indispensable to the functioning of reproductive health programmes. However, reproductive health services, particularly supplies in the Asia Pacific region, still do not adequately meet the needs of the people.

Resources for reproductive health are in decline, while demand for contraceptives and other reproductive health supplies is projected to rise. The Reproductive Health Supplies Coalition has identified three key factors in the supply crisis:

1. **Inadequate resources:** Demand for supplies is increasing, while international development assistance is in decline.
2. **Weak but complex systems:** A shift towards greater ownership at the country level has made supply chains more complex.
3. **Lack of coordination:** Supply chains, which rely on donors, suppliers, providers, government agencies and NGOs, collectively fail to coordinate and share information, and often fail to meet supply demands.

What needs to be done?

- Donors must increase commitments to help developing countries narrow the gap between unmet need and supply. Increasing access to reproductive health services, particularly supplies, is an investment with multiple dividends for developing countries in Asia and the Pacific.
- Governments in Asia and the Pacific must continue to target free and subsidised supplies to those least able to pay and encourage private, commercial and NGO sectors to prevent supply shortages.
- Governments in Asia and the Pacific must fund and assign budget lines for sexual and reproductive health services and supplies in national budgets.

What is…?

Reproductive health supplies are materials or consumables used in reproductive health services, specifically contraceptives, drugs for prevention and treatment of STIs and HIV, as well as medicines and equipment to ensure healthy pregnancy and delivery.

Reproductive Health Commodity Security (RHSC) is defined as having a secure supply and choice of quality contraceptives and other reproductive health commodities to meet every person's needs at the right time and in the right place. RHSC is achieved when all individuals can choose, obtain and use affordable and high quality reproductive health commodities whenever they need them.[11]

Contraceptive Security exists when people are able to choose, obtain and use high quality contraceptives and condoms whenever they want them for family planning and HIV/AIDS/STI prevention. This definition emphasises clients, commodities and long-term assurance.[12]

Challenges in Asia and the Pacific

- Increasing demand for contraceptives as national populations grow
- Possible higher demand for contraceptives if it becomes more acceptable among current non-users and excluded groups, such as single men and women
- Problems with accessing information and services for young people
- Disapproval of some churches of the use of modern contraceptive methods
- Strong, conservative beliefs around sexual activity and contraception
- Lack of political will to address some of the difficult sexual and reproductive health issues

Unless otherwise stated, information in this section is based on the Primer on Reproductive Health Supplies in Asia and the Pacific *published by APA in 2009.*

[11] UNFPA. 2008. Reproductive Health Commodity Security Advocacy Briefs. http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2008/RHCS advocacy (2008).pdf.

[12] USAID. 2004. Contraceptive Security: Ready Lessons Overview. http://pdf.usaid.gov/pdf_docs/PNACW660.pdf.

Southeast Asia Snapshot on Contraceptive Security

Across Southeast Asia, there are huge differences in contraceptive supply. Demand patterns vary greatly within countries and across borders. In many countries, women still rely on traditional methods of contraception to space births, which puts them at risk of contracting STIs, including HIV. Reproductive tract infections and STIs are widespread. There is a high unmet need for condoms to prevent HIV and STIs.

Although information about the unmet need of never-married women of all ages including youth is not available, it is expected to be high as most Southeast Asian governments target contraceptive services for married couples. There is also an expected increase in demand when STI/HIV prevention is integrated into reproductive health programmes.

Most governments in Southeast Asia fail to ensure contraceptive security

THE RULE. In general, Southeast Asian countries can be profiled according to each country's position on contraceptive provision and gaps in contraceptive security. The degree of government commitment, or the lack of it, to contraceptive security varies according to religious, demographic and/or economic reasons. These generally fall into three, at times overlapping, categories:

1. Countries with governments taking a pro-natalist stance that oppose or reduce access to modern contraceptives (the Philippines, Malaysia, Brunei Darussalam and Singapore);
2. Countries with strong family planning programmes that emphasise methods considered more effective to achieving population control, yet neglect short-term contraceptives (Vietnam and Indonesia); and
3. Countries hampered by a lack of resources in the provision of contraceptive services, with some not wholly supportive of contraception (Myanmar, Laos, Cambodia and Timor-Leste).

The implications of these different environments for the funding and provision of contraceptive services, procurement and distribution, contraceptive mix and private sector participation as well as other trends affect contraceptive security.

THE EXCEPTION. Thailand's contraceptive profile is Southeast Asia's best practice. The country implemented a bottom-up approach to reproductive health in the late 1960s and has kept its commitment and maintained momentum. Greater financial and human resources are allocated to provide free contraceptive services to the population. Thailand's family planning services and even manufacturing and distribution of contraceptives are commendable compared to the rest of the countries in Southeast Asia.

Challenges affecting Southeast Asia's reproductive health supply

- Across the region, migrant populations, people living with HIV and the urban poor and homeless tend to be marginalised from local health and care systems and have fewer means to access contraceptives.
- Minority ethnic groups in Vietnam and people in the predominantly Muslim region of Mindanao in the Philippines have much higher unmet needs for family planning, compared to national averages.
- Condoms are limited in family planning settings. In all countries, most condom programmes target groups most at risk of HIV infection—injecting drug users, sex workers and men who have sex with men.

Some recommendations for Southeast Asia:

1. Strategies to diversify funding in the poorest, donor-dependent countries in the region need to be developed.
2. Universal health insurance systems should be considered to make reproductive health supplies and services more affordable.
3. Health ministries and donors need to take greater leadership and encourage the practical integration of family planning and HIV/STI prevention into comprehensive reproductive and sexual health services, including linkages with abortion care.
4. Governments and NGOs need to recognise the unmet need for contraceptives among unmarried, sexually active people, including young people.
5. The current gender bias in contraceptive policy and programmes should be redressed.
6. The region needs more accurate information and more reliable systems to collect and report on data on the sexual and reproductive health needs of unmarried women, young people and migrant populations.
7. The contraceptive commodity chain needs to be integrated into already existing procurement, storage and delivery mechanisms and more comprehensive mechanisms for monitoring should be established.[13]

Information in this section is based on findings from the synthesis paper Contraceptive Security in Southeast Asia *by Rocalia Sciortino, commissioned by APA in 2009. The report reviewed the provision of contraceptive services and commodities in Southeast Asia and assessed progress in achieving contraceptive security and meeting the reproductive health needs of the region's population.*

[13] For the report's full recommendations and findings, please visit http://www.asiapacificalliance.org/reproductive-health-supplies/182-contraceptive-security-and-meeting-reproductive-health-needs-in-southeast-asia.html.

Pacific Island Specifics

A region of small island developing states, the Pacific has diverse landscapes and population groups with high demand for SRHR services including RH supplies. Many Pacific Island countries still suffer from poor access to sexual and reproductive health information and services, particularly communities on outer islands and in rural areas. There is also a large youth population in the Pacific with 56% of the population under the age of twenty-five.[14]

Identified issues in SRHR include:

- Geographic isolation increases costs of providing services
- High unintended adolescent pregnancies
- Rising prevalence of STIs with poor access to treatments and syndromic management only
- Persistent high maternal and infant mortality in some countries
- High rates of violence against women and children
- High unmet need for contraceptives
- High total fertility rates
- Highly restrictive laws and policies on SRHR issues, such as abortion, sexual violence, etc.
- Widespread gender inequity and lack of policies to support women and girls
- A generalised HIV epidemic in Papua New Guinea
- A lack of attention by global donors to Pacific-specific needs

Contraceptives

A range of locally branded male condoms are available but only in simple colours and flavours. Female condoms are not readily available and for some people, they are a preferred alternative to male condoms. Vasectomy is not common and rarely available, although this is improving in some countries. IUD use is limited by the lack of skilled staff to insert these devices. Many health care providers require training on implant provision. In many countries, husbands are required to give signed consent for their partner's tubal ligation procedure. Family planning services are limited, many churches do not condone contraceptives (particularly condoms) and people who access family planning services are at a greater risk of discrimination and, potentially, violence.

Key challenges affecting the Pacific region's reproductive health supply:

- Small, isolated populations make it difficult to provide quality sexual and reproductive health services and information (lack of infrastructure, roads, boats, vehicles, internet/phone/power for communication, etc.)
- Lack of trained health care personnel
- Insufficient resources to strengthen quality services
- Corruption, lack of political will and lack of specific legislation affect health systems, including reproductive health systems
- Lack of quality storage facilities—lockable, air-conditioned, dry, etc.
- Problems obtaining consistent, quality reproductive health services and information
- Low staff capacity to accurately collect and analyse data, manage supplies and develop policies
- Little knowledge or a shortage of available data on reproductive health supplies and no qualitative research to support quantitative data that does exist
- Widespread public denial that young people engage in sexual activity outside of marriage
- Conservative religious beliefs and lack of community awareness on contraception and the importance of family planning
- Male partners usually determine contraceptive method and use

[14] Secretariat of the Pacific Community. 2010. Statistics for Development. http://www.spc.int/sdp/index.php?option=com_docman&task=cat_view&gid=28&Itemid=42.

Policy response

All Pacific Island country governments have committed to international agreements addressing reproductive health issues and most have integrated reproductive health services into the primary health care system. The Pacific Plan of Action on Reproductive Commodity Security was first adopted by health ministers in 2003. The plan aims to ensure that by 2015 every person in the region will have access to the widest range of reproductive health services and commodities. In 2008, governments adopted the Pacific Policy Framework for Universal Access to Reproductive Health Services and Commodities which was then reinforced by the Madang Commitment in 2009.[15]

However, despite progress in policies and commitments on regional frameworks and strategies there is an absence of political will to address some of the difficult sexual and reproductive health issues.

A regional reproductive health supplies warehouse was built in Fiji and is being managed by the United Nations Population Fund (UNFPA). The warehouse now supplies 14 Pacific Island countries with contraceptives. Government ministries receive these supplies at no cost and supplies are dispatched annually.

Complex supply chains highlight the urgent need for improved donor coordination and communication across the Pacific region. Multilateral agencies, large NGOs and private organisations all procure and provide reproductive health supplies and services in the Pacific. Only a few health ministries across the region have established reproductive health supply budget lines and are working towards reproductive health supplies independence. Most countries remain dependent on donor funding for commodity supply.

Reproductive health supply outages are less frequent than previously reported, but are still occurring. Many in-country storage facilities are not well-managed; expired supplies are being dispatched and distributed.

Communication breakdowns are reported between donor agencies sending supplies and the receiving agency in-country. The complex supply chain places an enormous resource strain on small, locally-run services, particularly in reporting.

Recommendations to improve sexual and reproductive health and rights in the Pacific

- Increase training and develop infrastructure to make sexual and reproductive health services youth friendly
- Integrate HIV and sexual and reproductive health services and information to optimise limited resources
- Improve data collection and analysis, and find ways to improve knowledge gaps, particularly for young people
- At the country level, health ministries should take all measures necessary to expand the availability of drugs and supplies on the World Health Organization's Interagency List of Essential Medicines for Reproductive Health
- Improve coordination and communication mechanisms to avoid supply chain problems
- Engage community leaders (including religious leaders) to find common ground and solutions to conflicting views

Unless otherwise stated, information in this section is based on the APA's 2009 Primer on Reproductive Health Supplies in Asia and the Pacific, *and the research* Reproductive Health Supplies in the Pacific 2008 *conducted by Family Planning International (New Zealand). The research drew on qualitative information on the reproductive health supplies situation in Vanuatu, Kiribati and Tonga. Family Planning International (New Zealand) provided updates in 2011.*

[15] WHO. 2009. Madang Commitment. http://www.wpro.who.int/internet/resources.ashx/PIC/2009/madang_commitment_2009.pdf.