

A report on

**Achieving Universal Access to
Reproductive Health Services
& Commodities; and
THE PACIFIC POLICY FRAMEWORK
2008 - 2015**

**Pacific Ministers of Health Meeting
November 5-7, 2008 Nadi, Fiji**

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TABLE OF CONTENTS

LIST OF ACRONYMS

PREFACE

EXECUTIVE SUMMARY

Chapter 1	Introduction	1
Chapter 2	Global and Regional Overview to Achieving Universal Access to Reproductive Health Services and Commodities	4
Chapter 3	Achieving Reproductive Health and Reproductive Health Commodity Security: Progress in the Pacific	12
Chapter 4	Good Practices from the Pacific on Achieving Reproductive Health Commodity Security	23
Chapter 5	HIV and other Sexually Transmitted Infections (STIs) in the Pacific Region	30
Chapter 6	Development of the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities	36
Chapter 7	Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities	44
ANNEXES		58
I.	Programme	59
II.	List of Participants	64
III.	Keynote Address by Deputy Prime Minister of the Kingdom of Tonga	75

LIST OF ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired immuno-deficiency syndrome
APLF	Asia Pacific Leaders Forum
AusAID	Australian Agency for International Development
BCC	Behaviour change communication
CCG	Central Control Group
CCP	Comprehensive condom programming
COMMAT	Commonwealth Medical Trust
CPR	Contraceptive prevalence rate
DFID	Department for International Development (UK)
DHS	Demographic and Health Surveys
DVD	Digital Versatile Disc
EU	European Union
FLE	Family life education
FP	Family planning
FSM	Federated States of Micronesia
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human immuno-deficiency virus
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
ICPD@10	10th Anniversary of the International Conference on Population and Development
IEC	Information, education and communication
IOC	International Olympics Committee
IPPF	International Planned Parenthood Federation
IT	Information technology
IUCD	Intrauterine contraceptive device
JICA	Japan International Cooperation Agency
LMIS	Logistical management information system
LMS	Logistical management system
MCH	Maternal and child health
MDG	Millennium Development Goal
MDG5	to Improve Maternal Health
MDG6	to Combat HIV/AIDS, malaria and other diseases
MMR	Maternal mortality ratio
MSIP	Marie Stopes International Pacific
NDMO	National Disaster Management Office
NGOs	Non-governmental organizations
NZAID	New Zealand Agency for International Development

ONOC	Oceania National Olympics Committees
PEP	Post exposure prophylaxis
PIAF	Pacific Island AIDS Foundation
PICs	Pacific Island Countries
PICTs	Pacific Island Countries and Territories
PIFS	Pacific Island Forum Secretariat
PLHIV	People living with HIV
PNG	Papua New Guinea
PoA	Programme of Action
PPAPD	Pacific Parliamentary Assembly on Population and Development
PRSPs	Poverty reduction strategy papers
RH	Reproductive health
RHCS	Reproductive health commodity security
RHR	Reproductive Health and Research
RHS	Reproductive health survey
SPC	Secretariat of the Pacific Community
SRH	Sexual and reproductive health
SRO	Sub-Regional Office
STIs	Sexually transmitted infections
SWAps	Sector-wide approaches
TB	Tuberculosis
TBA	Traditional birth attendants
TFR	Total fertility rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCCT	Voluntary, confidential counselling and testing
WHO	World Health Organization

Preface

Following the World Summit, a new Millennium Development Goal (MDG) Target 5B, 'to achieve universal access to reproductive health by 2015' was introduced and endorsed by countries, including Pacific Island Countries (PICs). The MDG 5B indicators include: contraceptive prevalence rate (moved from MDG6); adolescent birth rate; antenatal care coverage (at least one visit and at least four visits); and unmet need for family planning (FP). The challenge PICs face in achieving this target is that most countries have very young populations; high fertility rates; high teenage fertility rates, high sexually transmitted infections (STI) rates and low rates of contraceptive prevalence. Furthermore, scattered populations over huge expanse of ocean as well as inaccessible populations living in the interior of large islands make it difficult and expensive for quality reproductive health services to be provided for all populations.

In the Pacific Island Reproductive Health Commodity Security (RHCS) Plan of Action (PoA), that was endorsed in Auckland in 2003 by Ministers of Health and Senior Officials from ten PICs, commitment was made to universal access to reproductive health (RH) and to ensuring that by 2015 every person in the region would have access to the widest possible range of RH information and services including commodities.

In November 2008, Ministers of Health met in Nadi, Fiji to assess the progress made over the past five years towards achieving the Pacific PoA. They developed, adopted and signed the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2009-2015 (Pacific Policy Framework). The Pacific Policy Framework included specific areas such as policy and structure; services; supply chain management; and financing. It also identifies as essential strategies that need to be supported: political will and action; RH commodity supply management; resources for RH services and commodities; meeting clients' needs; improving the information base for priority setting, programme monitoring and service delivery; partnership collaboration; and human resource development. This endorsement of the Pacific Policy Framework demonstrates their commitment to ensure the achievement of universal access to RH services and commodities in the region.

UNFPA would like to acknowledge all Ministers and senior health representatives from the 15 Island Countries at the meeting. Gratitude is extended to Dr Mike Mbizvo from World Health Organisation, Geneva, and Mr. Jagdish Upadhyay, UNFPA, NY, for the technical input at the meeting and for their support of the Pacific Sub-Regional Office. The Fund would like to also express its gratitude to development partners and non-governmental organisations for their contribution to the meeting. UNFPA would also like to express its sincere gratitude to Ms. Marianne Haslegrave, who compiled the meeting report; Mr. Ray Skinner, who contributed to the development of the Pacific Policy Framework; Ms Erica Kotnik, who prepared manuscripts; and Dr. Annette Sachs Robertson, who provided technical assistance for the meeting and

this report. Special thanks are also extended to each and every member of the UNFPA Pacific SRO team, including technical, programme, communications, operations and support staff, for their extensive contribution and involvement in the preparation and conduct of this meeting. Without their support, this meeting would not have been the success it was.

A handwritten signature in blue ink, appearing to be 'N. Assifi', written in a cursive style.

Mr Najib Assifi
UNFPA Director, Pacific Sub-Regional Office/Country Representative.

Executive Summary

In addition to the existing Target 5A on maternal mortality, a new Millennium Development Goal (MDG) Target 5B- to achieve universal access to reproductive health by 2015- has been introduced following the 2005 World Summit. The indicators for its achievement are: contraceptive prevalence rate (moved from MDG6); adolescent birth rate; antenatal care coverage (at least one visit and at least four visits); and unmet need for family planning (FP). As such MDG Target 5B provides significant challenges to Pacific Island Countries (PICs). They all have very young populations, with some 40 percent of the population under 15 years of age and a further 20 percent between 15 and 24 years; high fertility rates; and low rates of contraceptive prevalence. This combination has led to unacceptably high teenage fertility rates in many countries in the Pacific, suggesting that the unmet need of teenage girls for contraception is not being met. Of particular concern are the numbers of girls aged 16 and younger who give birth each year. In addition there are high incidences of sexually transmitted infections (STIs), particularly Chlamydia, in young people under the age of 25. While many countries in the region have already begun to increase family life education (FLE) and provide peer education and special services for young people, this is an area that clearly needs to be further addressed fully.

In some of the countries in the region with the highest maternal mortality ratios, decreases have been seen during the past fifteen years and it is likely that many of them will achieve MDG Target 5A. With the exception of two countries, all PICs have already reported that over 85 percent of births are attended by skilled birth attendants. Nevertheless, more needs to be done in most countries to achieve 100 percent access by 2015.

In order to achieve MDG Target 5B it will be necessary to increase the contraceptive prevalence rate (CPR), which appears to be under-reported in some countries where significant declines in the total fertility rate (TFR) have occurred without concomitant increases in CPR. In addition there appears to be a significant unmet need for FP. Quantifying unmet need, however, is a problem in itself insofar as few countries in the region have undertaken Demographic Health Surveys (DHSs), which is the usual method for measuring unmet need. This is a situation that requires urgent attention.

HIV infection rates vary greatly in countries in the region, with most HIV infection either being among heterosexual couples or among men who have sex with men. While two countries have no reported cases of HIV, one country has a very high prevalence rate, particularly among the 15-35 age groups. Other STIs are prevalent in the region, with Chlamydia being the most common.

Underlying many of the problems is gender inequality and lack of empowerment among women. In addition, in some countries there is a lack of universal access to sexual and reproductive health (SRH) services, particularly in outer islands and rural areas and among marginalized and vulnerable groups as a result of lack of trained health care personnel and insufficient resources to strengthen quality services.

In 2003 in Auckland, New Zealand, Ministers of Health and Senior Officials from ten PICs committed themselves to ensuring the centrality of universal access to reproductive health (RH) and that by 2015 every person in the region would have access to the widest possible range of RH information and services in the *Pacific Island Reproductive Health Commodity Security (RHCS) Plan of Action (PoA)*.

In the Pacific PoA, Governments agreed that they would demonstrate political leadership to improving RH, through ensuring to have in place and implement an up-to-date policy on RH, integrated into national policies, strategies and actions plans to the fullest extent possible, with a separate RH budget line.

Since 2004, much progress has been achieved including the establishment of a Regional Warehouse, with a regional RHCS manager and technician. This has led to bulk purchasing for PICs, thereby ensuring more efficient and timely delivery of commodities to all PICs and the immediate response to the Solomon Islands tsunami in 2007. Stockouts, moreover, have been reduced in many PICs and supplies of RH and obstetric equipment have been provided to selected countries. In addition reviews of the RHCS situation analysis have been carried out throughout the region, with regional and national level workshops being held. Automated logistics management systems (LMS) are also being established in most countries in the region and efforts are being made to ensure the full integration of contraceptives into the national medicine supply chains.

Nearly all countries in the region are dependent on donors for their commodities and efforts are being made to ensure a greater degree of self-sufficiency through the introduction of budget lines for RH, including commodities. Although RH policies do not exist in all countries in the region, progress has been made with at least 6 PICs introducing them. While not widely available, programmes to promote male involvement in RH have so far been initiated in three countries. All countries have appointed RH coordinators and national RHCS coordinating committees and/or national focal points.

To address the challenges facing Governments in PICs in implementing MDG Targets 5A and 5B, it will be necessary in the first instance to advocate for a comprehensive strategic approach to SRH, including maternal health, FP, RHCS, STIs and HIV. It will, moreover, be necessary to mobilize government institutions, development partners, NGOs, professional associations and the private sector in order to involve them in renewing their support to improve and invest in RH. Reproductive health policies, strategies and guidelines should include FP and RHCS as

integral components. Sexual and reproductive health, including FP, RHCS and HIV, should be incorporated into national and sub-national development plans. Investing in FP will lead to savings in other areas of maternal and newborn care.

It was against this backdrop that Ministers of Health met again in November 2008 in Nadi, Fiji to assess the progress made over the past five years and to develop and adopt the *Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2009-2015* (Pacific Policy Framework). Included in the Pacific Policy Framework is an assessment of the key areas of progress towards meeting the goals of the Pacific PoA in areas such as policy and structure; services; supply chain management; and financing. The Pacific Policy Framework clearly identifies the proposed actions that need to be taken with regard to political will and action; RH commodity supply management; resources for RH services and commodities; meeting clients' needs; improving the information base for priority setting, programme monitoring and service delivery with an emphasis on RH services and commodity security; partnership collaboration; and human resource development.

All the Ministers participating in the meeting in Nadi signed the Pacific Policy Framework, which has subsequently been endorsed by other Ministers in the Region. This clearly demonstrates their commitment to ensure the achievement of MDG Target 5B and for the continued improvement in RHCS in the region.

Chapter 1

Introduction

“Reliable access to contraceptives and other commodities is a fundamental requirement for reproductive health. Yet thousands of women and men in the Pacific go without these essentials, leaving them vulnerable to unwanted pregnancy, sexually transmitted infections including HIV and the risk of childbirth without basic equipment or medical supplies. While the need for reproductive health products is rising, donor support is declining. During the 1990s, governments and individuals provided 60 per cent of the costs of contraceptives worldwide, while donors covered 40 per cent of the costs. Today, donor support has declined to around 27 per cent of the total.”

(Keynote address, Honourable Dr Viliami Tangi,
Deputy Prime Minister and Minister of Health, Tonga)

Pacific Island Countries (PICs) commitment to ensuring the centrality of universal access to reproductive health (RH) and that by 2015 every person in the region would have access to the widest possible range of RH information and services is echoed in the *Pacific Island Reproductive Health Commodity Security (RHCS) Plan of Action*, which was adopted at the Meeting of Pacific Ministers of Health and Senior Officials held in Auckland, New Zealand in January 2003.

Ten countries participated in the meeting in Auckland, which was convened by UNFPA, the Commonwealth Secretariat and the Commonwealth Medical Trust. In the Pacific Plan of Action each Government agreed to “demonstrate political leadership to improving reproductive health, through ensuring that it has in place and implements an up-to-date policy on RH, integrated into national policies, strategies and actions plans to the fullest extent possible, with a separate budget line [for RH].”¹ Ministers of Health, moreover, committed themselves “to contribute to the goal of ensuring that by 2015 people everywhere in the region will enjoy the highest attainable level of reproductive health.” At the end of the meeting three Ministers of Health from the Cook Islands, Fiji and Vanuatu signed the Plan of Action and subsequently Ministers from Samoa, Solomon Islands, Tonga, Tuvalu and Kiribati, the Federated States of Micronesia (FSM), Papua New Guinea (PNG), Niue and Nauru also endorsed it.

Since 2003 commitment to improving access to RH services through RHCS has also been demonstrated in other Pacific forums: the Pacific Parliamentarians meeting included RHCS in its Suva Declaration on HIV/AIDS, 2004² and the Apia Communiqué of the PPAPD on

1 Commonwealth Medical Trust, Commonwealth Secretariat, UNFPA. (2003) Compiled and edited by Stephen A Matlin. *Reproductive Health Commodity Security in Pacific Island Countries and Pacific Plan of Action*, piv. London.
2 Pacific Parliamentary Assembly on Population and Development (PPAPD) (2004). *Suva Declaration on HIV/AIDS by Pacific Parliamentarians*; Pacific Assembly on Population and Development, Fiji 11-13 October 2004.

Safeguarding Pacific Youth, 2007³. Pacific Island Heads of Government, moreover, played an important role in ensuring that RH was addressed at the afore-mentioned 2005 World Summit.

Five years later, Deputy Prime Ministers, Ministers of Health and Senior Directors of Health from 15 Pacific Island countries⁴ met again in Nadi, Fiji from 5 - 7 November 2008 to discuss '*Universal Access to Reproductive Health Services and Commodities*'. Representatives from the Secretariat of the Pacific Community; UNAIDS; UNICEF; United Nations Population Fund (UNFPA) World Health Organization (WHO) as well as from AusAID; the High Commission of India; the Embassy of the Republic of Indonesia; the Japan International Cooperation Agency (JICA) and Embassy of Japan; and NZAID, together with NGOs working in the Pacific region.

The specific objectives for the Nadi meeting were to:

- Discuss the strategies for achieving the new MDG target of universal access to reproductive health services;
- Review progress on Reproductive Health Commodity Security since the 2003 Ministers of Health Meeting;
- Discuss the linkages between poverty, population and reproductive health, including family planning;
- Elicit support from Ministers of Health, government institutions and development partners to have supportive policies and strategies for sustainable rights-based reproductive health services.

At the official opening ceremony, following the welcoming remarks by Najib Assifi, Director and Representative, UNFPA Pacific Sub-Regional Office (SRO), the Honourable Dr Viliami Tangi, Deputy Prime Minister and Minister of Health, Tonga gave the keynote address. (See Annex III). A DVD entitled 'RHCS in the Pacific' was also shown.

The programme consisted of overview presentations on Millennium Development Goals (MDGs), UNFPA Global Policies on RHCS, and Partnerships for Health Care, Progress towards RH in the Pacific. Ministers of Health or Senior Directors of Health discussed the status of Reproductive Health and RHCS in their respective countries. Representatives of the Governments of Australia, Japan and New Zealand participated in a panel discussion on 'Commitment to reproductive health, including RHCS'. Presentations on 'Good practices from the Pacific on Achieving RHCS' by selected governments were shared with the participants. Discussions on Strengthening comprehensive condom programming and Leadership and advocacy with Parliamentarian champions in the Pacific were also facilitated by UN agencies.

3 PPAPD (2007). The Apia Communiqué on Safeguarding Pacific Youth: Accelerating Actions through Partnership with Pacific Parliamentarians.

4 Cook Islands, FSM, Fiji, Kiribati, Nauru, Niue, Palau, PNG, Republic of Marshall Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu.

Working group discussions focused on 'Progress on the Pacific Plan of Action 2003 and the way forward'. The work of the groups was divided in the following areas:

- Context – policies and legislation: Using a rights-based approach, for a supportive environment for access to RH by 2015;
- Client service and utilization issues: Removing barriers and promoting better services particularly for vulnerable groups including young people;
- Capacity of supply chain management and future progress (selection, forecasting, procurement, distribution, storage and waste management);
- Capital: Funding for RH services and commodities (developing sustainability, social marketing); and
- Coordination and collaboration (between ministries, NGO, donors and UNFPA).

Following the feedback, 'The Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008 – 2015' was developed, endorsed by all countries and signed by the Ministers of Health from Cook Islands, PNG, Solomon Islands, Tonga, Tuvalu and Vanuatu. Subsequently it was also signed by the Minister of Health of Fiji and Palau and the Secretary for Health for FSM.

The following report has been compiled, based on the presentations, working group discussions and reports and reflects other inputs from participants. The Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008-2015 is included in Chapter 7. The programme for the meeting and list of participants are included in the annexes.



Chapter 2

Global and regional overview to achieving Universal Access to Reproductive Health Services and Commodities

2.1 ICPD Programme of Action⁵

At the International Conference on Population and Development (ICPD) in Cairo in 1994, 179 governments, including those of several Pacific Island Countries (PICs), adopted a Programme of Action (PoA) for the next 20 years.⁶ The ICPD PoA clearly defined the concepts of sexual and reproductive health (SRH) and reproductive rights, including universal access to a full range of comprehensive reproductive health (RH) care services and RH commodities. The PoA also addressed such concerns as universal access to education, with special attention to closing the gender gap in primary and secondary education; universal access to primary health care; reduction in infant, child and maternal morbidity and mortality; and increased life expectancy. The ICPD Programme of Action established a historic global paradigm shift from a population control development approach to one that is people-centered and rights-based.

The implementation of the ICPD PoA was reviewed and targets were updated in 1999 at the 21st Special Session of the UN General Assembly, at which the Key Actions for the further implementation of the Programme of Action of the International Conference on Population and Development were adopted.⁷ In 2004 at ICPD@10 progress made to date by 165 countries (including 14 countries in the Pacific) was assessed by means of a Global Survey. The launching of the Pacific Policy Framework at the beginning of 2009 is a timely contribution to the 15th anniversary of the ICPD Programme of Action - ICPD at 15.

2.2 Millennium Development Goals (MDGs)

Another major milestone was the Millennium Summit in 2000, when 189 countries and 147 Heads of State (including three Heads of State from Kiribati, Marshall Islands and Micronesia; four Heads of Government from Papua New Guinea (PNG), Tonga, Tuvalu and Vanuatu; and three chair-persons from Palau, Samoa and Solomon Islands delegations) agreed to put the world on a more balanced, secure and sustainable path for development. Eight Millennium Development Goals (MDGs) were elaborated after

⁵ 2.1 & 2.2 based on Opening remarks of Najib Assifi, Director Pacific Sub-Regional Office and UNFPA Representative.
⁶ United Nations. (1994). Report of the International Conference on Population and Development. A/94/10/18. Programme of Action, para 7.6. New York.

⁷ United Nations. (1999). Report of the Ad Hoc Committee of the Whole of the Twenty-first Special Session of the General Assembly. A/S-21/5/Add 1. Key Actions for the further implementation of the Programme of Action of the International Conference on Population and Development. New York.

the Summit to free men, women and children from the dehumanizing conditions of extreme poverty and diseases; to combat discrimination against women; to ensuring environmental sustainability; and to achieving universal primary education. Three of the MDGs are health-related, namely MDG4 to reduce child mortality; MDG5 to improve maternal health; and MDG6 to combat HIV/AIDS, malaria and other diseases. Together the MDGs offer our best collective hope for accelerating action and bringing about real and lasting change.

Despite the fact that no RH goal was included, the vision and the promise of ICPD can clearly be linked to all the MDGs. There is evidence that increasing access to education and RH services, including family planning (FP) and sexual health, reduces poverty and hunger within families and poverty within nations. The links between RH and rights and gender equality and the empowerment of women are both strong and well established. Reproductive rights are essential to women's human rights. Reproductive health and FP play a key role in reducing child mortality, as a healthy mother is the first step to a healthy child. Reproductive health and rights are also of paramount importance for improving maternal health and there is wide recognition that SRH services provide an important opening for HIV prevention and testing. By having smaller families, environmental degradation is slowed. Furthermore, partnerships for RH services and commodities are needed to ensure universal access.

2.3 Achieving universal access to reproductive health: concepts & indicators⁸

2.3.1 Challenges in sexual and reproductive health systems

Globally, there are a number of challenges that have to be addressed with respect to SRH systems. In many countries, levels of sexual and reproductive ill-health remain unacceptably high exacerbated by weak health care systems; limited access to formal health care; and a lack of quality services, trained providers or commodities. Furthermore while most cases HIV is sexually transmitted, possibilities for linking (or integrating as appropriate) SRH and HIV/AIDS (or other) services have not always been fully explored.

While the use of research evidence is an important pre-requisite for policy formulation and programme strengthening, it nonetheless remains weak and investments in the necessary research for health are inadequate. Furthermore SRH continues to be a sensitive issue. There is no clear commitment to sustainable funding for essential SRH commodities and while donors are providing funding for Sector-Wide Approaches (SWAps), Poverty Reduction Strategy Papers (PRSPs) etc, these plans do not always include essential RH commodities.

Challenges to achieving MDGs 4, 5 and 6

Globally, every year there are:

- 536,000 maternal deaths, 99 percent occurring in developing countries;
- 200 million couples with an unmet need for safe and effective contraception;
- 340 million new curable sexually transmitted infections (STIs);
- 80 million unwanted pregnancies;
- 68,000 deaths from unsafe abortion;
- 2,800,000 deaths from HIV/AIDS;
- 500,000 new cases of cancer of the cervix and 250,000 deaths.

2.3.2 Opportunities

In 2004 the World Health Assembly adopted the *Global Reproductive Health Strategy*, which provides the blueprint for improving SRH.⁹ The following year the European Union (EU) drew attention to the fact that the MDGs cannot be attained without progress in achieving the Cairo goal of universal SRH and rights¹⁰ and in 2005 'Expanding access to sexual and reproductive health information and services, including family planning and contraceptive information and services, and closing existing funding gaps for supplies and logistics' was identified by the Millennium Project as a 'Quick Wins' for the achievement of the MDGs.¹¹

2.4 MDG Target 5B on universal access to reproductive health: the new challenge

Recognizing the omission of not including RH in the MDGs, at the World Summit held in New York in 2005 Heads of Government committed themselves to achieving universal access to reproductive health by 2015 calling for a new target to be added to MDG5 on improving maternal health, for which the original target (now referred to as MDG Target 5A) is to 'reduce by three quarters the maternal mortality ratio'.¹² This was finally achieved with the introduction of MDG Target 5B to 'achieve, by 2015, universal access to reproductive health', which echoes the ICPD Programme of Action access goal.¹³ The indicators for measuring progress on MDG Target 5B have been subsequently agreed as: Contraceptive prevalence rate (moved from MDG6); Adolescent birth rate; Antenatal care coverage (at least one visit and at least four visits); and Unmet need for family planning.¹⁴

9 See below Box on page 8.

10 Council of the European Union, External Relations Council, Brussels 24 May 2005. Council conclusions: Accelerating progress towards achieving the Millennium Development Goals.

11 Millennium Project. (2005) Report of the Secretary General. Investing in Development. A Practical Plan to Achieve the Millennium Development Goals, p66-67. New York.

12 Heads of Government committed themselves to: 'Achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, that are aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.' United Nations General Assembly A/RES/60/1. World Summit Outcome (2005) para 57(g). New York. UNFPA. (2007) <http://www.unfpa.org/icpd/about.htm>.

13 ICPD PoA, para 7.6.

14 <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>.

Targets and indicators for monitoring Millennium Development Goal 5

Goal 5:	Improve maternal health
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 (at least one visit and at least four visits)
5.6	Unmet need for family planning

Contraceptive prevalence rate (CPR): Serious disparities exist in the use of modern methods of contraception in different regions of the world. For example, 58% usage has been reported for Asia in 2005, but only 20% for Africa and 21% for Oceania excluding Australia and New Zealand. Moreover, it has been noted that in certain countries in the Pacific region, namely Tonga, Tuvalu and the Cook Islands, contraceptive usage has declined between 1990 and 2005/7.

Unmet need: While the unmet need for contraceptive has dropped from the 1992 levels and significantly post-ICPD in 1995, in Africa, North Africa and South-east Asia, they have subsequently risen since 2000 in some parts of the world.

Recommended four antenatal visits: There has been a steady increase in the percentages of women attending for one antenatal clinic; however the percentages of women, who attend for four visits, are significantly lower with greater differences from country to country.

Adolescent birth rate: The adolescent birth rate has remained unacceptably high during the past 15 years particularly in Africa and South Asia. It is also a problem in South East Asia. As discussed below in some countries in the Pacific births to adolescents are among the highest percentages in the world.¹⁵

MDG Target 5B complements the existing Target 5A as it encompasses FP, which is a pre-requisite for enabling women and couples to decide on the number and spacing of their children. It also complements initiatives for many of the major international concerns e.g. climate change and food security insofar as countries will not be able to manage their population growth rates when an estimated 201 million women have an unmet need for effective contraception.

15 See below p 15.

It is critically important, however, that Governments should adopt a SRH perspective that addresses the continuum of needs related to sexuality and reproduction with the aim to achieve universal access to FP; safe delivery; emergency obstetric and newborn care; antenatal and postnatal services; services to prevent unsafe abortion; and prevention, treatment, care and support for sexually transmitted infections (STIs), including HIV and cervical cancer.

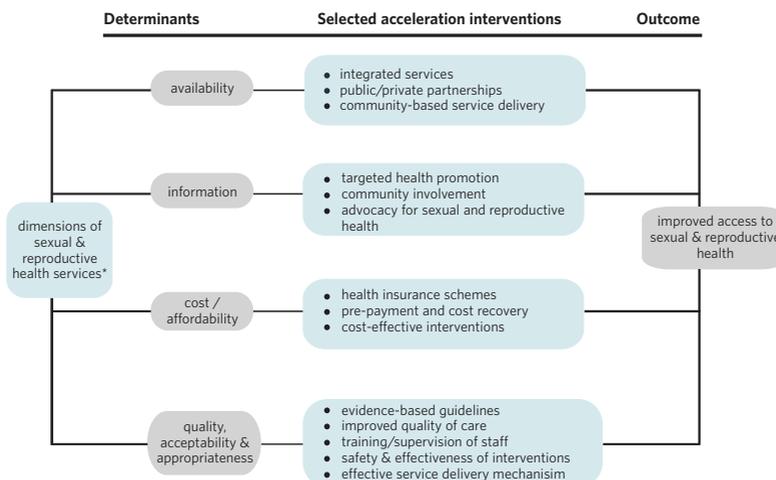
Implementing the Global Reproductive Health Strategy

The Global Reproductive Health Strategy, adopted in 2004, to accelerate progress towards the attainment of international reproductive health goals includes four main policy areas: financing sexual and reproductive health-care services; integrating sexual and reproductive health-care services; creating a supportive legislative and regulatory framework; and safeguarding the SRH needs of adolescents.

In order to monitor progress WHO and UNFPA have developed a recommended framework of indicators for priority aspects of RH and possible indicators for programmatic linkages between sexual and reproductive services and HIV prevention, care and treatment. Core indicators on which all countries should report, additional indicators on which they could report, based on special needs and extended indicators that are contextually relevant have all been identified.

2.5 Pathways to improving access to sexual and reproductive health ¹⁶

Figure 1:



* includes:
 1. Promoting family planning
 2. Controlling sexually transmitted and reproductive tract infections (STI)
 3. Maternal and newborn health (MNH)
 5. Prevention of unsafe abortion

2.6 Achieving and measuring progress on Target 5B

- (1) On the short and medium-term it will be necessary to develop, incorporate, or identify and report on interventions or input/process/output/indicators e.g. for family planning (FP):
 - (a) proportion of service delivery points incorporating WHO guidelines for improving quality of SRH care , specifically FP;
 - (b) percentage of primary health care facilities providing FP services;
 - (c) percentage of FP service delivery points offering counseling on dual protection (from STIs and unwanted pregnancies);
 - (d) demand for or establishment of community-based FP programmes;
 - (e) dedicated national funding for FP.
- (2) Formulate policy on universal access to RH.
- (3) Long-term: identify and measure outcome/impact indicators e.g.:
 - (a) percentage of women with an unmet need for FP;
 - (b) trends in total fertility rates (TFR)

“Collectively, we are accountable for anticipating their needs – in health, literacy and socio-economic development – and taking action to improve on indicators.”

Michael Mbitvo, Coordinator Senior Scientist RHR WHO

2.7 UNFPA global policies on reproductive health commodity security¹⁷

2.7.1 Reproductive health community security (RHCS)

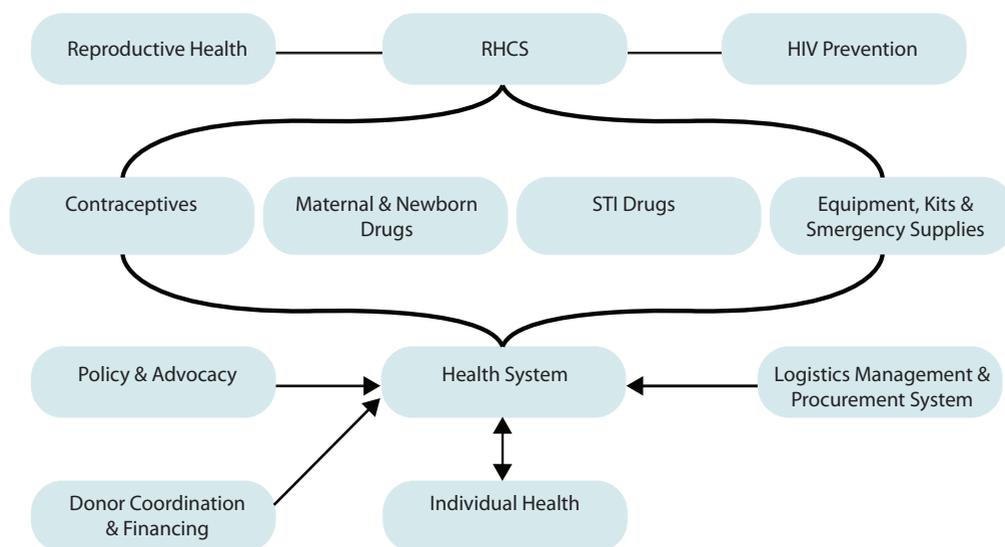
Reproductive health commodity security (RHCS) is achieved when all individuals can *obtain and use* affordable, quality RH commodities *of their choice* whenever they need them.

It is more than an issue of supply – it also has elements related to quality of care, access and demand. It involves making sure everyone, especially women, newborns and young people face no obstacles accessing and using *life-saving and health promoting supplies*. RHCS therefore goes beyond ensuring supplies of contraceptives alone, but includes a broad range of reproductive health supplies that underpin the successful implementation of MDGs 3, 4, 5 and 6 including their role in reducing maternal mortality but also preventing HIV infection.

17

Based on presentation by Jagdish Upadhyay, Chief, Commodity Security Branch, UNFPA, New York.

Figure 2: RHCS: Within the Context of Poverty



2.7.2 Need to reposition family planning

The decline in donor expenditures for FP is a major concern: from 1996 to 2006 the amount for family planning declined from \$653 million to \$393 million as European donors turned away, believing that the need for FP had been met. During the same period, funding for STIs and HIV/AIDS increased substantially from \$294 million in 1997 to \$5 billion in 2006, which was a necessary response to the HIV/AIDS epidemic. The increase in funding for HIV/AIDS has been, however, at the expense of FP.

The TFR of countries in the Pacific has been declining. It should be remembered that increased use of modern contraceptive leads to a decline in maternal mortality ratio (MMR) as well as in TFR. However, determination of unmet need for FP has not been made in most PICs given the relatively low priority given to universal access to contraception services for couples and women who would like to use them.

2.7.3 HIV prevention: greater commitment required

Today for every two people who start treatment for HIV, there are five new infections. Despite the need for a greater emphasis on prevention, condom gaps remain all over the world. Female condoms also require more resources and promotion. This is illustrated by the fact that while distribution has nearly doubled in the past three years, it translated into fewer than 30 million being distributed in 2007.

2.7.4 Expected global needs for reproductive health commodity security

The global need for RHCS is expected to increase. According to UNFPA projections the population of reproductive age in developing countries will increase by 23% between 2000 and 2015 and the demand for contraceptives is projected to rise by a total of 40%. Increased international and national efforts are therefore required to ensure that millions will be able to exercise their reproductive health choices.

2.7.5 UNFPA's response has been through its *Global Programme to Enhance RHCS*. Achievements have included increased support for countries that have reduced stock-outs and anecdotally appear to have led to an increase in the CPR. In partnership with UNHCR, UNFPA has provided commodities for refugees in war-torn areas. It has introduced comprehensive condom programming (CCP) and has coordinated its activities in commodity supply with other donors through the RH Supplies Coalition and has also undertaken advocacy work with 'Champions' and Parliamentarians.

2.7.6 New developments

UNFPA and WHO have initiated a review of access to critical medicines for the treatment of major causes of maternal mortality and morbidity. In addition global procurement mechanism with prequalification of manufacturers has been set up and models for global centres of excellence for RHCS are being established in Indonesia and other parts of the world. Software support e.g. Channel and RH costing and programme support e.g. condom programming are also being made available. Funding has been pledged for the next five years from donors including the UK Department for International Development (DFID), the Netherlands and the European Commission and it is estimated that UNFPA support for Pacific Islands Countries has leveraged US\$1.6 million for reproductive health commodity security since 2003.

Chapter 3

Achieving Reproductive Health & RHCS: Progress in the Pacific



3.1 Context

3.1.1 Regional overview

Of the 22 Pacific Islands Countries and Territories (PICTs), 15 are served by the UNFPA Pacific Sub-Regional Office in Suva, Fiji. They are scattered across a region that covers almost a third of the earth's surface and many of the countries themselves comprise a number of islands. The Federated States of Micronesia (FSM), for example, is made up of 607 islands with a land-mass of only 701 sq. km in more than two million square islands of ocean, of which only 65 are inhabited. Kiribati includes three island groups – Gilbert Islands, Line Islands and Phoenix Islands – with 33 mostly low-lying coral atolls with elevations of 0 to 81 metres, of which 21 are inhabited, spread over five time zones. Apart from Papua New Guinea (PNG), whose population was estimated at 5.7 million in 2005, all the other countries in the region have small populations. Fiji, the second largest has a population of 827,900, according to the 2007 census, which is a 6.8 percent increase over the 1996 census.

Several countries, including Cook Islands, Federated States of Micronesia (FSM) and Nauru, have negative population growth rates because of emigration, particularly to more developed countries such as New Zealand. Niue, according to the 2006 census, has a total population of 1,625, which has declined over the past four decades from 5,194 people in 1966.

The geography of the region provides a unique challenge for the provision of reproductive health (RH) services and commodities, with the situation differing from country-to-country. Inter-island travel by boat is slow because of the vast distances and air transport in addition to being expensive with infrequent services.

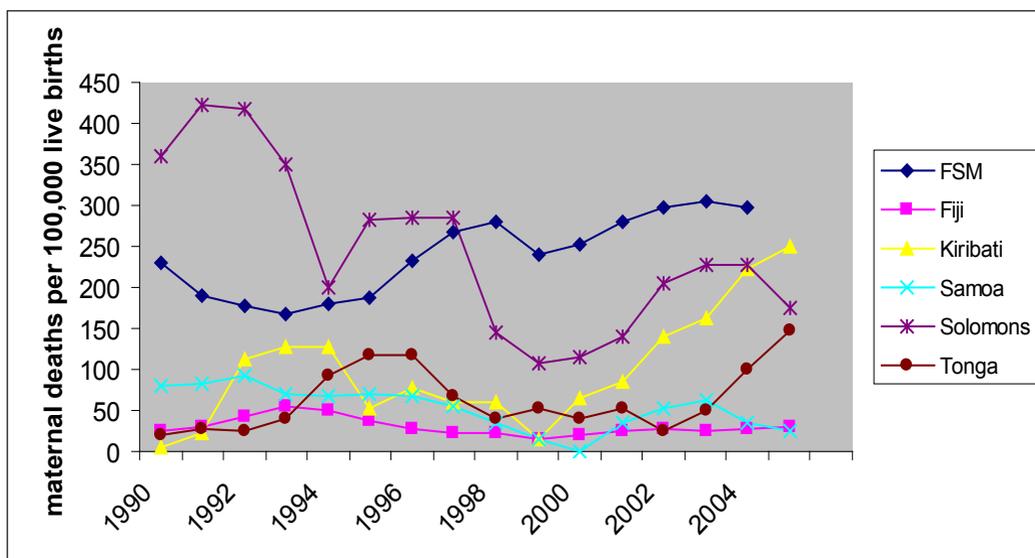
Countries in the region are also vulnerable to natural disasters; for example, the tsunami, which hit the Solomon Islands in 2007. Given the fact that many of the islands and atolls are low-lying, climate change and global warming pose a major threat. Population density is uneven, with high concentrations in urban areas and scattered populations in rural and out-lying areas. They also suffer from shortages of trained health personnel, since many migrate overseas once they have completed their training.

Moving towards achieving MDG target 5A¹⁸

With the exception of PNG, Pacific Island Countries (PICs) have populations of less than a million. These small populations have relatively rare occurrences of maternal death, which makes it difficult to measure mortality mortality. An aggregated indicator of maternal mortality that takes into consideration maternal deaths, near misses, perinatal mortality and relevant process indicators should be seriously considered as a substitute for the MMR. The following table, using three-year moving averages, shows maternal mortality ratios for selected Pacific Island countries, 1990-2005.

Maternal Mortality

Figure 3: Maternal Mortality Ratios (3 year moving averages) for selected Pacific Island Countries 1990-2006



Source: NSOs & MOHs, 1990-2006

In some of the countries with the highest maternal mortality ratios, including Samoa and the Solomon Islands, decreases have been seen during the past fifteen years. The figures from PNG should be interpreted with some caution as they are indirect estimates from mortality probabilities from Demographic and Health Surveys (DHS) and show substantial increases over the past decades from 370 per 100,000 in 1986 to 733 per 100,000 in 1996.^{19 20} According to current trends, the Solomon Islands appear to be on target to reach the Millennium Development Goals target, while it is unlikely that PNG, FSM or Kiribati will achieve the target by 2015 without relevant interventions being strengthened. In Tonga, the Ministry of Health carries out an inquiry if a maternal death occurs in order to learn from the tragedy and to decrease the likelihood of it happening again.

"One maternal death is one death too many. One maternal death warrants an audit meeting, chaired by a Minister."

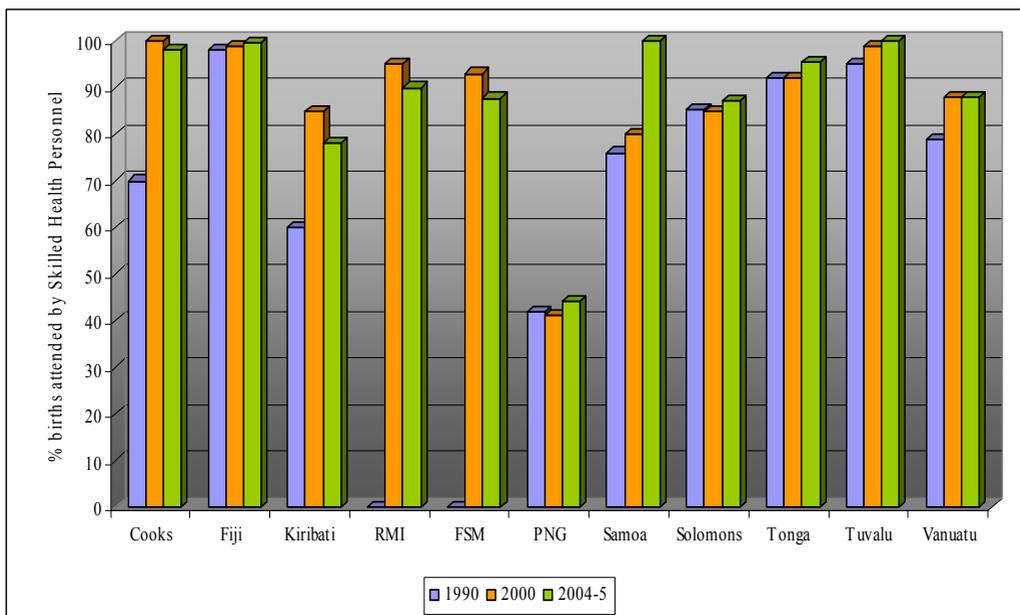
(Hon Viliami Tangi, Deputy Prime Minister and Minister of Health, Tonga)

19 Secretariat of the Pacific Community (SPC) (2005). Pacific Region Millennium Development Goals Report.
20 PNG DHS 1996, PNG DHS 2006-7

Proportion of births attended by skilled health personnel

With the exception of PNG and Kiribati, all PICs had already been reporting percentages of births attended by skilled birth attendants exceeding 85 percent by 2005. While in the majority of countries, the proportion of skilled birth attendants is increasing through improved health services, more needs to be done in most countries to achieve 100 percent access by 2015.

Figure 4: Proportion of Births Attended by Skilled Health Personnel in Pacific Island Countries, 1990-2005²¹



Source: MOHs, 1990-2006

Total fertility rate & Teenage fertility rate

The total fertility rate (TFR) is generally high, being over 4.5 in some countries, while the contraceptive prevalence rate (CPR) is comparatively low, for example below 30 percent in Kiribati, Solomon Islands, Tonga and Vanuatu in 2005. It appears that under-reporting of contraceptive usage may be occurring in some countries where significant declines in TFR have occurred without concomitant increases in CPR. Validation of the CPR, especially by age, is urgently needed in most Pacific Island Countries.

21

Robertson, A.S. Current Status of Sexual and Reproductive Health. Prospects for Achieving the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals in the Pacific. Asia-Pacific Population Journal (2007), 22;3.

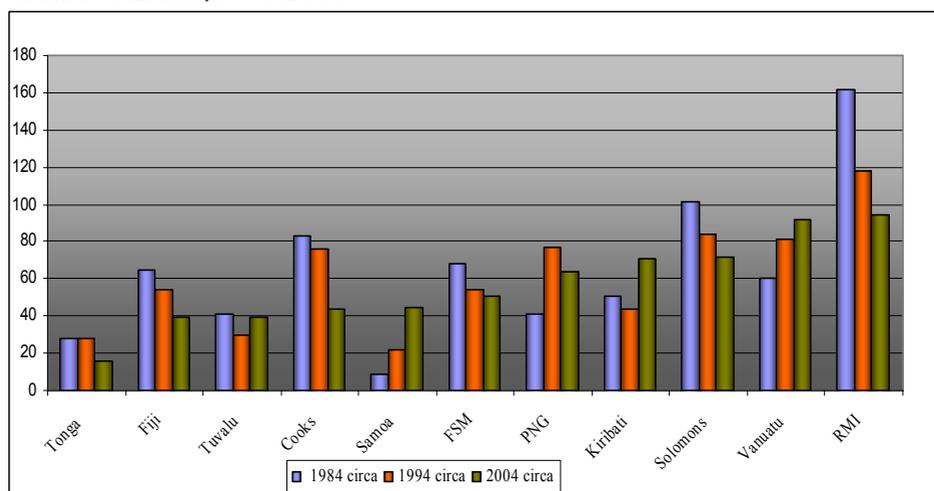
Table 1: Total fertility rate, age-specific fertility rate (15-19 years) and contraceptive prevalence rate in selected Pacific island countries, 1990-2005²²

	Total Fertility Rate		Age Specific Fertility Rate(15-19) (per 1,000 women 15-19)		Contraceptive Prevalence Rate (%)	
	circa 1990	circa 2005	circa 1990	circa 2005	circa 1990	circa 2005
Cook Islands	3.7	2.9	83	44	45.8	43.8
FSM	4.1	3.8	68	51	40	49
Fiji	2.9	2.7	65	39	31	35.5
Kiribati	4.5	3.5	51	71	17.4	22.1
RMI	6.9	4.5		94	30.6	42
Samoa		4.6	22	45	18	31
Solomon Is	4.8		101	69	10.6	10
Tonga	4.1	3.8	28	16	32.8	19.7
Tuvalu	3.4	3.7	30	39	39	31.6
Vanuatu	4.8			92	15	28

Sources: Pacific MDG Report (2004); MOH (2000-2005) and UNFPA Survey (2005-2007)

Teenage fertility rates in many countries in the Pacific, including the Republic of the Marshall Islands (RMI), Vanuatu, Kiribati, the Solomon Islands and the FSM are a major concern, which suggests that the unmet need of teenage girls for contraception is not being met. Of particular concern are the numbers of girls aged 16 and younger who are giving birth each year.

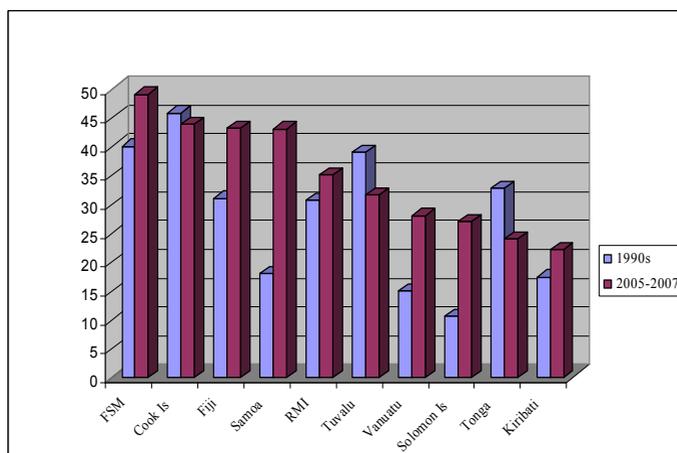
Figure 5: Teenage fertility rates, age-specific fertility rate (15-19 years) in selected Pacific Island Countries, 1990-2005



Source: SPC 2004, Census Reports PICs, Annual Health Reports

While some countries have shown significant gains in the contraceptive prevalence rate, including FSM, Fiji and Samoa, it remains low in many other countries in the Region. This indicates that there are a significant proportion of women and men who wish to determine the spacing and number of their children but are not currently using contraception.

Figure 6: Contraceptive Prevalence Rates in Selected Pacific Island Countries, 1990-2007



Source: MOHs, 1990-2006

Unmet need for family planning (FP)

In addition to the impact of unmet need on the lives of individuals, it may also threaten the national health and development goals of the countries concerned. Quantifying unmet need, moreover, is a problem in itself insofar as few countries in the region have undertaken (DHS), which is the usual method for measuring unmet need. Until the end of 2006 DHS had been carried out only in PNG, while the Cook Islands, Fiji, Samoa and Vanuatu had had Reproductive Health Surveys (RHS). In 2007, DHSs were undertaken in Solomon Islands, Nauru, Marshall Islands and Tuvalu and are planned for 2009 in Fiji, Kiribati, Tonga and Samoa. Available data illustrated in Table 3 confirms that unmet need is high.

Table 2: Unmet Need for Contraception in Selected Pacific Island Countries, 1995-2008

COUNTRY	UNMET NEED FP
Cook Islands	20% (2003)
Fiji	43-57% (1995)
RMI	8% (2007)
Papua New Guinea	46% (1996)
Samoa	20-53% (1995)
Solomon Islands	11% (2007)
Tuvalu	24% (2008)
Vanuatu	24% (1999)

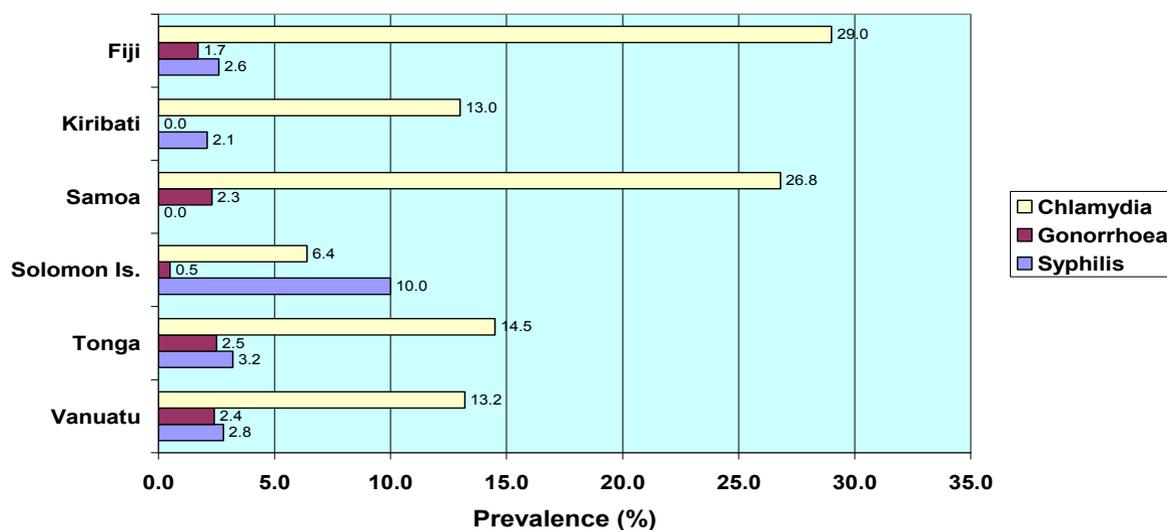
Sources: DHSs, RH Surveys

3.1.2 HIV and STIs in Pacific Island Countries²³

HIV infection rates vary greatly in countries in the region. While HIV infection is heterosexual or among men who have sex with men, in countries such as Cook Islands and Niue, there are no reported cases of HIV. In Kiribati HIV is found particularly among the sea-farers, while in PNG there is a very high prevalence rate, particularly among the 15-35 age groups.

It should be noted, however, that other sexually transmitted infections (STIs) are prevalent in the region, with Chlamydia being the most common. In Samoa, for example, it is estimated that one woman in three is infected. The high proportion of adolescents in the region, moreover, not only translates into a high number of adolescent pregnancies but also high incidences of STIs in this age group and results in teenage fertility rates, which are among the highest in the world, in the RMI, Vanuatu, Kiribati and the Solomon Islands.

Figure 7: STIs in Selected Pacific Island Countries (2005)



While adolescent sexual and reproductive health services with peer education programmes are expanding in many countries (Fiji, Kiribati, Solomon Islands, Tonga, Vanuatu) together with strategic interventions aimed at reaching the most vulnerable groups including young people, particularly adolescent girls, continued emphasis must be placed on the provision of family life education (FLE), as in Fiji, Solomon Islands and Vanuatu.

23 Based on presentation by Tim Sladden, Technical Adviser on STI/HIV, UNFPA Pacific SRO.

An enabling environment -- Paris Declaration

Countries in the Pacific Region are signatories to the *Paris Declaration on Aid Effectiveness, Ownership, Harmonization, Alignment, Results and Mutual Accountability* of 2005 and the *Pacific Aid Effectiveness Principles* of 2007, as are donor countries working in the region including Australia, New Zealand, Japan and the UK Department for International Development (DFID).

During the past five years, the adoption of the Paris Declaration Frameworks has occurred in some Pacific Island Countries. Some countries in the region have also adopted health Sector Wide Approaches (SWAps), including Solomon Islands, Samoa and Vanuatu, while other countries have ensured that there are budget lines for reproductive health, and in some cases reproductive health commodity security in their national Health Accounts.

There are a number of diverse issues that affect the availability of RH and RHCS in Pacific Island countries. For example, there are major variations in the population dynamics and economies of the PICs. There is also differing levels of Government priority for funding and human resource development in RH. In turn, there are also complex bi-lateral and multi-lateral arrangements for additional resources.

3.1.3 Progress towards achieving reproductive health commodity security in the Pacific²⁴

RHCS Pacific PoA 1: Political will

During the past five years, as stated above, 12 Ministers of Health have endorsed the Pacific RHCS PoA. The Pacific Parliamentarians meeting in 2004 included RHCS in its Suva Declaration on HIV/AIDS, 2004²⁵. Condom availability was also included in the Nadi Declaration (2004) of the World Council of Churches Pacific Member Churches²⁶ and the Apia Communiqué of the PPAPD on Safeguarding Pacific Youth, 2007²⁷.

In addition many Directors of Health have discussed progress in RHCS and have confirmed the need for more support for it in-country. Five PICs, namely Fiji, Nauru, Niue, Palau and PNG, have budget allocations for contraceptives and a further three plan to do so in 2008-9.

24 Based on presentations by Country Representatives and a Technical Paper by Annette Sachs Robertson, Technical Adviser, Health Systems & RHCS, UNFPA Pacific SRO.

25 Pacific Parliamentary Assembly on Population and Development (PPAPD) (2004). Suva Declaration on HIV/AIDS by Pacific Parliamentarians; Pacific Assembly on Population and Development, Fiji 11-13 October 2004.

26 World Council of Churches Office in the Pacific (2004). The Nadi Declaration: a Statement of the World Council of Churches' Pacific Member Churches on HIV/AIDS, 29 March - 1 April 2004, Tanoa international Hotel, Nadi, Fiji.

27 Pacific Parliamentary Assembly on Population and Development (PPAPD) (2007). The Apia Communiqué on Safeguarding Pacific Youth: Accelerating Actions through Partnership with Pacific Parliamentarians.

Several PICs have RHCS as an integral component of their National Reproductive Health Policy and Strategy (Cook Islands, Kiribati, Samoa, Tonga, Tuvalu, and Vanuatu).

RHCS Pacific PoA 2 & 3: Ensuring adequate, timely and efficient procurement and distribution

The establishment of a Regional Warehouse, donated by the Ministry of Health in Fiji, with a regional RHCS manager and technician, funded by UNFPA, has led to bulk purchasing for PICs, under an on-going Memorandum of Understanding. This in turn has ensured more efficient and timely delivery of commodities to all PICs and the immediate response to the Solomon Islands tsunami in 2007 (See below page 30) and the delivery of condoms, in a case of stockout, to PNG within two days. Stockouts, moreover, have been reduced in many PICs and supplies of RH and obstetric equipment have been provided to selected countries including the outer islands of Kiribati. (See below page 31)

RHCS Pacific PoA 4: Monitoring & evaluation & RHCS PoA 7: Planning Management & Logistics

Reviews of the RHCS situation analysis have been carried out in 15 countries in the region and two regional workshops have been held involving 14 of the countries. National and provincial level RHCS/LMS workshops have been conducted in the FSM, RMI, Vanuatu, the Solomon Islands, Tonga, Tuvalu and Fiji, involving over 250 participants. In addition, automated logistics management systems (LMS) are being established in most countries in the region and efforts are being made to ensure the full integration of contraceptives into the national medicine supply chains.

RHCS Pacific PoA 5: Ensuring adequate resources

Funding can be a limiting factor with respect to RHCS. Countries in the region, with the exception of Fiji, are dependent on donors for their commodities. UNFPA is the main supplier of contraceptives for use in the public sector for countries in the region, with IPPF as the main supplier to their affiliates, the Family Planning Associations. Substantial support has been received from the UNFPA Global Programme from the Commodity Management Branch, for capacity building and commodities; from NZAID for capacity building; from AusAID for Kiribati Emergency Obstetric Care commodities and capacity building; and from the Global Fund for AIDS Tuberculosis and Malaria (GFATM) for condom programming. Non-governmental organizations have also contributed support including Save the Children in PNG and the Red Cross in the FSM.

RHCS Pacific PoA 6: Meeting the needs for reproductive health commodities

While reproductive health policies do not exist in all countries in the region, progress has been made in developing policies, which include RH commodity security in six countries. In addition, RH programmes are being expanded in 11 countries that

include emergency obstetric care training and commodity provision. Youth friendly services have been introduced in 10 countries, including peer education programmes expanding in many countries. Family life education has also been initiated in many countries but further expansion is needed. While not widely available, programmes to promote male involvement in RH have been initiated in three countries, namely Fiji, Solomon Islands and Vanuatu.

All countries have reproductive health coordinators and national RHCS coordinating committees and/or national focal points have been established in Fiji, FSM, PNG, Solomon Islands and Vanuatu. Sixteen NGO-UNFPA partnerships and other innovative outlets have been established for condom programming.

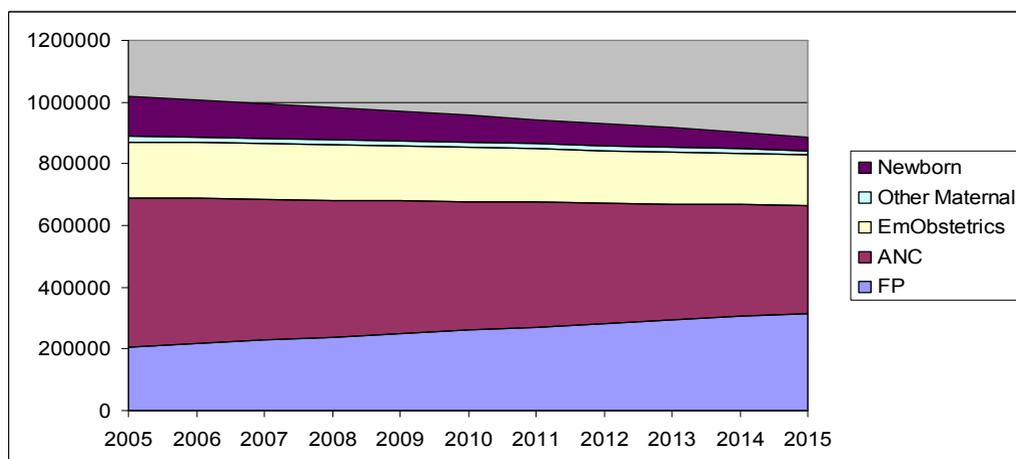
3.1.4 Challenges for the future in achieving reproductive health in the Pacific Region

Countries in the Pacific Region face challenges that must be addressed in the future in achieving MDG Target 5B by 2015. As already referred to above, the unmet need for FP is of major concern, which requires the availability of regular statistics and data for feedback, projections etc. There is also an increasing HIV prevalence in some countries, which requires that high-risk sexual behaviour particularly among young people must be addressed. It is also necessary to address the high levels of adolescent pregnancy. Underlying many of the problems is gender inequality and lack of empowerment among women. In addition, in some countries there is a lack of universal access to sexual and reproductive services (SRH), particularly in the outer islands and rural areas and among marginalized and vulnerable groups as a result of lack of trained health care personnel and insufficient resources to strengthen quality services.

3.1.5 Addressing the challenge

To address the challenge it will be necessary in the first instance to advocate for a comprehensive strategic approach to SRH, including maternal health, FP, RHCS, STIs and HIV. It will, moreover, be necessary to mobilize government institutions, development partners, NGOs, professional associations and the private sector in order to involve them in renewing their support to improve RH and to invest in maternal health, FP, RHCS, STI and HIV prevention and treatment services. Reproductive health and FP policies, strategies and guidelines should be reviewed to ensure that FP and RHCS are integral components. Sexual and reproductive health, including FP, RHCS and HIV, should be incorporated into national and sub-national development plans. Investing in family planning will lead to savings in other areas of maternal and newborn care.

Figure 8: Projected Costs in Family Planning* & Resultant Savings in Maternal & Newborn Care in Fiji 2005-2015



* RH Needs Assessment Model, Millennium Project

Source: UNFPA/CST2006

Advocacy is required to ensure that all women and men have access to a full range of information, services and commodities, especially for the young and disadvantaged and those living on remote islands and in rural areas. National institutional capacity for linkages for SRH and HIV should be strengthened with pre- and in-service training in FP and HIV counseling and testing. RHCS should be strengthened in areas such as forecasting, logistics management information systems and quality assurance. Finally, behaviour change communication campaigns for family planning and HIV prevention in populations should be available, particularly for those that are most at risk.

Chapter 4

Good practices from the Pacific for achieving Reproductive Health Commodity Security

The adoption of the Pacific RHCS Plan of Action (PoA) in 2003 has clearly had a significant impact on RHCS in the region. In addition to the general improvement of reproductive health (RH) services, there have been specifically targeted activities in certain countries. Examples of good practice discussed are set out below:

4.1 Commitment to Action: Fiji's Experience - Advocacy and Financing²⁸

In 2008, Fiji's total health budget was \$FJ 139 million. The major funding allocations included: 9.5 million to pharmaceuticals; 2.9 million to consumables; 500,000 to HIV prevention; 2 million for upgrading urban hospitals; 2 million to the Fiji School of Medicine; and 17 million for maintaining health centre and nursing stations countrywide.²⁹ Approximately \$180,000 has been allocated to RH commodity security and \$60,000 (projected to increase to \$100,000 in 2009) has been allocated to adolescent reproductive health.

Following the signing of the Pacific PoA by the Minister, the Government agreed, as a way of contributing to its implementation, to provide \$4,000 in token funding to UNFPA and to the establishment of regional warehousing facilities in Fiji for which the Government provides the building and UNFPA pays for the security.

The Government of Fiji has a strong advocacy policy which supports its RH programming through the National Development Plan 2020; the Ministry of Health Strategic Plan 2008-2011; and through the RH Policy 2005-2008, including both its FP Strategy and RHCS. It also extends its commitment to the regional and international levels.

Advocacy and funding go hand-in-hand - the adoption of the Pacific PoA was the catalyst, as it led to Cabinet agreement for a token amount of \$FJ30,000 being made available for RH commodities. Over time the funding level has increased so that the Government is now paying the full cost of RHCS. Once a budget line had been created, it has been possible to increase the level of support.

28
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Based on presentation by Lepani Waqatakiwera, Permanent Secretary of Health, Ministry of Health, Fiji Islands. Budget Brief, 2008.

4.2 Towards Integration of RHCS into Vanuatu's National Health Plans & Programmes³⁰

In 2006, steps were taken in Vanuatu to integrate the following programmes: RH and RHCS; sexually transmitted infections (STI)/HIV/AIDS; adolescent health; cervical screening; other RH services; and tuberculosis (TB), as they had shared goals and objectives, i.e. they addressed the same or similar issues. The vertical structure of the programmes was undermining an already weakened health system, with HIV/AIDS attracting substantial funding from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). Moreover despite there being insufficient staffing resources, programmes were targeting the same target groups, leading to overlap and duplication. Integration, in addition to cutting costs and saving time, is a valuable part of health sector reform in Vanuatu. For integration to be successful it should address structure, policy and implementation.

Capital:

- Government expenditures for salaries, programmes, commodities, infrastructure
- UNFPA provides all contraceptives
- Considering a five year mobilisation strategy to mainstream RH commodities including contraceptives into MOH budget

Structure:

All programmes were integrated under a TB and Sexual and Reproductive Health Manager in three main areas: TB/Leprosy; RH with subsets for cervical cancer screening and adolescent health; and STI/HIV/AIDS. Successful outcomes of the integration included co-organization of activities; co-sponsorship of workshops; integrated supervisory and evaluation visits; sharing of responsibilities and tasks; sharing of knowledge and expertise; and good teamwork.

Policy:

The programme is integrated and cross-referenced and is included in the Master Health Services Plan Priority 2: *Child spacing and reduce teenage pregnancy, Recommendation 2 Strengthen Primary Health Care to deal with Reproductive and Sexual Health*. RHCS is an integral thematic area of the National RH Policy and National RH Strategy. It is included as an area in the National FP and STI Service Guidelines and condom programming is included in National HIV Policy and Strategies. Linkages have also been developed between RH, HIV and adolescent health and contraceptives are included in the Essential Drugs List.

Supply system:

The integrated supply system is based on the five provincial hospitals, 30 health centres (run by nurse practitioners); and some 80 dispensaries and 210 aid posts. Commodities enter the country by sea and air and go into the Central Medical Store from which they are distributed as required. At the provincial and community levels everything is now integrated and health sector reform has enabled more positions to be created.

The Ministry of Health, moreover, coordinates its activities after the Ministries of Education and Health; NGOs such as the World Scout Bureau, Save the Children and the Red Cross; and cultural leaders, women's groups, youth groups and church-based organizations.

4.3 Disaster preparedness: response to the Tsunami in the Solomon Islands³¹

When a disaster, such as a tsunami, strikes the availability of RH care is important for various sectors of the population. Kits are required for pregnant women and new mothers to ensure clean and safe deliveries. Likewise couples need to be able to access family planning information and service and the general public should be able to receive services for the prevention and treatment of STIs and reproductive tract infections. Condoms, both male and female, must also be available for the prevention of HIV infection. Furthermore, the sexual and reproductive health (SRH) needs of young people should not be ignored in order to guard against unwanted adolescent pregnancy and STIs. In such situations UNFPA's rapid response is to provide funding, technical assistance and direct support such as emergency RH supplies and equipment.

The Solomon Islands were hit by the tsunami on 2 April 2007, which caused 52 deaths and destroyed homes and other buildings. The response was co-ordinated by the Central Control Group (CCG) and the National Disaster Management Office (NDMO) which together with NGOs and others were responsible for the distribution of aid to disaster affected areas.

Within four days UNFPA kits had arrived in the Solomon Islands. They included in the UNFPA Kits were emergency delivery kits; rape kits; pregnancy tests; urinalysis tests (multitests); STI kits; intrauterine contraceptive device (IUCD) insertion/removal kits; clean delivery kits; Post Exposure Prophylaxis (PEP)-HIV kits; and basic equipment such as autoclave pots, hanging scales, stethoscopes and thermometers. The next day (7 April) they were cleared and were being allocated by Ministry of Health and Medical Services Reproductive Health staff and airlifted to the health facilities in areas affected by the tsunami.

31

Based on presentation by William Horoto, Chief Pharmacist, Ministry of Health and Medical Services, Solomon Islands

Lessons were learned as a result of the response to the tsunami, which are being taken into account as part of disaster preparedness in the Solomon Islands. For example it showed the importance of ensuring that those using kits in emergencies were familiar with them and their contents. The instant response was important as was the communication on the ground with key stakeholders. The follow up assessment by the Reproductive Health Department showed positive results, particularly that the kits had been used effectively.

4.4 Promoting emergency obstetrics care delivery in Kiribati³²

In 2005, according to the Kiribati Family Planning and Emergency Obstetric Care Survey, there were 26 health facilities in Tarawa, Christmas Island and the Gilbert Group (West). Three were hospitals and the remainder health centres and dispensaries. The remoteness of some of the islands and atolls and scarcity of transportation meant that some women were unable to reach emergency obstetric care when required because of complications in childbirth.

According to the Survey, and based on 2004 statistics, 20 facilities were providing FP services with a choice of at least three contraceptive methods. Male condoms, however, were not routinely available in facilities in some of the outer islands and only ten facilities provided emergency contraception. While eleven facilities provided Norplant, seven reported stockouts and only the Tungaru Central Hospital routinely monitored FP stocks. Although female condoms were known about, very few were being distributed. FP guidelines (Medical Eligibility Criteria) were available in 15 (57%) facilities but in nine of them it was evident that they were not being used. No services were provided for men and services for youth were only provided at the Betio Hospital in South Tarawa.

The total number of deliveries was 1820, of which 64% were by skilled birth attendants and the remainder by traditional birth attendants (TBAs). The percentage of deliveries reported by Kiribati officials was 98%, but this included nurses aides. Three percent of deliveries were by Caesarean section (the ideal percentages being 5-15%) and six maternal deaths were recorded (three from postpartum hemorrhage; one from pregnancy-induced hypertension; one from complications following an abortion; and one other), giving a maternal mortality ratio (MMR) of 284 per 100,000 live births. No facility provided either comprehensive or basic emergency obstetric care.

EU-Kiribati Project

The European Union (EU) has subsequently provided funding for rebuilding 74 health facilities in the Gilbert Group. With the Fiji School of Medicine as the implementing agency, the project includes both infrastructure development and training of health personnel in-country. Labour is provided by locals. To date 16 health facilities have been completed and it is projected that it will take another three years for project completion.

Support for the project is also being provided by international agencies, for example UNFPA will supply RH commodities, including both drugs and equipment, and UNICEF will support the provision of radio and information technology (IT) infrastructure in the new facilities to ensure regular data consolidation. A logistics liaison officer will be appointed and staff will be trained in forecasting, proper recording, ordering, storage and distribution. An important focus is the recognition of the need for regular communication between the EU-Kiribati Project and UNFPA.

Other activities are in place to strengthen RHCS in Kiribati including support for health workforce training, in-country workshops where required and regional workshops. UNFPA has been responsible for carrying out a RHCS situation analysis and is providing contraceptives and technical assistance.

4.5 Pooled procurement for reproductive health commodities³³

Under pooled procurement, countries jointly negotiate prices and agree to purchase from select suppliers. The countries then purchase individually, making contract and deciding on delivery schedules and payment of supplies and performing all financial transactions.

Why pooled procurement should be used in Pacific Island Countries

Pooled procurement is an effective way of supporting the Pacific PoA politically. It is a strategy for synchronizing tender cycles and processes among participating countries. Pooled procurement implies pooled: purchasing power; tenders; knowledge; administrative costs; tools to facilitate clinical decision-making; regulatory requirements; quality control mechanisms; patents; and reliable suppliers. It will not affect sovereignty in decision making and contracting in procurement of pharmaceuticals. The budget for procurement remains in the country concerned and will not be managed by a 'third party'. At the same time it is not a panacea for solving all problems in-country but can make procurement more cost effective and more cost-effective.

On the 'supply side' it is possible to reach economies of scale; improve procurement practices; and ensure sustained supply chains, which require predictability of needs and prices, coordination of deliveries and increased supplier performance. On the 'demand side' it can lead to harmonization of registration; quality control; Essential Medicines Lists; and treatment practices. It can also lead to standardization e.g. the same items; the same therapeutics formulations; and the same manufacturers, thereby saving money.

In deciding to establish a pooled procurement scheme there are a number of issues that must be addressed including timing, methodology and sharing of risks and benefits. Schemes that have succeeded are characterized by strong political

commitment; harmonization and standardization of lists, procedures, requirements etc; secure payment mechanisms; and defined and carefully executed quality assurance components. Those who failed lacked legally binding agreements; a permanent secretariat; poor management of procurement cycles; poor definition of procedures and standards; and debt in the revolving fund.

In general to ensure a successful pooled procurement scheme it is necessary to harmonize Essential Medical Lists, procurement systems and procedures; and criteria for prequalification of manufacturers, suppliers and medicines. There should also be an analysis of the legislation governing procurement and financing of medicines in participating countries.

To date, although the Pacific Island Forum Secretariat has indicated its commitment to implement the Pacific Island RHCS PoA and despite the fact that pooled procurement has been discussed at length and that the Forum secretariat has been directed to 'develop proposals or strategies for the bulk purchasing, storage and distribution of key imported commodities, such as petroleum and pharmaceuticals, no formal agreement has been reached between Ministers of Health of the interested countries to participate in such a scheme. At this time the Forum Secretariat does not have a designated person to cover health and/or pharmaceuticals; health related issues are not addressed by the Forum Secretariat and no committee or working group is working exclusively on issues of regional harmonization. Pooled procurement does not automatically imply establishing a revolving fund: payment of suppliers would remain the responsibility of individual countries and their purchases would continue to depend on their ability to pay.

A regional approach should be taken in regulating the pharmaceutical market, regardless of the introduction of pooled procurement and in setting standards for quality assurance 'A Model Quality Assurance System for Procurement Agencies'³⁴ can be used.

4.6 Commitment to reproductive health, including reproductive health commodity security in the Pacific

Sexual and reproductive health, including RHCS in the Pacific Region relies on the support of regional partners, national level partners, donor partners and UN family partners. In addition to programmes that are funded directly by UNFPA, three donor countries in the region are committed to supporting SRH within the framework of the ICPD Programme of Action, including the provision of commodities towards the implementation of the Pacific Plan of Action, namely Australia, Japan and New Zealand.

34 WHO. (2007) Interagency Guidelines (A Model Quality Assurance System for Procurement Agencies. Geneva.

The Australian Government, through the Australian Agency for International Development (AusAID) supports reproductive health in developing countries within a broader health and development framework, with a focus on women and children's health. In particular, Australia supports maternal health, SRH, access to safe and effective contraception based on informed choice, nutrition and education for girls and programmes to combat gender-based violence. Funding for RH is governed by Australian Family Planning Guidelines *Family Planning and the Aid Programme: A Comprehensive Guide* and supports the implementation of the ICPD Programme of Action. Australia supports the Pacific Plan as an appropriate framework for addressing regional challenges unique to the Pacific.

The Government of Japan, which is one of the largest contributors to UNFPA at the global level, through the Japan International Cooperation Agency (JICA) is committed to improving maternal, newborn and child health within the framework of the Millennium Development Goals. It also supports the strengthening of health systems. At the meeting, Mr. Yutaka Yoshizawa, Ambassador of Japan in Suva drew attention to the fact that, at the G8 Hokkaido Toyako Summit Meeting held on 7th-9th July 2008, the importance of improving maternal, newborn and child health had been highlighted. He also stated that Japan was one of the major donors of UNFPA core programs and provided substantial development assistance program in the Pacific region in the area of health.

New Zealand, though the New Zealand Agency for International Development (NZAID) interests in relation to RH and RHCS in the region include effective coordination between all parties (governments, civil society organizations, regional organizations, and the UN system); closer integration between SRH and HIV; and health system strengthening. Despite an international trend away from funding support for family planning, New Zealand has generally maintained its level of support for SRH and RHCS. As at 2008, Pacific funding commitments for SRH were approximately \$4.5 million per year.

Programmes in the Pacific region have also benefitted from support from the European Union³⁵, as can be seen by the EU-Kiribati Project, and from other bi-lateral donors, such as the UK Department for International Development (DFID). Multi-lateral support has been provided through the GFATM³⁶. In addition, they have received strong support from international non-governmental organizations (NGOs), including the International Planned Parenthood Federation, Marie Stopes International Pacific (MSIP), the International Federation of Red Cross and Red Crescent Societies and Save the Children.

35 See page 26.
36 See page 24.

Chapter 5

HIV and other Sexually Transmitted Infections (STIs) in the Pacific Region³⁵

HIV and STI Epidemiology

Over the past five years, the percentage of adults living with HIV worldwide has leveled off. In 2007 there were an estimated 33 million [30 million – 36 million] people living with HIV (PLHIV), with 2 million deaths and 2.7 million [2.2 million – 3.2 million] new HIV infections – a decline from 2001, when there were 3.0 million [2.6 million – 3.5 million] new infections. While the rate of new HIV infections has fallen globally this favourable trend is at least partially offset by local increases in new infections in some countries. The percentage of women among PLHIV has remained stable (at 50%) for several years, although women's share of infections is increasing in some countries including in the Pacific region. Young people aged 15-24 account for an estimated 45% of new HIV infections worldwide and an estimated 370,000 children under 15 years of age became infected in 2007³⁷.

The numbers of reported cases of HIV in the Pacific Island Countries (PIC) continue to increase. The majority of the persons infected live in Papua New Guinea (PNG), where infections appear to be approaching a generalized epidemic with distinct clustering of very high rates in some specific provinces and locations. The estimated number of infections in PNG increased from 18,000 [17,000 – 18,000] in 2003 to 54,000 [53,000 – 55,000] in 2007. Of these an estimated 21,000 [20,000 – 22,000] are women, who are at extreme vulnerability owing to widespread male dominated risk behaviours including demand for commercial sex and violence against women³⁸.

A gradual increase in the number of cases can also be seen in other parts of the region and particularly in Melanesian countries such as Fiji and New Caledonia. High rates of HIV are also seen in the French Polynesian territory, and US territory of Guam. In Kiribati, Tuvalu and elsewhere HIV infection rates are disproportionately high among seafarers. In many other Pacific Island Countries (PICs), HIV surveillance and voluntary counselling and testing (VCCT) are insufficient to give a clear picture, although recent surveys in pregnant women are perhaps reassuring as there appears to be no widespread HIV infection at this time.^{39,40}

Across the Pacific, the mode of transmission is heterosexual in half of all cases, with a further third of infections occurring among men who have sex with men. In addition, over time, an increasing number of infections have occurred in women, who by 2004 accounted for nearly

37 UNAIDS/WHO, (2008) Report on the global AIDS epidemic. Geneva.

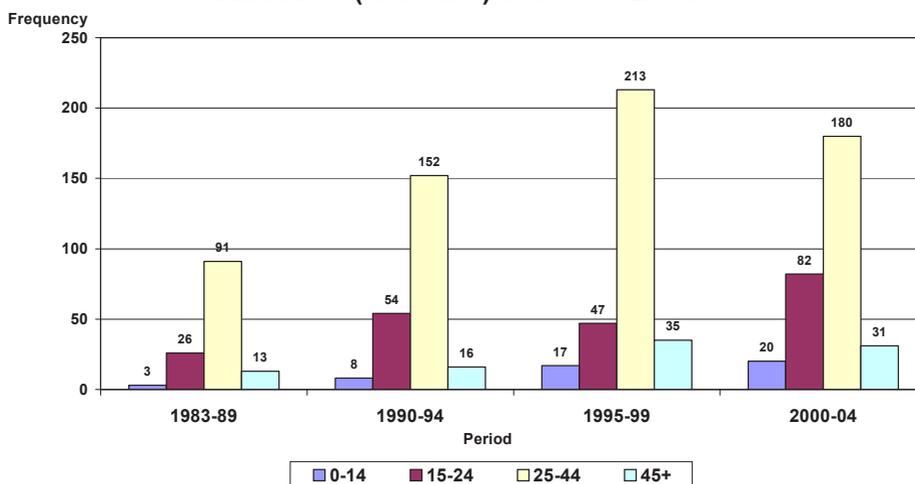
38 IPPF. (2006) Report Card: HIV Prevention for girls and young women – Papua New Guinea.

39 Pacific Health Dialog. (2005) Sladden T. Twenty years of HIV surveillance in the Pacific.

40 Published reports of SGS surveys can be downloaded from:<http://www.spc.int/hiv/downloads/second-generation-surveillance-surveys/>

half of all cases. Some perinatal transmission is also associated with this rise in infection of women. For both men and women, the highest numbers of infections have been occurring in the 25-44 age group, though there has been a disturbing increase in numbers of infection in the 15-24 age group, indicating an increase HIV risk in young people in the Pacific.

Figure 9: HIV Cases Age distribution, All PICTs (exc PNG) 1980's to 2004



5.1 Sexually transmitted infections

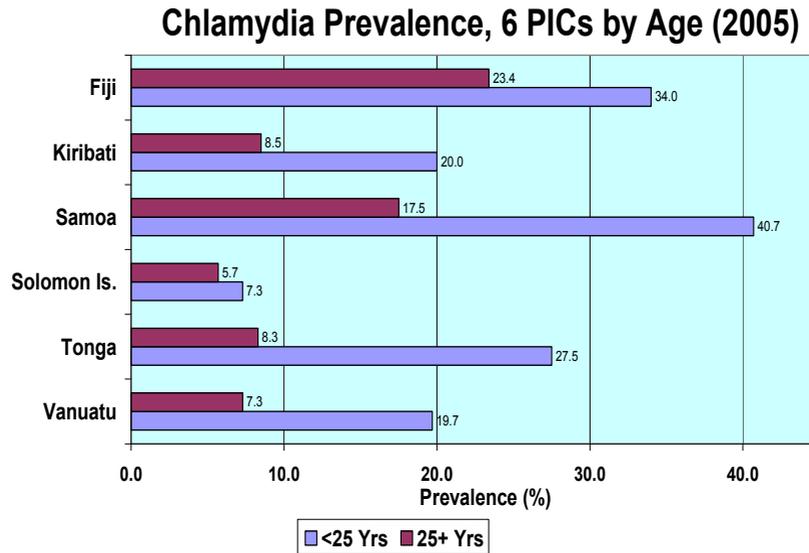
The most common sexually transmitted infection (STI) in the Pacific is Chlamydia. It is hyperendemic in the region, circulating freely in the adult population with extremely high prevalence rates in countries such as Fiji (29.0%), Samoa (26.8) and is found commonly in most, if not all, other PICs⁴¹. Long term sequelae of Chlamydia infection include pelvic inflammatory disease in women and infertility in both men and women. Other STIs such as gonorrhoea and syphilis are also common in the region. A high prevalence of syphilis (10%) was reported in the Solomon Islands. Elimination of congenital syphilis is dependent upon widescale syphilis testing and further efforts at HIV/STI prevention. Herpes and cervical cancer, the latter associated with Human papillomavirus (HPV) infection, are also common across the region. The occurrence of all STIs (including non-ulcerative STIs) greatly increases the risk of HIV transmission when and where HIV exposure occurs.

The highest prevalence of Chlamydia is occurring in young people under the age of 25. This, combined with high rates of teenage pregnancy observed in all PICs, again indicate widespread unprotected sexual activity in many young Pacific Island people. This appears to be confirmed by Second Generation Surveillance surveys showing young age at first sex and condom use generally to be low including in this agegroup.

41

Cliffe S et al, Sexually Transmitted Diseases, (2008) Chlamydia in the Pacific, the silent epidemic. 35(9):801-806.

Figure 10:



5.2 Addressing stigma and discrimination

Harassment, discrimination and criminalization of sex workers, men who have sex with men and other high risk groups drive risky behaviours underground. This reduces uptake of services and thereby increasing the risk of HIV/STIs, violence and risk to the whole community. Ensuring that health promoting policies, anti-discrimination legislation and the decriminalization of risk behaviours, all of which contribute to the protection of human rights, is a more successful alternative. Confidentiality is important although difficult to ensure in a region such as the Pacific where communities are small, close-knit and 'everyone knows everyone's business'. Individuals perceiving themselves to be at risk of HIV will not go for an HIV test unless confidentiality is ensured.

Governments have a responsibility to ensure user-friendly health services with supportive, accepting, non-judgmental attitudes of staff to persons most at-risk of HIV/STIs. These services need to be confidential, free, discreet and accessible with flexible opening times. A range of services can be offered -- a 'one-stop shop' including prevention, VCCT, treatment, care and support not only for HIV but also for other STIs and drug and alcohol use. The youth-friendly, comprehensive adolescent sexual and reproductive health (SRH) services set up under the Adolescent Health and Development (AHD) programme provide a good model that could be replicated elsewhere and for different age groups and at-risk groups. Referral can be made available as required. Health workers can be trained to protect the confidentiality of PLHIV, and to reduce stigma and encourage accepting community attitudes. HIV-positive Pacific Islanders can be Champions in advocating for acceptance, support and services.

5.3 Comprehensive condom programming

There are examples in Asia and the Pacific that show that increased condom use leads to significant reduction in HIV and other STIs. Comprehensive condom programming (CCP) is an integrated and holistic approach to ensuring ongoing supply of condoms to all sexually active adults. CCP⁴² covers all stages of condom supply from forecasting, bulk procurement, stock management and quality assurance, to distribution, supply chains, increasing accessible outlets, condom marketing, promotion and demonstration and community mobilization to increase demand. All stages of condom supply need to occur to ensure quality condoms are available as required by all sexually active adults. Marketing and promotion needs to occur of both male and female condoms, with awareness and interest in the latter beginning to increase in the Pacific.

Countries are encouraged to setup national CCP Working Groups as part of broader insert reproductive health commodity security (RHCS) management to coordinate and facilitate condom supply, management and promotion. There is much work to do in shifting community attitudes and removing barriers and bottlenecks that prevent access, awareness and acceptance of condoms – which are the only proven effectively prevention method for HIV/STIs. The currently favoured “ABC” prevention approach is not working, with selective focus on abstinence and faithfulness messages being ignored or rejected by many young people in the region. The high rates of STIs and teenage pregnancies clearly indicate early and unprotected sexual activity is occurring in many young Pacific Islanders. “ABC”⁴³ messages also do not assist many women in the region where decisions about sexual activity are often male-initiated, and gender-based violence including rape and domestic violence are common. Promotion of female condoms is one of the few prevention methods that can be female-initiated and provides a useful avenue by which women can raise SRH issues with their male partners.

To assist promote condom use, UNFPA Pacific SRO has developed branding for both male and female condoms, and packaging (“safe sex kits”) that appeal specifically to young people. This promotion has done much to increase acceptability and uptake of condoms by those most at-risk in the community.



Condom Branding, Marketing/Promotion
Pacific Brand Condoms

42 Population Council & UNFPA. 2009 Comprehensive condom programming: Rapid needs assessment and strategic planning tool. (Draft). New York

43 ABC Abstinence, Be faithful and Condom use

5.4 Resource mobilization in the Pacific region

In addition to the routine supplies of condoms provided by UNFPA and in-country budgets for RH commodities, other sources of support are available. A Pacific HIV/STI Response Fund has been set up, administered through SPC, currently with bilateral country donors being Australia, New Zealand and France. Multi-lateral donors such as The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and Asian Development Bank (ADB) also make funds available to support condom supplies and promotion in the Pacific region. Countries wishing to access the Pacific Response Fund may include CCP activities within National HIV Strategic Plans (supported under stream I of the Response Fund), or submit separate CCP specific projects under a number of other streams.⁴⁴

5.5 Parliamentarians as Champions for leadership and advocacy for HIV prevention

Parliamentarians can play an important role as champions for leadership, advocating for the prevention of HIV in the Pacific Islands. In 2004 the Pacific Parliamentary Assembly on Population and Development (PPAPD) adopted the Suva Declaration on HIV/AIDS, including advocating for provision of RH commodities including condoms. In the same year, the Pacific member churches of the World Council of Churches adopted the Suva Declaration, including support for the availability of condoms to enable adults to make informed choices and have access to condoms. The follow-on 2007 meeting of the PPAPD adopted the Apia Communiqué on Safeguarding Pacific Youth: Accelerating Actions through Partnership with Pacific Parliamentarians. This too reaffirmed the need for the availability of condoms.

In light of the recognition of the importance that sports play in the lives of young people a partnership has been developed between the Pacific Island Forum Secretariat (PIFS), UNAIDS, the Asia Pacific Leaders Forum (APLF), the Pacific Islands AIDS Foundation (PIAF), the Oceania National Olympic Committees (ONOC) and the Secretariat of the Pacific Community (SPC). Its remit is to:

- Encourage partnerships between Pacific Island National Olympic Committees and National AIDS Committees;
- Develop an HIV policy for sports;
- Adapt the global International Olympics Committee (IOC)/UNAIDS tool kit for national use;
- Prepare events-based HIV prevention campaigns;
- Develop role models in sport and involve people living with HIV.

44

Further detail of the Response Fund are available from the Fund Manager, Mr Jerry Cole at SPC (jerryc@spc.int).



Parliamentarians are in a position to link and partnership with both the church and sports leadership to promote HIV prevention. In addition they can work with faith-based organizations on common areas of the Nadi and Suva Declarations such as stigma and discrimination; affordability of drugs and reaching vulnerable groups including young people. They can, moreover, play a vital role in working on issues related to legalization, decriminalization of sex-work and male-to-male sex and ensuring HIV transmission does not become criminalized. Parliamentarians can strengthen budgeting and accountability on funding for HIV programmes - whereby on some countries HIV prevention activities are not reported to Parliament and are not linked to the national development plan.

Chapter 6

Development of the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008-2015⁴⁵

6.1 Context: Policies and legislation, using a rights-based approach, for a supportive environment for access to reproductive health by 2015

Progress had been made at the national level in developing policies and legislation for a supportive environment for access to reproductive health (RH) by 2015:

- The Cook Islands has developed a RH Policy in which reproductive health commodity security (RHCS) should be included;
- The Federated States of Micronesia (FSM) was in the process of drafting public health policy and family planning (FP) policy which includes key reproductive health (RH) nor RHCS elements;
- Fiji has a RH policy including RHCS;
- Kiribati has developed a draft RH policy which will be finalized in 2009;
- The Marshall Islands (RMI) have no assessment, nor is one expected;
- Nauru's RHCS report and RHCS Strategy is awaiting Ministry of Health approval;
- Niue has neither a RH, nor a RHCS strategy;
- Papua New Guinea (PNG) has introduced a national population policy and has a Committee on RHCS;
- Palau does not have a RH Policy;
- Samoa is developing a RH Policy which includes RHCS;
- The Solomon Islands' RHCS committee was established in 2005, but it has not met in 2008 and its future will be reviewed;
- Tokelau has no RH Policy at present;
- Tonga has formulated its RH Policy, which includes RHCS, and will finalise it in 2009;
- Tuvalu is currently developing its RH Policy; and
- Vanuatu has developed its RH Policy which includes RHCS.

At the regional level, a regional warehouse has been established in Fiji and RHCS reviews are available for 11 countries. Approval for another four is awaited.

The following were recognized as important issues for future action:

- The need for RH/RHCS policies to have mandatory sections/clauses;
- The lack of regular statistics and data for feedback, projections etc;

- The importance of educating men that condoms/commodities should protect both women and men and ensuring that condom machines be readily accessible;
- The need for technical assistance as an important consideration in policy development;
- The availability of national policies of other countries for those countries who are considering drafting theirs including lessons learned and pitfalls to avoid;
- The holding of meetings on RHCS every two to three years, instead of every five years, as they tend to spur on activity;
- The availability of advocacy strategies for instances where RHCS is not a national or Ministry of Health priority, in comparison with non-communicable diseases; and
- Availability of funding, as it can be a major limitation factor with respect to the development of new policies, whether RHCS or otherwise.

Strategies

The following strategies were identified:

- Promoting advocacy to persuade change in sections of society that may be resistant to RH or RHCS;
- Identifying champions in the churches who understand the importance of RH and access to it and are able to convey this to other church members;
- Convincing domestic stakeholders about the importance of RHCS in the delivery of RH;
- Developing a regional progress card that annually confirms the rate of implementation of the Pacific Plan of Action;
- Identifying champions to spearhead RH policy formulation, particularly in those countries that do not have a policy committee;
- Ensuring access to RH services for young people, including special services as required, in RH policy;
- Considering whether there should be a unified health policy as opposed to a specific RH policy;
- Making dispensing machines condoms readily available;
- Making greater use of existing social networks; and
- Mainstreaming RH into the educational curriculum.

6.2 Client services and utilization issues: Removing barriers and promoting better services, particularly for vulnerable groups including young people

Progress had been made at the national level in removing barriers and promoting better services, particularly for vulnerable groups including young people:

- An increased choice of contraceptives is available in some countries, e.g. some women are using implants, emergency contraception and female condoms;
- Adolescent sexual and reproductive health (SRH) services are available in some settings with peer education programmes expanding in many countries. Family life education (FLE) has been initiated in many countries but further expansion is needed;
- Programmes to promote male involvement in RH have been initiated in three countries (Fiji, Solomon Islands, Vanuatu);
- Most countries have National Reproductive Health Coordinators and Coordination Committees to undertake RH programme planning, implementation and coordination;
- Reproductive health policies and strategies which include adolescent SRH and RHCS being developed in several countries;
- Evidence based service guidelines for family planning (FP) and sexually transmitted infection (STI) have been introduced in most countries.

Issues

The following were recognized as important issues for future action:

- Inadequate community based SRH services, including outreach services particularly for young people;
- Low utilization and availability of contraceptives in many countries as evidenced by the low contraceptive prevalence rates (CPR) and unmet need for FP;
- Lack of demand for SRH services because of low levels of awareness on availability and potential benefits of accessing services;
- Variable levels of access to user friendly SRH services;
- Unintended pregnancies, including teenage pregnancies, persisting in many countries;
- High rates of sexually transmitted infections (STIs), especially in young people;
- Lack of adequate data for evidence-based planning and programming -- most countries do not have good data upon which to track progress e.g. CPR, unmet need for FP, which means that it cannot be measured;
- Need for training of planners and programme managers in utilizing the data for monitoring progress;
- Lack of information on unmet need for FP and proportion of pregnant

- women with >4 antenatal care visits in many countries;
- Lack of male involvement in RH;
- Lack of primary infrastructure for supportive services including laboratories.

Strategies

The following strategies were identified:

- (a) To address availability, access and utilization issues
 - Strengthening community based service delivery for young people, by showcasing models of successful youth-friendly services and expanding them to other centres to increase access to contraception, STI treatment and counseling;
 - Promoting integrated SRH service delivery throughout the health system and strengthening linkages, as appropriate, such as “One Stop Shop”;
 - Increasing targeted health promotion and community involvement by:
 - Strengthening community-based mobilisation programmes for awareness raising and addressing unmet need for FP and other RH services;
 - Creating demand through health promotion programmes in schools and supporting and strengthening FLE in schools and out of school behaviour change communication (BCC) programmes;
 - Engaging clients in the planning and delivery of their services including early youth participation in the planning process; and
 - Promoting condom use for prevention of STIs, HIV and unintended pregnancies in sexually active persons in a culturally sensitive manner.

- (b) To promote advocacy for sexual and reproductive health
 - Identifying role models to whom clients can relate for positive mentoring to promote responsible behaviours, e.g. prominent sports persons; and
 - Engaging church leaders and community leaders to contribute in discussions and advocacy for improving SRH.

- (c) Improving quality, acceptability and appropriateness of services
 - Developing/updating/implementing RH policies and strategies for achieving universal access to RH services and commodities;
 - Adopting evidence-based guidelines in FP, maternal and newborn care, STIs/reproductive tract infections including cancer of cervix, HIV and screening for breast cancer;

- Undertaking training and regular updating of knowledge and skills of service providers for the delivery of SRH;
 - Strengthening health systems to deliver more responsive SRH services that meet the needs of the population.
- (d) Improving information base for priority setting
- Increasing capacity for monitoring and evaluation of SRH programmes by:
 - Strengthening health information systems;
 - Undertaking timely demographic and health surveys (DHSs); and
 - Ensuring that there are proxy indicators on progress for all the areas.
 - Strengthening analytical capacity to inform policy and practice by training health programme managers and planners in utilizing data for more evidence based planning.

6.3 Capacity of supply chain management and future progress

Progress had been made at the national level in:

6.3.1 Selection

In selecting commodities most countries will have an Essential Drugs List, although the actual products are pre-determined. They will have reviewed the list in light of the WHO Model List or other Inter-agency Health List, and products will therefore follow the WHO standard. Countries' national drug policy/system should enable and encompass the private sector needs as well, to ensure broader client choices. Affordability may, however, become an issue.

6.3.2 Forecasting

Most countries face difficulties in forecasting due to lack of capacity in who is carrying out the forecasting and how skilled they are. There is often a lack of appropriate data regarding demographics and population-based forecasting; and inventories – usage-based forecasting. No countries have health information systems that collect information on RH and unmet need for FP, or have inventories with usage-based forecasts. In addition to a lack of computer hardware at sub national levels, many do not have inventory suites that are equipped to do forecasting.

To improve forecasting capability, Ministries should:

- Collect all the appropriate types of data;
- Provide necessary training for staff and managers;
- Have available the appropriate information technology;
- Review software capabilities in forecasting with links to forecasting modules;
- Provide the logistics to support the forecasting.

6.3.3 Procurement ⁴⁵

Progress has been to date in the following areas:

- A pooled procurement feasibility study has been carried out;
- The benefits have been identified and concepts developed;
- Sources and pre-qualification has been carried out by UNFPA in most Pacific Island Countries (PICs).

Issues to be addressed include the following:

- National procurement systems should be simplified and made more transparent;
- Efforts should be made to reduce the lack of flexibility on procurement practices.

Actions that should be taken include:

- Adopting the pooled procurement concept
- Identifying a host for a pooled procurement system;
- Training sufficient personnel;
- Instigating good procurement practices, including transparent and accountable practices, including pre- and post- qualification on suppliers and product and monitoring quality assurance of products and supplier performance.

6.3.4 Distribution

In assessing the progress made to date, the problem of geographical constraints was identified and it was recognized that the most appropriate supply methods were not always being used. It was therefore thought that parallel systems should be explored only under very unusual circumstances. Health system strengthening addressing improved distribution systems should be considered first.

Distribution could be improved by taking the following actions:

- Identifying a budget line to cater for distribution of supplies by using appropriate transport mechanisms;
- Training managers
- Instituting an integrated distribution system.

6.3.5 Storage

Progress had been made with regard to storage with the establishment of the central warehouse in Suva, though there remained a lack of suitable storage facilities in some countries in the region. Appropriate storage facilities along the pipeline were important. Storage could be improved by developing, adopting and implementing standards for appropriate storage at all levels.

45

See also Chapter 4, Pages 4-6.

6.3.6 Waste management

While some progress had been made in waste management and much work had been done locally with regard to clinical waste management control, problems still existed because of poor inventory control and also un-solicited donations.

In order to minimize wastage, it was important to have an appropriate inventory control. Where they do not already exist, medical drug supply waste management guidelines should be introduced that incorporate pharmaceutical waste. In addition, good donation practices should also be introduced and/or complied with.

6.4 Capital: funding for reproductive health services

Progress has been made in providing funding for RH services in a number of areas. The Paris Declaration Frameworks⁴⁶ have been developed in some PICs. Some Sector-wide Approaches (SWAps) have been developed for health and some national health accounts have lines for RH. Reproductive health policies have been developed and/or reviewed and in some countries RH related issues have been crafted into statutes.

In the region there are a number of key common concerns, despite varying population dynamics and economics. There is a lack of long-term human resource development across sectors and differing levels of Government priorities for funding exist. Governments lose valuable human resources to donors, which is one facet of sovereignty issues. Within governments, there is a lack of commitment to RHCS as a national issue of priority. Some governments find the multiple bilateral and multilateral arrangements too complex, when they are mainly concerned in having easy access to free or cheap commodities.

6.5 Coordination and collaboration

Coordination and collaboration is easier in smaller countries as stakeholder communication is easier e.g. Ministry of Health with other ministries, the media, schools, churches etc. Within this context, ranges in levels of integration of SRH services exist. It is important that the separate vertical programmes, e.g. FP, RH, HIV/STI, maternal and child health (MCH) are integrated into holistic SRH services. Reproductive health commodity security (RHCS) committees are functioning in some PICs and complimentary Ministry of Health-NGOs services, e.g. Ministry of Health-IPPF sharing of commodities in Tonga and NGO delivery of the adolescent health programme.

In assessing regional coordination, it can be seen that a wide range of commodities is included e.g. contraceptives, drugs, test kits, vaccines etc, which are financed by a range of donors e.g. Governments, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), UNFPA, UNICEF, Marie Stopes International Pacific (MSIP) and WHO. Commodities are sourced by different development partners including

46

See also Page 19.

UNFPA, Secretariat of the Pacific Community (SPC), International Planned Parenthood Federation (IPPF), UNICEF and MSIP for distribution to different service delivery points e.g. hospitals, out-patient's departments, primary health care facilities and NGO clinics. Its complexity has led to duplication, gaps and inefficiencies.

Strategies

Coordination strategies are therefore required to improve coordination in the provision of commodities including:

- Ensuring that RHCS committees in PICs function with multi-stakeholder representation and relevant sub-committees e.g. maternal and infant mortality review and condom programming;
- Exploring further integration of SRH, HIV/STI and MCH services;
- Extending partnerships to other sectors including construction, environment, resources (mining/logging/fishing) and education; and
- Coordinating RHCS security waste disposal;
- Ensuring that all essential RH commodities are on the country's Essential Drugs List;
- Improving full logistics management information system data collection and feedback to service providers;
- Integrating national RHCS plans within the broader national strategic plans; and Improving and sustaining monitoring and evaluation over the Pacific Plan of Action.

At the regional level strategies for improving coordination should include:

- Strengthening joint United Nations presences in countries to coordinate inputs, including joint UN planning and programming;
- Improving communication e.g. coordination of timetabling of development partner assistance including joint missions and advanced notice of workshops;
- Coordinating dissemination of information and increasing updates, reporting to PICs on the new Strategic Framework;
- Developing consistent RH information, education and communication (IEC) materials and messages;
- Coordinating regional procurement of all commodities;
- Integrating further SRH, gender and programme development issues;
- Increasing rights-based approaches including 'family rights';
- Strengthening regional coordination between SPC and United Nations;
- Improving resources mobilization;
- Increasing support for country monitoring and evaluation processes, ensuring integration within programmes.

Chapter 7

Pacific Policy Framework for achieving Universal Access to Reproductive Health Services and Commodities 2008 – 2015

1 Preamble

1.1 As Ministers of Health and Government Health Officials from fourteen Pacific Island Countries (PICs) meeting in Denarau, Nadi, Fiji on 5-7 November 2008, we have agreed on the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008-2015 (Pacific Policy Framework), which incorporates and builds on the Pacific Plan of Action for Reproductive Health Commodity Security, 2003. The Pacific Policy Framework has been developed in the context of decisions taken at the International Conference on Population and Development (ICPD) in Cairo 1994, and at Twenty-first special session of the General Assembly (ICPD+5) in New York 1999 and supports the achievement of the Millennium Development Goals (MDGs), especially MDG3, Promote gender equality and empower women; MDG4, Reduce child mortality; MDG5, Improve Maternal Health; and MDG6, Combat HIV/AIDS, malaria and other diseases. In particular, the Pacific Policy Framework is crucial to the achievement of MDG5 Target 5A -- Reduce by three quarters the maternal mortality ratio and Target 5B -- Achieve, by 2015, universal access to reproductive health, and MDG6 Target 6a -- Halt and begin to reverse the spread of HIV/AIDS. Its goal is to ensure that by 2015 every person in the region will have access to reproductive health (RH) services and commodities of their choice.

1.2 In pursuit of this goal, the objectives of the Pacific Policy Framework are to attain universal access to reproductive health services and enhance reproductive health commodity security (RHCS) through innovative mechanisms and health system strengthening. It is recognized that RHCS greatly depends on the operation of good supply systems. While progress has been made in information technology (IT) systems supporting supply management since 2003, RH commodities supply management in all PICs remains fragile and often struggles, because of geographical and economic constraints. Each participating Pacific Island Government therefore agrees to further its commitment and action for RHCS by enhancing its leadership role; ensuring that increased resources are available from government sources; and strengthening services to enable its people to enjoy the highest attainable possible standard of reproductive health (RH) and to have access to a wide range of RH commodities. Since the adoption of the Plan of Action in 2003 there has been a growing recognition of the importance of linking prevention and control of sexually transmitted infections (STIs), including HIV, with RH.

- 1.3** Within the context of geographical, financial and human resource constraints faced by each of the countries in the Pacific Region, the Pacific Policy Framework recognises the importance of government commitment and programmes within a supportive legislative environment using a rights-based approach; the removal of barriers and promotion of better services to ensure client-centred services and utilization; capacity of supply chain management; and the necessary funding for RH commodities and services. It recognises the need for strengthened coordination and collaboration at all levels within and between Ministries and with NGOs and development partners, including UNFPA and WHO, in conformity with the Paris Declaration on Aid Effectiveness, Ownership, Harmonization, Alignment, Results and Mutual Accountability, 2005⁴⁷, and government leadership, and the Pacific Aid Effectiveness Principles, 2007.⁴⁸
- 1.4** We call on the other Pacific Island Countries to join in commitment to this Pacific Policy Framework, which will enhance the opportunities for successful implementation through mutual cooperation and support and will contribute to the goal of ensuring that by 2015 people everywhere in the region will enjoy the highest attainable level of reproductive health, through RHCS as part of the comprehensive range of sexual and reproductive health (SRH) services.

2 Key areas of progress towards meeting the goals of the Pacific Plan of Action for RHCS 2003

- 2.1** During the past five years, significant progress has been made towards achieving the goals of the Pacific Plan of Action for RHCS in Pacific Island Countries:

2.2 Policy and structure

Most countries have developed, or are developing, reproductive health policies and strategies, which include adolescent sexual and reproductive health and RHCS. They have also appointed National Reproductive Health Coordinators and established Coordination Committees to undertake programme planning, implementation and coordination. In some PICs, RHCS Committees or Focal Points are functioning and are providing a coordinating role. The Pacific Parliamentarians meeting included RHCS in its Suva Declaration on HIV/AIDS, 2004⁴⁹. Availability of condoms was also included in the Nadi Declaration (2004) of the World Council of Churches Pacific Member Churches⁵⁰ and the Apia Communiqué of the PPAPD on Safeguarding Pacific Youth, 2007⁵¹.

47 OECD (2005). Paris Declaration on Aid Effectiveness, Ownership, Harmonisation, Alignment, Results and Mutual Accountability.

48 Pacific Islands Forum Secretariat (2007). Pacific Aid Effectiveness Principles.

49 Pacific Parliamentary Assembly on Population and Development (PPAPD) (2004). Suva Declaration on HIV/AIDS by Pacific Parliamentarians; Pacific Assembly on Population and Development, Fiji 11-13 October 2004.

50 World Council of Churches Office in the Pacific (2004). The Nadi Declaration: a Statement of the World Council of Churches' Pacific Member Churches on HIV/AIDS, 29 March - 1 April 2004, Tanoa International Hotel, Nadi, Fiji.

51 Pacific Parliamentary Assembly on Population and Development (PPAPD) (2007). The Apia Communiqué on Safeguarding Pacific Youth: Accelerating Actions through Partnership with Pacific Parliamentarians.

2.3 Services

A broad range of RH services, including family planning (FP) and essential commodities are being provided. There is a broadened choice of available contraceptives, including the use of implants, emergency contraception, and female condoms by some women in some countries. Adolescent SRH services with peer education programmes are expanding in many countries together with strategic interventions aimed at reaching the most vulnerable groups including young people, particularly adolescent girls. Family life education has also been revised or updated in some countries but further strengthening is required. Programmes to promote male involvement in reproductive health have been initiated in Fiji, Solomon Islands and Vanuatu. Some countries have commenced integration of reproductive health, including family planning, HIV/STI and other related services to provide comprehensive, holistic SRH services.

2.4 Efforts have also been made both by Ministries of Health and NGOs to extend the reach of RH services into the community, especially to some at-risk key populations. For example, in Tonga NGO service providers work with populations not reached by the Ministry of Health. Reciprocal arrangements are also in place between Ministries of Health and NGOs for sharing commodities in stock-out situations and training workshops. Meanwhile, there is still room for further partnering between Government and NGO service providers.

2.5 Supply chain management

A regional database and RH commodity depot, provided by the Fiji Ministry of Health has been established in Fiji by UNFPA with dedicated staff and software to support its operations of procurement and distribution of commodities. Comprehensive reviews of the status of RHCS have taken place in fourteen countries⁵². Regional and national capacity building in RHCS has been conducted but further in-country strengthening is needed, particularly in the areas of forecasting and LMIS. Storage facilities in countries vary considerably, regular quality assurance mechanisms have not been initiated and long lead times persist. Most countries have introduced some form of automated logistics management information system for their national medical supplies and, in many countries; contraceptives have been integrated within the supply chain management system. Forecasting for contraceptives on the basis of sound logistics, service and demographic data is still problematical in many PICs.

2.6 Financing

In moving towards self-sustainability for the provision of reproductive health services and commodities, most PICs have adopted the Paris Declaration framework and at least two have begun using Sector Wide Approaches (SWAs) for coordinated donor funding for their programme activities. Some PICs have developed National Health Accounts annual reporting for mapping the flow of Government, donor, developmental and out-of-pocket payment expenditures for health.

52 Cook Islands, Federated States of Micronesia, Fiji Islands, Kiribati, Nauru, Niue, Palau, Papua New Guinea, Republic of the Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu

- 2.6.1** There is a growing recognition of the need for earmarked in-country funding, however to date only five countries have made specific budgetary allocations for contraceptives.

3 Pacific Policy Framework: Proposed actions

3.1 Political will and action

- 3.1.1** Ministers of Health will take action to sensitize their cabinet colleagues and other parliamentarians to the importance of RH and the need for improved RHCS, in order to secure commitment and strengthen their leadership role in RH at the highest levels of Government.
- 3.1.2** Through the Ministry of Health, each Government will introduce, or where it exists, review and update, a Policy and/or a Strategy on Reproductive Health, including measures to reposition⁵³ family planning and enhance the security of RH commodities.
- 3.1.3** Recognizing the links between RH and socio-economic, environmental and health development, Governments will assign a high priority to policies that address RH, including FP, maternal health, STIs and HIV, in the region. Each Ministry of Health will review and, where necessary, take steps to augment its policies to ensure that:
- (a) policies are appropriate for RH and core services of RH care, and are in line with the goals of relevant conferences and the MDGs;
 - (b) reproductive health, including FP, maternal health, STIs and HIV, is integrated into national health policies, strategies and action plans to the fullest extent possible;
 - (c) where appropriate, integrated approaches that are human rights and gender-based are adopted within broader national plans to address RH, including family planning, maternal health, STIs and HIV.
- 3.1.4** Each Ministry of Health will work to ensure, where it does not already exist, a separate budget line for RH with the intention of moving towards self sustainability in commodity supplies.
- 3.1.5** Each Ministry of Health will ensure that medical supply requirements for RH services are managed under an up-to-date National Medicines Policy that should promote the right conditions for a robust system to procure and manage all health supplies, including contraceptives, RH essential medicines and other RH commodities.

⁵³ Repositioning family planning is a policy approach utilized to improve services and remove obstacles to family planning use

- 3.1.6** Each Government will establish policies and programmes to ensure that the RH needs of the population are met, including those of groups such as adolescents and unmarried women, as well as taking account of the RH needs of men in different situations. This will require a variety of approaches to reach into the community to identify hidden needs.
- 3.1.7** Each Ministry of Health should ensure that standard treatment guidelines are in place for RH, including maternal and newborn care, family planning, STI/reproductive tract infections (RTIs) including prevention of cervical cancer, HIV and infertility.
- 3.1.8** Each Government will advocate for increased acceptance of people living with HIV and other STIs to reduce stigmatisation, and increase awareness about transmission and misconceptions.
- 3.1.9** Each Government will develop and continuously strengthen a multisectoral approach to enhance RH. This will include RH education both in primary and secondary schools and in the wider community; the sensitization of community-based and civil society leaders and organisations; the promotion of greater knowledge, opportunities to make informed choices; and acceptance of responsibility by each individual.

3.2 RH commodities supply management

- 3.2.1** Each Ministry of Health should recognise the critical importance of successful RH commodity supply management, and ensure that there is adequate policy leadership, budget, and management support for:
- (a) exploring initiatives in regional collaborative procurement of RH commodities;
 - (b) appropriate national selection of RH commodities, including contraceptives and RH essential medicines on the Essential Medicines List, and development and implementation of guidelines on medical donations;
 - (c) appropriate national and local quantification of needs and demands for RH commodities, and the proper use of relevant methods to forecast commodities requirements to ensure all client needs are met; recognising particularly the very urgent need to strengthen the prevention of transmission of HIV and other STIs (e.g., through greater condom acquisition and distribution);
 - (d) proper management of RH commodities inventory including procurement, storage and distribution at all levels in the supply chain and in RH service provision;
 - e) development and implementation of appropriate national standards, and/or common regional standards, for quality assurance, quality testing, optimizing good RH commodities usage, and minimizing and managing wastes.

Note: There is a large range of important and urgent technical matters embodied in the above. More detailed action proposals to address these technical matters, thereby improving RH commodity supply management, are contained in Annex 1.

- 3.2.2** Each Ministry of Health should ensure that its pharmaceutical and logistics officers consider the detailed action proposals in Annex 1, and plan for critical outcome improvements in health supply management, to ensure effective and efficient delivery, and quality use, of RH commodities.

3.3 Resources for reproductive health commodity security

- 3.3.1** Each Government should develop resource mobilization strategies and action plans to ensure achievement of RH policy goals, with appropriate programme budget lines for effective management of RH services and programmes.

- 3.3.2** Each Ministry of Health should ensure that RH commodities are included in standard emergency kit definitions and are made available automatically in emergencies and disaster responses for displaced populations or areas affected by natural disasters or civil unrest.

- 3.3.3** Given the varied range or types of RH services at various levels of service providers, skills developed need to be matched to competency requirements of the service profile, which may include supply management skills. Each Ministry of Health therefore should seek partners at national and international levels to ensure that appropriate training is provided to ensure essential RH services are available.

- 3.3.4** Governments and partners should improve resource mobilisation and coordinate this via use of pooled funding mechanisms such as the “Pacific HIV/STI Response Fund”. They should examine further ways of unifying disparate funding mechanisms for a more coordinated approach to securing RH commodities and services in PICs.

3.4 Meeting the needs of clients

- 3.4.1** Noting that historical levels of demand for RH commodities are often an under-representation of the real needs of people, each Government should take the following measures to increase supplies and demand to bring commodities into alignment with user needs and call upon their national and international partners for support in these actions:

- (a) Where appropriate, each Government should conduct community-based mobilization programmes and sensitization campaigns (including through the media, peer education groups and, IEC materials) among politicians, religious groups, civic leaders, parents and teachers to encourage more open debate

and understanding of the RH needs and rights of all sections of the population, including minority groups previously under-served or excluded from access. Role models to whom clients can relate for positive mentoring to promote responsible behaviour should be identified;

- (b) Governments should support and strengthen as appropriate family life education in the school curriculum to ensure sustainability of programmes aimed at raising awareness about healthy sexual behaviour and out-of-school targeted behaviour change communication programmes should be undertaken for vulnerable groups and young people;
- (c) Successful youth friendly services should be strengthened, expanded and replicated to provide access to contraception, STI prevention, treatment and counselling to young people through appropriate community based service delivery models.

3.4.2 Ministries of Health should strengthen the role of National Reproductive Health Coordinating Committees, where they exist, to encompass all stakeholders involved in the provision of RH services, including other Government departments, NGOs and other organisations and to avoid any wasteful duplication of provision of RH commodities to the community. Other Ministries of Health in the region should consider establishing similar coordinating committees.

3.4.3 Governments, in particular Ministries of Health should improve accessibility to quality maternal and newborn care services and that ensure basic and comprehensive emergency obstetric services to all pregnant women.

3.4.4 Ministries of Health should strengthen integrated services and linkages between RH and HIV to enable the delivery of integrated services, as appropriate, and increased opportunities for prevention and care

3.4.5 Governments should strengthen efforts to promote condom use for prevention of STIs, HIV, and adolescent and other unplanned pregnancies via comprehensive condom programming. Young people, people living with HIV and other stakeholders should be included in the planning, design, implementation and evaluation of the programme.

3.4.6 In RH matters, greater partnership is needed between men and women. Lessons learned from the *Men as Partners in Reproductive Health project* (piloted in Fiji) and the *Male in Reproductive Health Programmes* in Fiji, Solomon Islands and Vanuatu could be drawn on in implementing this approach.

3.5 Improving information base for priority setting, programme monitoring and service delivery with emphasis on commodity security

- 3.5.1** Each Ministry of Health should promote the improvement of quality RH care through, among other things, the adoption of evidence-based guidelines and tools in maternal and newborn care, family planning, STIs/RTIs including prevention of cervical cancer, HIV, infertility.
- 3.5.2** Where appropriate, each Ministry of Health should use existing Essential Drugs systems for the planning, management and monitoring of essential RH commodities and services.
- 3.5.3** To facilitate cooperation and collaboration, each Ministry of Health should work towards the development of a consistent standard in information systems in health and to integrate fully the monitoring and evaluation of RH services and commodities to improve and sustain monitoring and evaluation over the whole cycle for the implementation of the Pacific Policy Framework. Partners should consider providing increased support for country level monitoring and evaluation processes ensuring they are integrated within relevant programmes.
- 3.5.4** Governments and partners should support efforts to strengthen regional data collection, analysis and reporting eg MDG indicators, to enable analysis of trends and identification of common themes that may be addressed to improve SRH in the Pacific populations.
- 3.5.5** To strengthen monitoring and evaluation of SRH programmes, each Ministry of Health should ensure the implementation of suitable information systems at all levels, including data analysis, software and training, and building capacity undertaken at local levels for data interpretation. The following should be introduced, undertaken and/or upgraded:
- (a) management and accounts information systems;
 - (b) health information systems for health/needs information;
 - (c) inventory/pharmaceutical integrated information systems for supply management;
 - (d) timely demographic and reproductive health surveys to ensure progress towards universal access to RH through monitoring of the MDG 5 indicators for the new target, specifically unmet need for family planning, contraceptive prevalence rate, ante-natal coverage, age specific fertility rate (15-19 years) and to assess barriers to RH services and opportunities for increasing uptake.

- 3.5.6** Steps will be taken to increase the sharing of information about RH within ministries and also between Governments, NGOs and all health professional associations.

3.6 Partnerships and collaboration

- 3.6.1** Governments and partners should implement a monitoring system to evaluate the efficiency and effectiveness of programmes and using the results to inform improvements in policies and programmes.

- 3.6.2** Governments and partners should consider strengthening the compilation of quantification data at the national and regional levels and mechanisms for their sharing among the whole range of potential providers and supporters with emphasis on LMIS data collection and feedback to service providers should be developed.

- 3.6.3** NGOs will be encouraged to participate fully in increasing access to RH services and commodities as part of encouraging alignment of all RH NGOs in meeting the aims and objectives of government programmes and increasing capacity for delivery.

- 3.6.4** Governments and regional partners should support the coordination of dissemination of information and increase regular and timely reporting on all aspects of the Pacific Framework, similarly over the whole Framework period.

3.7 Human resource development

- 3.7.1** Each Government through its Ministry of Health should support the development and capacity strengthening and training of a critical mass of sustainable human resources to provide care and support towards the improvement of SRH and adequate commodity management.

- 3.7.2** Each Ministry of Health should ensure that the training of all medical and health professionals includes sensitization on attitudes and behaviour towards all RH commodity users, so that their rights to confidential, ethical and user-friendly services are respected. Measures should include strengthening the capacity of educators; review of the curriculum at medical, nursing and teacher training institutions to integrate RH issues; provision of appropriate training manuals and demonstration kits.

- 3.7.3** Each Government should undertake training of staff to enhance their management skills, to improve their effectiveness and also enhance transparency and encourage good governance practices. Particular attention will be provided to training health programme managers and planners on how to utilize relevant data to inform policy and practice.

Adopted in Denarau, Nadi, Fiji on 7 November 2008

Addendum to Chapter 7

3.2 Reproductive health commodity supply management

Regional collaboration

(a) **Regional RH commodities stocks**

Countries should utilise existing arrangements between UNFPA and the Government of Fiji, to hold regional stocks of contraceptives and other emergency RH supplies in Suva, to provide for small scale and urgent needs. Smaller countries may be able to obtain all, or almost all, their contraceptives commodity requirements ex-stock from this source, at good prices, on short lead times.

(b) **Regional pooled procurement**

Governments should harmonize their RH commodity procurement policies, and position themselves to obtain maximum benefits from options in sub-regional pooled procurement. UNFPA and other agencies are requested to support a multi-country collaboration to determine and operate a suitable pooled procurement scheme for RH commodities and other supplies.

(c) **Storage and inventory management**

As they are medical items all RH commodities should be received into properly constructed and well-managed national level medical storage facilities. A Pacific standard should be developed and applied to the construction and management of national or central medical stores, and RH commodity supply/storage integrated into them.

(d) **Web-based information resources**

To support Governments and Ministries of Health, UNFPA and other agencies should continue their support of web-based information resources that offer current information on pre-qualified sources of RH commodities.

Recognising that logistical problems vary greatly across the region, the common geographic and climatic realities must be taken into consideration when designing effective RHC supply programmes. Pacific Islands logistics are characterised by long shipping lead times that markedly affect the design of effective RHC procurement and distribution systems. To ensure successful RH commodity supply management, Ministries of Health should:

Forecasting (quantification)

- (a) Make special efforts to strengthen skills in estimating RH commodity requirements at the national level, which are fundamental to successful procurement, and ensure continuity without over-supply and with support from agencies as required. UNFPA and other agencies should assist in the

development and application of training materials and the delivery of training on quantification, with particular reference to improving the understanding and use of multiple methods.

- (b) Ensure that staff at service delivery points are capable of estimating their local requirements, but also utilise supply methods that, as far as possible, will simplify local quantification and RH commodity ordering.
- (c) Pay particular attention to obtaining data that expose unmet needs and to the right means for uncovering previously unexpressed demand. Very close attention should also be given to the impact of stock out periods on RH commodity consumption data. Maximum targets should be set through total population-based methods, which can then be modified to a closer reality via service-based and usage-based methods.

Selection

- (a) Ensure that a sufficient range of quality-assured RH commodities, including RH essential medicines and contraceptives, is selected, and included in the national essential medicines and supplies lists. Clinical equipment for RH services should similarly be selected and listed in an essential package. In family planning methods, as a minimum, all clients should have a choice of at least three methods at every service delivery point.
- (b) Frame national medicines policy so that the private sector is encouraged to participate in RH improvement by additionally offering a quality-assured range of alternative FP methods and products at attractive prices.

Procurement

- (a) Target procurement over a forward period that accounts correctly for lead-time effects, which do not have to be bound in procurement strategies based on an annual cycle, with purchasing of single massive annual orders. Other options should also be considered. Period contracts can extend several years in advance, with pre-arranged or actively confirmed multiple deliveries, so that smoother in-flow of RH commodities can be achieved, and a more ordered cash flow.
- (b) Enter procurement of RH commodities within the Ministry/Department, and integrate them as far as possible under the responsibility of a qualified person. Tender processes should be simple, short and transparent. In order to obtain best value, at assured quality, Ministries of Health may wish to use a preferred supplier such as UNFPA, UNICEF, etc.

Note: UNFPA and other agencies can act in a third party ordering capacity.

Storage and Inventory Management

- (a) Ensure the storage of RH commodities, particularly pharmaceuticals, according to recognised standards and conditions. Standards should be set and implemented for all levels of medical supply and all levels of health care (i.e. RH service delivery points).
- (b) Equip every facility for receiving, storing and distributing medical supply, including RH commodities, with an appropriate inventory management system (software), which should be integrated with suitable accounting functions, and have integral modules for supply to service delivery points, and dispensing to patients (or be immediately compatible to other suites for pharmacy management and dispensing).
- (c) Ensure that every RH commodity is suitably coded and flagged in the inventory system so that a comprehensive range of inventory reports on RH commodities transactions, usage, and stock can be generated on request or at will.
- (d) Ensure that regular, programmed stock be performed at all stores and service delivery points, and records reconciled to reveal and manage discrepancies, and to increase security.

Distribution

- (a) Recognizing the importance of a maintenance of a continuity of supply, ensure that the correct method of supply is chosen, and properly implemented. Distribution methods should be chosen having a clear regard to the local logistical situation. The use of inappropriate supply methods, which may artificially or unwittingly choke supply in conditions of extreme logistical difficulty should be guarded against.
- (b) Ensure that service delivery point standard stock lists and order forms contain all relevant RH commodities for that level of health care (profile of RH services), and particularly to provide clients with a minimum three choices of contraceptive method.
- (c) Ensure that country-level officers responsible for RH commodity distribution are enabled to engage in a specific dialogue with the Transport Ministry and local transport industry to ensure an active network of information and communication to ensure that no opportunity for the delivery of RH commodity is wasted.
- (d) Ensure that transport resources dedicated to any specific health programmes can carry/deliver supplies on all suitable occasions. Where possible, the

integration of health supply activity should be pursued, and duplication avoided. The multiplication of special stores under the Health Department can be extremely costly.

- (e) Plan for regular refresher training of all personnel involved in procurement, handling, storage and distribution of health goods.

Quality

- (a) Recognize and take appropriate action given the rise in counterfeit and sub-standard medicines in the region which must be countered by close attention to matters of quality assurance, inspection, and testing.
- (b) Work in collaboration with relevant government agencies to ensure that the best possible standards of quality are adhered to, given the adverse climatic conditions and that long residency of products on the shelf will mean that even the best products will deteriorate and can become less than optimal despite being well within their labelled expiry date.

Batch quality certification, and prequalification

Import only RH products with adequate batch quality documentation, obtained only from suppliers who have been adequately quality-certified under international Good Manufacturing Practice Standards recognising that quality assurance is absolutely required and is feasible to manage, even though the operation of comprehensive Medicines Regulatory affairs is onerous, and formal registration of products (marketing authorization) is an unreal short-term goal in PICs. Whenever possible, utilize suppliers who are, or whose products have been, pre-qualified by recognised UNFPA and other agencies including UNICEF and WHO.

Quality assurance in storage and transit

Ensure that storage conditions, and the conditions of handling and transport, are suitable for each and every RH commodity. UNFPA and other agencies should continue their support in health systems strengthening and the special monitoring of the management of health supply.

Quality testing

Ensure that all health products, including RHC, in both public and private sectors, are subject to a scheme of random sampling and quality testing. To that end UNFPA and other agencies are asked to continue their support for PIC to access quality laboratory facilities for regular product testing from random sampling and for queried cases. They are also asked to support suitable initiatives to expedite the building of in-Country capacity for local quality testing (*rapid testing, screening*).

Medical donations

Protect the quality of RH services and products used, by ensuring that donations of medicines and supplies are appropriate, to which end adopt and implement Guidelines on Medical Donations (Drugs and Equipment). Such guidelines have been developed in several PICs, based on the 1999 WHO-sponsored international guideline (available on the WHO website).

Minimizing loss and management waste

Ensure that required stock reports and order requests are provided by SDPs in a timely fashion to their supply point to optimise the continuity of supply. Stock reporting and in-country ordering should be scheduled on intervals that take realistic account of the local logistical situation. Timely accurate stock reports will also assist the national level SDPs to minimise over-supply and reduce the possibility of waste.

Ensure optimal usage and further reduce the risk of wastage and ensure that sound principles for improving “quality use of medicines” are included in the National Medicines Policy and applied to the prescribing, supply, and use of RH commodities.

Ensure that adequate guidelines for health waste management include proper provisions for the safe handling and disposal of expired and unwanted pharmaceuticals and other non-clinical natural waste from the use of RH commodities (sharps and syringes, injection vials, used medical disposables, packaging, etc).

Annexes

- I Programme**
- II. List of participants**
- III. Keynote Address by Deputy Prime Minister of the Kingdom of Tonga**

Annex 1

Programme



Pacific Sub-Regional Office

**Pacific Ministers of Health Meeting
"Achieving Universal Access to Reproductive Health Services and Commodities"
November 5-7, 2008**

Wednesday, November 5

8.30-9.00 Registration

9.00 Official Opening Ceremony

Prayer

Welcome Remarks

Najib Assifi, Director & Representative,
UNFPA Pacific Sub-Regional Office

Key Note Address

Honorable Dr. Viliami Tangi, Minister of Health, Tonga

DVD on RHCS in the Pacific

Group Photograph

10.30 Morning Tea

11.00 Election of the Chairpersons

Working Sessions

SESSION 1:

(1) Objectives of the Meeting & Adoption of the Agenda

Peter Zinck, RHCS Manager, UNFPA, SRO Pacific

- 11.15 (2) Overview Presentations**
- Achieving the new MDG target: Universal Access to Reproductive Health**
 Michael Mbizvo, Coordinator/Senior Scientist, Director's Office,
 Reproductive Health and Research (RHR), World Health Organization,
 Geneva, Switzerland
- UNFPA Global Policies on Reproductive Health Commodity Security**
 Jagdish Upadhyay, Chief, Commodity Security Branch,
 UNFPA New York
- Partnership for Universal Access to Health Care in the Pacific**
 Rufina Latu, Adviser, SPC
- Achieving reproductive health and RHCS: Progress in the Pacific**
 Annette Sachs Robertson, Technical Adviser, Health Systems & RHCS,
 UNFPA Pacific SRO
- 12.15 Plenary Discussion**
- 12.30 SESSION 2:**
- Country Presentations (10 minutes)**
 Cook Islands
 Federated States of Micronesia
 Fiji
- 13.00 Lunch**
- 14.00 Country Presentations (10 Minutes)**
 Kiribati
 Marshall Islands
 Nauru
 Niue
 Palau
 Papua New Guinea
 Tonga
 Tuvalu
 Samoa
- 15.30 Afternoon Tea**
- 16.00 Country Presentations (10 Minutes)**
 Solomon Islands
 Vanuatu
- 16.20 Plenary Discussion**
- 16.35 Panel Discussion:**
 Commitment to RH, including RHCS, in the Pacific
 Australia, New Zealand, United Kingdom, European Union, Japan

- 17.00** **Plenary Discussion**
- 1.30** **Close of Session**
- 1.30** **Welcome Reception**

Thursday, November 6

- 8.30** **Summary of the Previous Day**
Marianne Haslegrave

8.45 **SESSION 3:
Good Practices from the Pacific on Achieving RHCS**

- (1) Commitment to Action: Fiji’s Experience of Advocacy & Financing**
Lepani Waqatakirewa, Permanent Secretary, MoH, Fiji
- (2) Towards Integration of RHCS into Vanuatu’s National Health Plans and Programmes**
Len Tarivonda, Director Public Health, MoH, Vanuatu
- (3) Disaster Preparedness: Response to the Tsunami in the Solomon Islands**
Willie Horoto, Govt Pharmacist, MoHMS, Solomon Is(TBC)
- (4) Promoting Emergency Obstetrics Care Delivery in Kiribati**
Airam Metai, Director of Public Health, MoHMS, Kiribati
Wame Baravilala, UNFPA RH Adviser
- (5) Pooled Procurement for Reproductive Health Commodities: Operationalising the Pacific RHCS Plan of Action**
Peter Zinck, RHCS Manager, UNFPA, SRO Pacific

- 9.35** **Plenary Discussion**

9.50 **SESSION 4:
Preventing HIV: Strengthening Comprehensive Condom Programming**

- (1) UNFPA Support for Condom Programming - Increasing Condom Usage in the Pacific**
Tim Sladden, Technical Adviser, Pacific SRO
- (2) Leadership and Advocacy with Parliamentarian Champions in the Pacific**
Steven Vete, Asian/Pacific Leadership Forum on HIV/AIDS

10.10	Plenary Discussion
10.30	Morning Tea
11.00	<p>SESSION 5: Working Group Discussions on Progress in the Pacific PoA 2003 & Way Forward Working Groups will discuss key issues related to the Pacific PoA 2003 and discussed previous day for further strengthening</p> <ul style="list-style-type: none"> ▪ Context - Policies and legislation: Using a rights-based approach, for a supportive environment for access to RH by 2015 ▪ Client service and utilization issues: Removing barriers and promoting better services particularly for vulnerable groups including young people ▪ Capacity of supply chain management and future progress (Selection, Forecasting, Procurement, Distribution, Storage & Waste Management) ▪ Capital: Funding for RH services and commodities (Developing sustainability, Social marketing) Coordination and collaboration (Between Ministries, NGOs, Donors, UNFPA)
12.45	Lunch
14.00-15.00	<p>SESSION 5: Working Group Feedback on Progress in the Pacific PoA 2003 & Way Forward: Presentations & Discussion</p>
15.00	<p>SESSION 6: Development of Plans for Commitment to Action Najib Assifi, Director & Representative, UNFPA Pacific Sub-Regional Office</p> <p>Development of Plans for Commitment to Action (Group Work)</p>
15.30	Afternoon Tea
16.00	Advocacy Action Plan Development by Country (Group Work) Continued
17.00	Close of Session
1.1-1.30	Drafting Committee consolidates feedback from Working Group Discussions to formulate Draft Pacific RHCS Plan of Action 2008-2015

Friday, November 7

- 9.00** **Summary of the previous day**
Marianne Haslegrave
- 9.15** **SESSION 7:**
Draft Pacific RHCS Plan of Action +5 & Country Advocacy Action Plans
- 1.** **Presentation of Draft Pacific RHCS Plan of Action +5**
Chair of the Drafting Committee
 - 2.** **Presentation of Analysis of Common Themes emerging from**
Country Advocacy Action Plans
UNFPA technical team
 - 3.** **Plenary Discussion**
 - 4.** **Revisions and finalization of the Draft RHCS PoA +5**
Drafting Committee
- 10.30** **Morning Tea**
- 11.00** **SESSION 8:**
Adoption of a revised RHCS Pacific PoA +5 &
Country Advocacy Action Plans
Plenary Discussion
- 12.00** **Closing**
- 1.30** **Lunch**

Annex 2

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Annex 3

Keynote Address by Deputy Prime Minister & Minister Of Health, Tonga

Honourable Ministers, Heads of Delegation, Excellencies and Diplomats, Najib Assifi, Director and representatives, UNFPA Pacific Sub- Regional Office, Senior Representatives from WHO, SPC and other organizations, Donor Partners and UN Family

Ladies and Gentlemen,

Malo lelei, ni sa bula and namaste!

Firstly I would like to sincerely thank UNFPA and the organizing committee of this important meeting for this great honour. This is a great privilege for me and I am very happy indeed to be here with you this morning.

Over five years ago, senior health representatives of Pacific Island Countries, gathered to discuss the issues around Reproductive Health Commodity Security (RHCS). Let us remind ourselves that RHCS is defined as *ensuring 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*. That meeting, in 2003, was jointly sponsored by the Commonwealth Medical Trust, the Commonwealth Secretariat and UNFPA. Not surprisingly therefore our brothers and sisters from the United States Associated Pacific Island countries were not present. Our meeting starting today is much more representative, with more countries in attendance.

At the ICPD +5 review the international community agreed that 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.

Starting today and for this week provides us with an opportunity to review the progress of RHCS in the Pacific and to determine how the Ministries or Departments of Health that we each represent has contributed to this. We may not have been physically present five years ago but it is important to become reappraised of what our individual countries committed themselves to fulfill. It is easy to sign a document but more difficult to convert this to meaningful and substantive action. A gathering such as this is important for the opportunity it affords us to be accountable to our colleagues from other Pacific countries and to our development partners and donors and agencies.

In the report of the last meeting it was noted that a key factor in meeting the reproductive

health needs of the people of the Pacific is the question of access to reproductive health services and commodities. The report says that “In many cases, logistic systems and infrastructure concerned with procurement, warehousing, distribution, quality assurance, stock monitoring and management, all need considerable improvement. Pacific islands logistics are often unusual in respect of long lead times – this markedly affects the design of reproductive health (RH) commodities procurement, as well as the design and operation of successful inventory management and RH commodity distribution.”

The report continues to say, “Absence of a consistent standard in information systems in health adds to the difficulties of coordination across the region. Better training and management of human resources and refocusing of programmes are required, to widen access and improve the quality and range of RH services and supplies.”

The report further states that “Partnership between the countries and development agencies is of central importance to evolving regional solutions, with UNFPA as the largest international supplier of RH commodities. It is the key agency contributing to RHCS in the region, assisting in strengthening RHCS national capacities for forecasting, financing, procurement, warehousing and distribution of commodities.”

The main outcome of that meeting in 2003 was an agreement and commitment we made and signed up to. This was the Plan of Action (PoA) for Reproductive Health Commodity Security in Pacific Island Countries. The Pacific PoA includes seven broad areas, with a total of 26 clauses, each of which consolidates the general thrust to ensure improved and quality access to reproductive health commodities for women, men and youth of the Pacific.

The POA covers:

1. Political will and action;
2. Procurement and distribution;
3. Quality;
4. Measurement, monitoring and evaluation;
5. Meeting the needs for RH commodities; and
6. Planning, management and logistics.

The key points in the PoA include agreement that each government will demonstrate political leadership to improve RH through ensuring that it has in place and implements an up-to-date, multi-sectoral policy on RH, integrated into national health policies, strategies and action plans to the fullest extent possible and with a separate budget line. I am sure we will be hearing this week of the progress that we have made to these ends.

It is a matter of common knowledge that UNFPA now has a regional bulk store in Suva, in space kindly provided by the Fiji Ministry of Health.

But the question that matters most is what have we each done in our countries to ensure that

the reproductive health needs of our people are being met through the timely supply of quality RHCS? What have we done in the interim? Of course there are many pressing priorities in each of our countries. Have we been committed to pushing the issues forward in cabinet or at high ministry or departmental level to achieve substantive progress in the last few years? No doubt we will learn from each other during this meeting.

Reliable access to contraceptives and other commodities is a fundamental requirement for reproductive health. Yet thousands of women and men in the Pacific go without these essentials, leaving them vulnerable to unwanted pregnancy, sexually transmitted infections (STIs) including HIV and the risk of childbirth without basic equipment or medical supplies. While the need for reproductive health products is rising, donor support is declining. During the 1990s, governments and individuals provided 60 per cent of the costs of contraceptives worldwide, while donors covered 40 per cent of the costs. Donor support had declined to around 27 per cent of the total.

However last year the British Government injected a substantial amount of funding for RHCS into UNFPA. For that we are grateful.

The consequences of shortages in funding for commodities are quite bleak. Globally each \$1 million shortfall in support for contraceptives means an estimated:

- 360,000 more unwanted pregnancies;
- 150,000 additional induced abortions;
- 800 maternal deaths;
- 11,000 infants deaths and
- 14,000 additional deaths of children under 5.
- 500,000 maternal death in the world every year

While for the Pacific the numbers would be much smaller let us not get complacent. In some of our countries reproductive health indices have plateaued while in some others they have deteriorated. In this situation it is urgent to take stock and to help our countries' reproductive health programmes become self-sustaining and to help them ensure that the reproductive health supply and distribution chain work efficiently. UNFPA's strategy is a step in this direction, with the aim to help develop and install national RHCS plans, beginning with a better understanding based on an analysis of the situation regarding RHCS in each country. Let us acknowledge with gratefulness the tremendous work of these dedicated people at UNFPA. What needs to be done at country level are national capacity building, advocacy, sustainability and coordination.

Advocacy requires raising awareness and political support, reducing policy and process barriers including taxes, price controls, advertising, promoting consumer-centered strategies and improving the funding environment among public, NGO and private sectors for long-term efforts.

Sustainability requires moves for cost recovery, consideration of social marketing, participation

of the private sector and improved management systems.

Coordination requires the setting up of a RHCS working group, linking all partners with elements of leadership, capacity building, incorporation into RH programming mechanisms and interfacing with UNFPA and other development partners.

We have traveled long distances to this meeting. In my journeys around the Pacific I am struck by the vast amount of ocean that we have to cross to get anywhere else. Frequently I think of our brave forefathers, who three thousand five hundred years ago sailed towards the horizon in exploration, in pursuit of a dream perhaps, leading their families to new lands, untouched by anyone before them.

I marvel at their single minded pursuit of their goal. I don't think we can appreciate the enormity of their challenge, the uncertainty of their future, their sheer determination to achieve what they set out to conquer. Let us remind ourselves that this was a time before anything that we take for granted as assisting sea voyages had been invented.. But remember our forefathers were the best navigators the world had seen up to that point in time. They set for us a shining example of pursuing a goal which may not have been crystal clear but which was enough to allow them to depart and set sail for the future, buoyed by self-belief and perhaps faith in a greater power than themselves.

For inspiration Ladies and Gentlemen let us take a page out of the example of our forefathers and work towards adding to the achievements that have been made in the last five years. We owe it to the women, the men, the youth and the children who look to us for leadership, for inspiration and for solutions to their problems and their concerns. I would like to wish us all fruitful and productive deliberations in the coming days and look forward to an excellent outcome ofr this meeting

Thank you for your attention.