A report of the

Conference on Advocating Universal Access to Reproductive Health Services and Commodity Security

28-30 July 2009
Kathmandu, Nepal

UNFPA

A report of the

Conference on Advocating Universal Access to Reproductive Health Services and Commodity Security

28-30 July 2009
Kathmandu, Nepal

UNFPA
Asia and the Pacific Regional Office
Bangkok, Thailand
September 2009

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

TABLE OF CONTENTS

ACRONYMS

ADB	Asian Development Bank
AFPPD	Asian Forum of Parliamentarians on Population and Development
ANC	Antenatal Care
APRO	Asia and the Pacific Regional Office
BCC	Behaviour Change Communication
BPHS	Basic Package of Health Service
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CCS	Contraceptive Commodity Security
DMT	Decision Making Tool
DPRK	Democratic People's Republic of Korea
EAG	Economically Assisted Group
EDL	Essential Drug List
EmOC	Emergency Obstetric Care
EPW	Empowered Procurement Wing
FP	Family Planning
FWCW	Fourth World Conference on Women
GMP	Good Manufacturing Practices
GoB	Government of Bangladesh
HIV	Human immuno-deficiency virus
ICPD	International Conference on Population and Development
IDC	Institutional Delivery Care
IDP	Internally Displaced Population
IEC	Information, Education and Communication
IMR	Infant Mortality Ratio
IT	Information Technology
IUCD	Intra-Uterine Contraceptive Device
LGU	Local Government Unit
LISP	Logistics Improvement Strategic Plan
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal

MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MoHP	Ministry of Health and Population
MOHFW	Ministry of Health and Family Welfare
MSU	Mobile Service Unit
NGOs	Non-governmental Organizations
ODA	Overseas Development Assistance
PHC	Primary Health Care
PNC	Postnatal Care
PoA	Programme of Action
QA	Quality Assurance
RCH	Reproductive and Child Health
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHS	Reproductive Health Services
SAARC	South Asian Association for Regional Cooperation
SBA	Skilled Birth Attendant
SRH	Sexual and Reproductive Health
STG	Standard Treatment Guidelines
STIs	Sexually Transmitted Infections
SWAps	Sector-wide approaches
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
TOT	Training of Trainers
UN	United Nations
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

Less than seven years from 2015, significant challenges remain to meeting the Millennium Development Goals (MDGs). The countries of South Asia are unlikely to meet MDG 5: "Improve maternal health", which includes reducing maternal mortality. The maternal mortality ratio (MMR) is declining too slowly. The MDG target is to reduce the MMR, the number of women who die in pregnancy and childbirth, by three-quarters between 1990 and 2015. About 188,000 women in South Asia die each year due to pregnancy-related complications, accounting for more than 50 per cent of Asia's maternal deaths in 2005. All of these deaths are avoidable. To achieve MDG 5 by 2015, improving health care for women and providing universal access to reproductive health services (RHS) must be prioritized.

The Conference of SAARC Parliamentarians on "Advocating Universal Access to Reproductive Health Services and Commodity Security" was organized to improve the capacity of South Asian parliamentarians, media professionals and senior policymakers to advocate in a coordinated manner to their respective national governments for a stronger commitment to achieving MDG 5. The Conference was organized by UNFPA Asia and the Pacific Regional Office (APRO) in close collaboration with the Asian Forum of Parliamentarians on Population and Development (AFPPD) and hosted by UNFPA Nepal Country Office. Delegates included two parliamentarians, one media professional, one senior policymaker and representative of the UNFPA Country Offices from each SAARC (South Asian Association for Regional Cooperation) country. In addition, delegations were invited from four non-SAARC Asian countries: Indonesia, Lao PDR, Mongolia and Philippines.

Through the Conference delegates gained knowledge on UNFPA Global Policies on reproductive health commodity security (RHCS) in order to achieve universal access to RH, and increased their understanding of the concept and relationship between achieving universal access to RH and the MDGs. The delegates strengthened their capacity to advocate effectively for increased support for RHCS. The Conference had two major outcomes: (1) a Joint Declaration committing delegates to support the achievement of universal access to RH services and commodity security in their countries; and (2) country specific Action Plans comprising two activities which delegates will carry out during 2009 in their home countries to advocate for increased support for RHCS among their peers and colleagues in parliament, government, and the news media.

Following the opening ceremony, which included a keynote address by the Rt. Hon. Dr. Ram Baran Yadav, President of the Federal Democratic Republic of Nepal and a videotaped message from Ms. Thoraya Obaid, Executive Director of UNFPA, New York, delegates were briefed on the new MDG Target of Achieving Universal Access to Reproductive Health, and on UNFPA Global Policies on Reproductive Health. A later presentation covered the UNFPA-WHO Initiative on Critical Life Saving Medicines. Media delegates from all eight SAARC countries as well as the four non-SAARC countries participated in a panel discussion on the Role of the Media partnering with parliamentarians. Country presentations from the SAARC countries acquainted the delegates with the specific situations facing each South Asian nation. Presentations from the non-SAARC countries focused on sharing their experiences with RHCS advocacy efforts.

The signing of the Joint Declaration of Commitment was a major highlight of the Conference. The Declaration pledged delegates to work towards improving the health of women, men and young people in the countries of South Asia. As parliamentarians, policymakers and media professionals, the delegates promised to advocate for greater awareness and a stronger commitment to achieving the MDGs, and in particular MDG 5, which shows the least progress. The Declaration was signed by the head of each country delegation.

Another significant product was the preparation of individual Country Plans of Action for advocacy on RHCS. Each PoA delineated two specific activities to be carried out between August and December 2009. The UNFPA APRO committed to provide US$2,000 to each Country Office to support carrying out these plans. Many plans incorporated consultations with other parliamentarians, policymakers and media representatives to sensitize them to the issues surrounding RHCS.

The closing address of the Conference was given by Rt. Hon. Subas Chandra Nembang, Chairman of the Constituent Assembly of the Republic of Nepal. Mr. Nembang noted the alarming situation that has resulted from a decline in donor support for RHCS at a time when the size of the population seeking reproductive services and commodities is increasing due to a large cohort of young people entering into the reproductive age groups. "If we fail to effectively advocate to our national governments in partnership with other stakeholders, we will fail to meet our commitments and will disappoint the expectations of our people", he declared.

Najib M. Assifi, Regional Director, a.i., of Asia and the Pacific Regional Office, Bangkok identified the following major concerns of the UNFPA Regional Office: the funding gap, weak health systems, and emergency situations. He outlined the major strategies for the years to come:

- Creating a politically supportive environment;
- Creating a commitment for action;
- Building capacity for forecasting and logical management systems; and
- Developing strong and functional systems in all countries.

Background

Less than seven years from 2015, significant challenges remain to meeting the Millennium Development Goals (MDGs). Although according to the 2008 joint report of UNESCAP, ADB and UNDP, MDG 1: "Eradicate extreme poverty and hunger" is likely to be achieved in Asia, most countries will miss at least some of the other targets and goals, including MDG 5: "Improve maternal health", which includes reducing maternal mortality. Secretary-General of United Nations Ban Ki-moon has declared that progress on improving reproductive health (RH) is critical to the achievement of the other MDGs and targets. Following the World Summit in 2005, a new Millennium Development Goal Target was introduced and endorsed. Target 5 B is "to achieve universal access to reproductive health by 2015". The MDG 5 B indicators include the contraceptive prevalence rate (CPR); adolescent birth rate; antenatal care coverage; and unmet need for family planning (FP).

In particular, according to the joint report, the maternal mortality ratio (MMR) – reducing the number of maternal deaths per 100,000 live births, a target of MDG 5 – is declining too slowly. The MDG target is to reduce the maternal mortality ratio, the number of women who die in pregnancy and childbirth, by three-quarters by 2015. The poor results toward meeting this target, which is not likely to be reached, are deeply disappointing. About 188,000 women in South Asia die each year due to pregnancy-related complications, accounting for more than 50 per cent of Asia's maternal deaths in 2005. All of these deaths are avoidable.

To achieve MDG 5 by 2015, improving health care for women and providing universal access to reproductive health services (RHS) must be prioritized. This includes access to family planning, prevention of unplanned pregnancies and provision of high-quality pregnancy and delivery care, including emergency obstetric care (EmOC) and the availability of RH commodities including contraceptives.

ICPD, the International Conference on Population and Development, held in Cairo in 1994, recognizes RH as a basic right of all couples and individuals. The ICPD Declaration highlights the rights of individuals to decide freely the number, spacing, and timing of their children, and to have the information and means to do so. The Declaration enshrines the right to attain the highest standards of RH; and the right to make decisions concerning reproduction that are free of discrimination, coercion, and violence. The agreed-upon ICPD goal of universal access to reproductive health states:

> *"All countries should strive to make accessible, through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015".* ICPD Programme of Action, paragraph 7.6

Country level challenges to achieving universal access to sexual and reproductive health (SRH) include: (1) the changing aid environment (e.g., common basket funding, national priority setting) in the health sector; and (2) United Nations reform processes. The World Health Organization (WHO) has identified the need for a clear and diverse "road map" that integrates the social context, health systems, and outcome indicators that can be incorporated into the national applications.

Slow progress towards achieving MDGs frequently results from inadequate commitment, lack of an integrated framework of policies, and insufficient monitoring of implementation in terms of results. Based on the needs assessments of the UN Millennium Project of 2005, Bangladesh needs to increase per capita investment on health from US$13 in 2006 to US$30 in 2015, Bhutan from US$46.5 in 2006 to US$98.3, and Nepal from US$7.4 in 2005 to US$12.5. While the primary responsibility for achieving the MDGs lies with national governments, strong advocacy from other stakeholders, such as parliamentarians, civil society, media, donors and international organizations, is a must.

Purpose

This Conference of Parliamentarians from SAARC countries on "Advocating Universal Access to Reproductive Health Services and Commodity Security" was organized to improve the capacity of South Asian parliamentarians, media professionals, and senior policymakers to advocate in a coordinated manner to their respective national governments for a stronger commitment to achieving MDG 5. This requires increased resources, an integrated framework approach, and coordination.

The objectives of the Conference were to provide delegates with the following:

- Increased understanding of the concept and relationship between achieving universal access to RH and the MDGs;
- UNFPA Global Policies on reproductive health commodity security (RHCS) in order to achieve universal access to RH;
- Advocacy approaches to increase the government commitment; and
- Exchange of experiences.

The results of the Conference were the following:

- Participants increased their understanding of the complexities related to ensuring universal access to RH services and commodities;
- Participants shared experiences and lessons learned from the countries they represent and from other Asian countries;
- Participants strengthened their capacity to advocate effectively for increased support for RHCS;
- Participants developed and signed a Joint Declaration committing them to support the achievement of universal access to RH services and commodity security in their countries;
- Participants developed an Action Plan including two specific activities which they will carry out in their home countries to advocate for increased support for RHCS among their peers and colleagues in parliament, in government, and in the news media; and
- Media representatives are expected to publish/broadcast news reports in their respective news outlets about the RHCS situation in their countries.

Organization

The Conference was organized by UNFPA Asia and the Pacific Regional Office (APRO) in close collaboration with the Asian Forum of Parliamentarians on Population and Development (AFPPD) and the Commodity Security Branch/Technical Division of UNFPA HQ. The Conference was hosted by UNFPA Nepal Country Office.

The Conference included as resource persons RHCS Champions–selected parliamentarians and media professionals from certain South and East Asian countries–who shared their approaches to advocacy for achieving universal access to RH. At the same time, parliamentarians from the participating countries shared their country situations, identified gaps and bottlenecks, and suggested strategies and priorities to achieve MDG 5.

The Conference was attended by a total of 84 delegates, who included parliamentarians, senior policymakers, media professionals and UNFPA officials from 8 SAARC countries, observers and resource persons from selected countries of East and South-East Asia, UNFPA Headquarters, WHO Headquarters, donors and INGO/NGOs. The Conference was held between 28-30 July in Kathmandu. The opening ceremony was chaired by the Honorable President of the Federal Democratic Republic of Nepal and the closing was chaired by the Chairman of Nepal's Constituent Assembly.

Opening Ceremony

Opening remarks

> In South Asia about two hundred thousand women die each year due to pregnancy-related complications... The irony is that these deaths are avoidable.
>
> *Rt. Hon Dr. Ram Baran Yadav,*
> *President of the Federal Democratic Republic of Nepal*

The MDG 5's target to reduce the maternal mortality ratio by three quarters by 2015 is unlikely to be met as maternal mortality is declining much too slowly. Every minute a woman dies while giving life. Worldwide 1,400 women die daily because they lack access to reproductive health supplies. Two hundred million women want to avoid or reduce the number of pregnancies, but have no means or opportunity to do so. Such lack of progress is due to a gap between commitment and implementation. MDGs 4 and 5, reducing child mortality and improving maternal health, cannot be achieved by doing "business as usual". Access to a few inexpensive medicines during pregnancy and delivery would prevent most of the complications that lead to the deaths of almost 200,000 women in South Asia every year. Improving health care for women and providing universal access to reproductive health services must be a top priority. Parliamentarians, media professionals, and policymakers have the capacity to advocate for stronger commitment on achieving MDG 5 by pushing for increased resources, an integrated framework approach, and greater coordination. Three crucial factors are needed to assure that MDG 5 becomes a reality: leadership, partnership, and investment.

The economic arguments for the investment in maternal health are strong. Maternal and infant mortality are estimate to lead to US$15 billion in lost potential productivity globally every year. High birth rates and high population growth result in high poverty rates, overburdened health and education systems. In Thailand, every dollar invested in the country's family planning programme saved the government more than US$16 in other social expenditures. In Viet Nam, every dollar invested in FP would save about US$8 in health, education, and other services.

Maternal mortality is the largest health inequity in the world, with 99 per cent of the deaths occurring in developing countries. A woman in South Asia faces a 1 in about 35 risk of dying during her lifetime from pregnancy related causes, while a woman in the developed world has a risk of 1 in 7,300, a greater than two hundred times difference. No other health indicator illustrates as starkly the global disparities in human development.

The World Bank estimates that mere access to family planning (FP) could reduce maternal death rates by 25-40 per cent and could minimize the number of high-risk births that lead to substantial infant mortality. Reliable access to contraceptives and other essential reproductive health supplies means solid commitment from governments and many other sectors of society to provide the funds, the quality health services, and the efficient supply chains to ensure reproductive health commodity security, which simply means that every person can choose, obtain, and use affordable and quality RH supplies whenever needed.

While RHCS is critical to improving maternal health and HIV prevention, it is also fundamentally linked to all the MDGs, and more specifically to MDG 4 – reduce child mortality, MDG 5 – improve maternal health, and MDG 6 – combat HIV/AIDS, malaria and other diseases, as well as MDG 8 – develop a Global Partnership for Development – as it is a human right.

Progress has been made and there are many glimmers of hope. The contraceptive prevalence rate (CPR) in developing countries has risen from 10 to 60 per cent in the last 40 years. Awareness about RHCS is increasing. In a recent UNFPA study, collaged RHCS core indicators show that 57 per cent of Asian countries have the capacity to forecast and procure RH commodities without outside technical assistance. Moreover, 62 per cent have a multi-sectoral National Coordination mechanism already in place for better coordination among different stakeholders at the national level.[1]

This is most important because the benefits of investing in reproductive health and rights are well-documented and substantial. Universal health depends on strengthened health systems staffed with skilled health workers and well-stocked warehouses, reaching everyone who needs services. Increased investment is urgently needed in RH as part

1 From remarks by Jagdish Upadhyay, Chief, Commodity Security Branch, UNFPA, New York.

of overall efforts to strengthen health systems and ensure international health security. What are required are political will and a sense of urgency to make a greater investment in the health sector so that reproductive health and rights become a reality.

UNFPA is guided by the Programme of Action (PoA) adopted by 179 Governments at the International Conference on Population and Development (ICPD) in Cairo in 1994. The main goals of the PoA include:

- Universal access to RHS by 2015;
- Universal primary education and closing the gender gap in education by 2015;
- Reducing maternal mortality by 75 per cent by 2015;
- Reducing infant mortality;
- Increasing life expectancy; and
- Reducing the HIV infection rate by 25 per cent by 2010.

The ICPD objectives are consistent with the MDGs. The recent adoption by the UN General Assembly of a new target – "to achieve universal access to RH by 2015" – under MDG 5 on maternal health ensures the centrality of universal access to RH in improving maternal and infant health and reducing poverty. The ICPD and the MDG principles share the same vision for a better and safer world, and each is critical for realizing the other.

Through the new programme cycle of assistance for 2008-2011, UNFPA is committed to supporting universal access to RHS and reducing maternal mortality in South Asia. In order to achieve RH, a secure supply and choice of RH commodities, including good quality contraceptives, is required to meet every person's need in a timely manner. RHCS includes adequate forecasting, mobilizing support and building capacity for financing, procurement, distribution, and storage of commodities.

The main objectives of the Conference were:

- Increased understanding about the concept and relationship between achieving universal access to RH and the MDGs;
- Increased knowledge of UNFPA Global Policies on RHCS to achieve universal access to RH;
- Increased knowledge of advocacy approaches to increase government commitment; and
- Exchange of experiences from and among parliamentarians, media professionals, and senior policymakers.

Reproductive health must be fully integrated into development plans, sector policies, and budgets. An essential package of RH information, services, and supplies must be delivered to the women, men, and young people of the SAARC countries.[2]

2 From remarks by Najib M. Assifi, Regional Director, a.i., of Asia and the Pacific Regional Office, Bangkok.

Establishing the Context

Achieving the new MDG target: Universal Access to Reproductive Health[3]

Collectively we are accountable for anticipating the needs of today's young people – in health, literacy and socio-economic development – and taking action to improve on the indicators.

The world faces many challenges in the area of sexual and reproductive health (SRH) systems. A key challenge for international community is to turn global commitments into reality for all people. The commitment of the new MDG target 5 B is to achieve by 2015 universal access to reproductive health, meaning equitable access to quality care, services, information and coverage.

Global context

"As we seek out connections there is perhaps no single issue that ties together the security and progress of our world more than women's health. It touches the heart of every issue and in every society … today maternal mortality is the slowest moving target of all the Millennium Development Goals and that is an outrage".

Mr Ban Ki-moon, UN Secretary-General at WHO's 62nd World Health Assembly 18-22 May 2009, Geneva

At present, levels of sexual and reproductive ill-health remain unacceptably high, and weak primary health care systems impede the provision of quality services. Universal access to formal health care is limited in many settings and progressive assessments of access are not conceptualized. Optimal ways of linking or integrating SRH and HIV/AIDS or other services are not being explored. In fact, elements of SRH continue to be sensitive topics. Investments in necessary research for improving health are inadequate, and the use of research evidence for policy formulation and programme strengthening remains weak. There is no clear commitment to sustainable funding of essential SRH commodities.

The international community has made many global commitments to remedy this situation. These include the ICPD, FWCW, the Millennium Declaration, the World Health Assembly (WHA) Resolutions, and the Global Reproductive Health and Sexually Transmitted Infection (STI) Prevention and Control Strategies. These commitments must be turned

3 This presentation was made by Dr. Michael Mbizvo, Director a.i., Department of Reproductive Health and Research, WHO, Geneva, Switzerland.

into reality for all people. On 25 September 2008 a joint declaration to this effect was signed by the Director-General of WHO, the Executive Director of UNFPA, the Executive Director of UNICEF, and the Vice President of the World Bank.

> We will enhance support to countries to achieve the two MDG 5 targets ... we will work with governments and civil society to scale-up quality health services to ensure universal access to reproductive health ... ensuring linkages with HIV, prevention and treatment.
>
> *From the Joint Declaration of WHO, UNFPA, UNICEF, and THE WORLD BANK*

The reality for those most in need of access is one of facing delays, denials, and lack of choice. Services are distant and may be costly. There are stock outs, poor quality or outdated interventions, low capacity providers, limited resources, and sub-optimal technologies. Comprehensive needs remain unmet. In contrast to this dismal situation, the world commitment is to provide universal access to SRH. MDG 5 is "Improve Maternal Health". Two targets and six indicators have been established in regards to this goal.

Targets and indicators for monitoring Millennium Development Goal 5

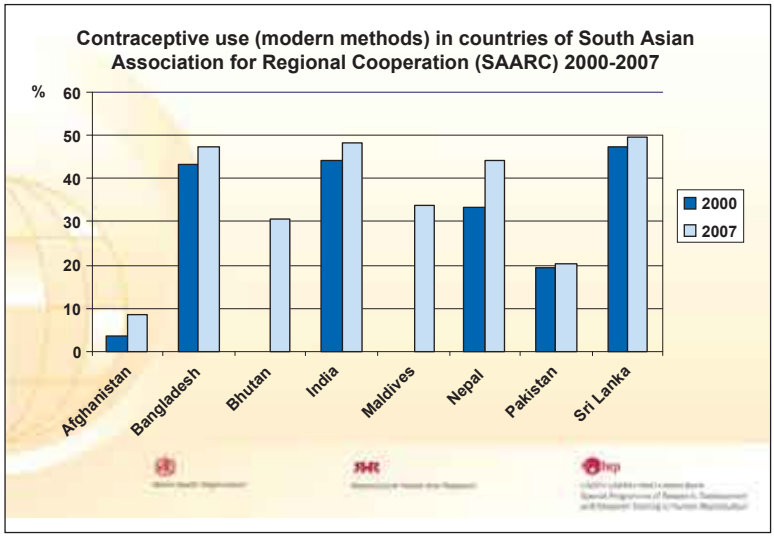
Goal 5: Improve maternal health

• 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

(*Source:* 12th Inter-Agency and Expert Group meeting on MDG indicators, Paris, November 2007)

Providing universal access means ensuring equitable access, ensuring in other words that everyone with a need is served, regardless of status. In health care; universal access entails increasing the provision of services through increased *uptake*, sustained *usage* of services, and expanded *coverage* and reach. What is required is to adopt a SRH perspective that addresses the continuum of needs related to sexuality and reproduction with the aim of achieving universal access to:

- Family planning;
- Safe delivery;
- Emergency obstetric care;
- Antenatal and postnatal services;
- Services to prevent unsafe abortion; and
- Prevention, treatment, care and support for STIs, including HIV and cervical cancer.

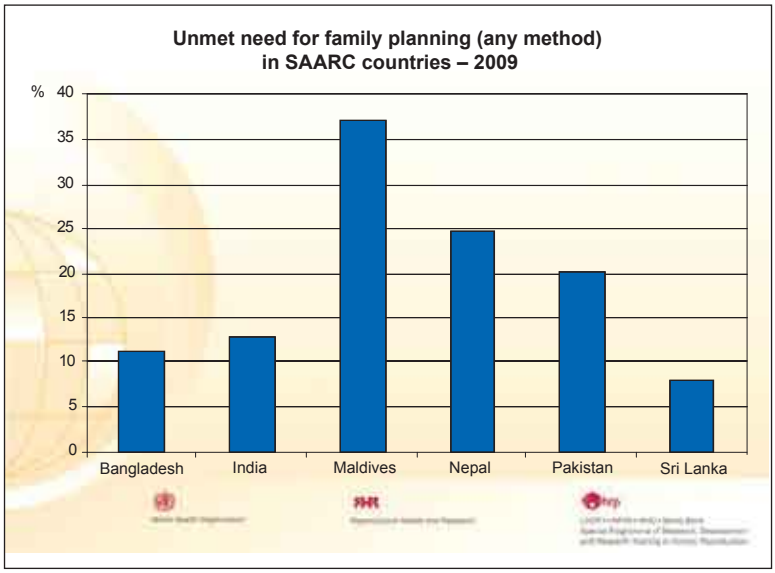


Source: UN Population Division: World contraceptive use 2007 – No data available for 2000 for Maldives and Bhutan.

Progress has been made, but not enough. Looking at contraceptive use (modern methods) in the countries of South Asia in 2000 and 2007, we see that the CPR is less than 50 per cent in all countries, barely 20 per cent in Pakistan and less than 10 per cent in Afghanistan.

The unmet need for family planning by any method in the countries of South Asia varies between 8 per cent and 37 per cent.

This lack of care persists even after pregnancy, as can be seen by the low prevalence of recommended antenatal care.



Source: UN Population Division: World contraceptive use 2007 – Data not available for Afghanistan and Bhutan.

In order to help countries implement the Global RH Strategy, a series of publications has been prepared. These include "Accelerating progress towards the attainment of international reproductive health goals: an implementation framework" and four policy briefs:

- Financing SRH-care services;
- Integrating SRH-care services;
- Creating a supportive legislative and regulatory framework; and
- Promoting and safeguarding the SRH needs of adolescents.

In addition, in March 2007 WHO and UNFPA jointly prepared a technical consultation designed to help countries monitor progress towards universal access in SRH. The contents include a recommended framework of indicators for priority aspects of SRH, and possible indicators of programmatic linkages between SRH services and HIV prevention, care, and treatment.

The following figure details the components of a programme designed to improve access to SRH.

Short-, medium- and long-term indicators have been identified for measuring progress on universal access to SRH.

Achieving and measuring progress on universal access to SRH, e.g., family planning

(a) **Short- and medium-term**: develop, incorporate, or identify and report on interventions or input/process/output/indicators, e.g., for family planning (FP):

(i) Proportion of service delivery points incorporating WHO guidelines for improving quality of sexual and reproductive health care, specifically FP;

(ii) Percentage of primary health care facilities providing family planning services;

(iii) Percentage of family planning service delivery points offering counselling on dual protection (from STIs and unwanted pregnancies);

(iv) Demand for or establishment of community-based family planning programmes; and

(v) Dedicated national funding for family planning.

(b) **Formulated policy on universal access to reproductive health.**

(c) **Long-term**: identify and measure outcome/impact indicators, e.g.:

(i) Percentage of women with an unmet need for family planning; and

(ii) Trends in total fertility rates.

Advocating Universal Access to RH Services and Commodity Security[4]

Commodity security is like food security ... Women are dying silently from something that can easily be prevented.

RHCS (Reproductive Health Commodity Security) is achieved when all individuals can ***obtain and use*** affordable, quality reproductive health commodities ***of their choice*** whenever they need them.

When advocating for better RHCS the numbers speak for themselves:

- Globally, about 535,000 women die each year from complications of pregnancy and childbirth;
- Each year, approximately 4.3 million newborn infants die during the first month of life;
- An additional 4 million are stillborn;
- Many of these deaths are due to complications during pregnancy or childbirth; and
- More than 2.7 million new HIV infections occurred in 2007 – for every two people that begin treatment, five new infections occur.

To eradicate these tragedies, ICPD in 1994 set the goal of universal access to RHS by 2015, and this commitment was reaffirmed with the development of target 5 B of MDG 5: Reduce the MMR by 75 per cent by 2015. Nevertheless, progress on this target has been very slow. This is most often a result of:

- Inadequate commitment;
- Lack of an integrated framework of policies; and
- Insufficient monitoring of implementation in terms of results.

ICPD highlights the rights of individuals to decide freely the number, spacing, and timing of their children, and to have the information and means to do so; the right to attain the highest standards of reproductive health; and the right to make decisions concerning reproduction which are free of discrimination, coercion, and violence.

4 This presentation was made by Jagdish Upadhyay, Chief, CSB, UNFPA, New York.

RHCS is achieved when all individuals can obtain and use affordable, quality RH commodities of their choice whenever they need them. Three words – Obtain, Use, and Choice – are critical in this definition. RHCS is more than a supply side issue and relates to the quality of care, access and demand. It involves making sure that everyone – especially women, newborns and young people – face no obstacles accessing and using life-saving and health promoting supplies. RHCS is a pre-requisite for achieving universal access and MDGs.

RH commodities include a wide choice of contraceptive commodities for family planning, but *also* all the other essential drugs, equipment, reagents, and consumables. Without secure supplies, the MDGs cannot be achieved. Family planning programming is something that everyone knows about because countries have FP for years. For advocacy purposes, knowing what FP can achieve is important:

- 30 per cent of maternal deaths (over 150,000) and 10 per cent of childhood deaths (1 million) can be reduced through FP;
- 200 million women have an unmet need for contraception; and
- Each year there are about 60 million unintended pregnancies, causing about 50,000 abortion related deaths.

Unintended pregnancies and unsafe abortions occur in many countries. This kind of data should be shared with parliamentarians and discussed in parliaments.

Economic arguments about the importance of RHCS can be made to finance ministers. For example, a 10 per cent decline in investment in RH will lead to the death of 19,000 women. Conversely the investment of each dollar leads to considerable saving. This has been seen in many countries. There is generally a 4 to 1 return for each dollar. It might be useful to compare the expenditure made for RHS with military spending.

Overall the need for RHCS is expected to increase in the coming years. UNFPA projects that the population of reproductive age in developing countries will increase by 23 per cent between 2000 and 2015, and that the demand for contraceptives will increase by 28 per cent. Estimates are that an additional 6 billion dollars will be needed to improve maternal health and accomplish MDG 5 around the world. At the same time, donor expenditure for FP has been declining and the current world financial crisis will exacerbate this decline. Underdeveloped countries spend about US$26 per capita on health while some of the richer countries spend over US$4,000. Of the US$26, US$10 is out of pocket, and US$6 is ODA. Better analysis of the numbers is needed.

The UNFPA Response to this situation is the Global Programme to enhance RHCS. Launched in 2007, this programme aims to increase national action and mainstream RHCS into national health policies, programmes, budgets, and plans. The following actions must be taken now:

- Advocate for national governments' stronger commitment to achieving MDG 5;
- Lobby for increased resources using an integrated framework approach; and
- Improve coordination among all parties involved.

Ensuring that RH supplies are ***available, accessible, and affordable*** will bring countless benefits to individuals, families and nations.

Partnering with Media to Promote Investing in Reproductive Health[5]

> *People must be made aware of the real situation. For instance, how can we develop the country if by 2030 most of the population will be in elementary school?*

Media is an important advocacy tool for RHCS because better coverage of the gaps as well as the progress made in reducing maternal death can strongly complement other advocacy efforts. The media reaches the public – the political constituency – as well as the policymakers, parliamentarians, local political and community leaders who are the focus of advocacy efforts. In this way the media helps build a public constituency for increased resources for RH.

The public is mostly unaware of MDG 5 and its impact on other development goals. People must be educated about this. The language used should be clear so the issues are easy to grasp. Significant media interest in RH issues has been lacking over the years. The low media interest parallels lack of real progress in reducing MMR, although in recent years coverage has increased somewhat as funding has grown. Nicholas Kristof of the New York Times has written several articles focusing on RH issues in South Asia and the impact on women. Generally the media prefers to focus on maternal death rather than success stories, and there is a greater interest in disaster and conflict situations than in the day-to-day problems commonly faced by women in the developing world. A good starting point for advocacy is the fact that better access to FP would significantly reduce maternal death. However, covering FP issues remains sensitive in some contexts. The reality, the political situation, and the constraints that journalists face in each country must be understood.

The journalists on the panel, one from every country present at the Conference, represented a spectrum of media and included four print journalists, a news editor, an anchor person, a columnist and two radio reporters. Based on their extensive and varied experience a number of key points were made:

- Space for the RH issues must be found in the news. This can be done by linking it with other issues, such as human resources, in which people are more interested. Competition for limited space for coverage of different stories is a fact of life in the newsroom;
- The language used needs to be translated into familiar and easily understood concepts. Most people will not understand the term “commodity security”, nor do most people know what the MDGs are or their significance;
- The mindset of the media must be changed. Media is generally involved in selling a product and is not interested in this kind of issue, but the information being discussed is no less important than political affairs, and media professionals must be made aware of this. For example, health has become

5 This panel discussion was facilitated by William Ryan, Regional Communications Manager, UNFPA Bangkok.

an important issue in the "young India" mode. These days, in India anything on health gets coverage, much as political stories did earlier. Health is a headline issue;

- Alternative forms of media, such as folk songs, plays, short films, musical videos, and animation, can be used to cover populations that do not watch news programmes;
- Stories need to be personalized and gender barriers broken down. Women journalists appear to have a shorter learning curve than men;
- Capacity constraints hamper reporting from rural areas, where RH is a major problem. Limited numbers of reporters must cover all issues so only high profile cases receive coverage;
- Various social and cultural strictures prevent reporters from covering RH. Some subjects are taboo, and in several countries certain words cannot even be used on television;
- The media can also play an educational role to provide the population with information on RH issues. This is more easily done with state run media; and
- A suggestion was raised to develop Asian forum for media on population issues, similar to the Asian Forum of Parliamentarians on Population and Development.

UNFPA-WHO Initiative: Critical Life Saving Medicines[6]

The best time to plant a tree is 25 years ago. The next best time is now.

It cannot be denied that Maternal Mortality remains unacceptably high in the developing world. More than 500,000 women die every year during pregnancy, childbirth, or in the six weeks after delivery. 99 per cent of these deaths occurred in the developing countries, with Sub-Saharan Africa and South Asia accounting for 86 per cent. The developed world has made huge shifts in the MMR with relatively simple interventions over the past few decades. In the developing world, countries like Sri Lanka and Bhutan have also made drastic reductions. Ensuring antenatal care (ANC) is the simplest and most vital component of decreasing death, as is birth by skilled attendants. Much variation is found in the incidence of these interventions. In South Asia and South-East Asia a maximum two-thirds of women[7] attended ANC once during pregnancy, and a maximum of 40 per cent of deliveries were handled by skill health workers.[8]

In Asia, a woman's risk of dying from treatable and preventable complications of pregnancy and childbirth over the course of her lifetime is estimated to be 1 in 35 as compared to 1 in 7,300 in the developed regions. The top three causes of these maternal deaths are pre-eclampsia/eclampsia, post partum bleeding, and infection. These account for two-thirds of total maternal deaths. Medicine is available that could take care of 40 per cent of these deaths. They are:

- Oxytocine/Ergometrine (for post partum bleeding);
- Magnesium Sulfate (for pre-eclampsia and eclampsia); and
- Antibiotics, e.g., Ampicillin, Gentamycin and Metronidazol (for infection).

The objectives of the UNFPA-WHO Collaborative Initiative on Life Saving Medicines are the following:

- To determine access, supply and rational use, and to raise awareness;
- To guide institutional support and capacity building in RHCS; and
- To suggest ways forward for consideration by the governments.

Progress to date includes a desk review and compilation of reports, studies, and publications. Over 300 documents in various languages have been accessed. A planning meeting including tools development took place in WHO/Geneva in 2008. Joint assessments were conducted (UNFPA-WHO-MOH) in Lao PDR, Nepal and Ethiopia (2008), and Philippines and Mongolia (2009). Other assessments will be conducted during 2009 in DPRK, Sri Lanka, PNG, Solomon Islands, Vanuatu, and Fiji.

---

6 This is based on a presentation by Dr. Kabir Ahmed, Technical Adviser, Commodity Security Branch, UNFPA/New York.

7 This varies between 20 and 60 per cent.

8 This varies between 12 and 40 per cent.

The following issues were identified from the countries surveyed. These situations were common to most of the countries:

- Availability of these life saving medicines:
  - Stock outs/or over stocks;
  - Inadequate standard guidelines; and
  - Discrepancies between availability and usage.
- Essential Medicine List (EML):
  - Some are not in EML, but available in country; and
  - EML not reviewed and updated for long time.
- Standard treatment guidelines and protocols:
  - Lack or absence of STGs/Inadequate compliance with the STGs; and
  - Gap between availability and practice.
- Rational Use:
  - Knowledge practice gap;
  - Irrational use at different levels;
  - Inadequate prescription/dispensing practices;
  - Inadequate/poor record (case) keeping; and
  - Inadequate supportive supervision, coaching, training.
- Registration and Quality Assurance:
  - Lack/inadequate quality testing/lab facilities;
  - Absent/lack in product information;
  - Unregistered and expired medicines available; and
  - Insufficient training and supervision of pharmacies.
- Storage:
  - Lack of knowledge/awareness of correct storage; and
  - Efficacy/potency is a concern at end user levels.
- Procurement/Supply Chain Management:
  - Inadequate capacity of forecasting/estimation; and
  - Priority in procuring all life saving medicines.
- Costs:
  - Wide variation, lack in price control, effect on poor.
- Coordination/Integration:
  - Inadequate public-private-stakeholders partnerships; and
  - Vertical approaches/piloting-needs.

Future directions from UNFPA and WHO includes extending support to countries:

- **Globally:** (a) harmonize approaches among UN agencies and other stakeholders in collaboration with governments; and (b) Jointly raise resources; and
- **Country Level:** (a) Mapping situations to determine who is procuring what, who is using what, and who is controlling what is coming into the country; (b) Support the continuum of care; (c) Technical support; (d) Identify relevant partners and support government coordination efforts; (e) M&E linked to reaching MDGs 4 and 5 (infant mortality ratio [IMR], maternal mortality ratio); and (f) Resource mobilization/raise funds.

Discussion Points

This initiative of assessment studies arose because of the huge undertaking, difficulties and expense of conducting comprehensive studies on emergency obstetric care (EmOC). These studies are done jointly with the government counterparts/MOH and key stakeholders in the countries and are very simple. They take only about 2-3 weeks, and while they could be expanded, they provide a jump start and can lead to more in-depth studies. Short, intermediate and long-term suggestions are made, and some of the suggestions are taken up. These studies are advantageous because they are participatory, use a simple methodology, bring quick results, and are low cost. One of the principles of doing this exercise is to provide technical assistance to many stakeholder partners. Many key stakeholders within the country are involved in doing the studies in an effort to build capacity.

Considerable interest has been shown from different countries so a method has been developed to build up capacity at the country level. During the Philippines study, two people from Mongolia participated so they could learn to conduct a similar assessment on their own. Likewise, in the Mongolia study two MOH officials from DPRK participated. In this way the study was conducted and capacity built at the same time. This is a strategy to create a critical mass of those who can go to other countries and assist with their studies. Transferring the technology is a good way to help other countries and also promote the “south-south” modality of technical assistance/partnership.

Country Presentations SAARC Countries

Afghanistan

How can we prioritize support for reproductive health?

Background

Afghanistan faces a difficult situation regarding reproductive health. The MMR is 1,600/100,000 live births and the IMR is 129/1,000 live births, by far the highest in the region. The total fertility rate is 6.6, and the CPR in 2006 was 16 per cent, a major improvement from 2002, when the rate was a mere 6 per cent. Rapid progress is being made. Since 2004 the availability of FP methods at health facilities has increased from 61.4 per cent in 2004 to 94.9 per cent in 2008. The number of Basic Package of Health Service (BPHS) facilities providing antenatal care has grown from 62 per cent in 2004 to 95.2 per cent in 2008. The number of BPHS facilities providing delivery services has increased from 25.4 per cent to 71.2 per cent during the same period, and drug availability has increased from 71.1 per cent to 86.3 per cent. The percentage of health facilities with at least one female health worker increased from 38 per cent to 76 per cent between 2003 and 2008.

Current strategy

Afghanistan's health sector framework is found in the Afghanistan National Development Strategy, the Health and Nutrition Sector Policy and Strategy 2008-2013, and the health law. The two main strategies for health care provision are the Basic Package of Health Service and the Essential Package of Hospital Services, which are contracted out. A public/private partnership for health policy and legislation has been developed.

A number of steps have been taken to improve the RHCS situation in the country:

- Improved capacity of central and regional warehouse staff on storage practices and logistic management;
- Introduced and implemented the CHANNEL LMIS (Logistics Management Information System) to improve database for RH commodities, along with capacity building at the central and regional levels;
- Developed a national RHCS strategic plan for 2007-2010; and
- Constructed a warehouse for contraceptives and RH commodities.

Expected results are that the MMR should decrease to 800 by 2015, with antenatal care coverage reaching 60 per cent, skilled birth attendants (SBA) reaching 50 per cent and the CPR reaching 50 per cent.

Priorities are the following:

- Ensuring technical and managerial capacity at the country level for forecasting, financing, procurement and distribution;
- Establishment of a regional warehouse for storage of contraceptives and RH commodities;
- Increased capacity on RHCS at the national level;
- Increased capacity of the FP health providers to meet the increasing demand; and
- Increased awareness through information, education and communication (IEC)/BCC.

Challenges

Country needs include:

- Strengthened national capacity;
- Long-term commitment from the national government and donors for contraceptives and RH commodities;

- Improved quality control for contraceptives;
- Establishment of proper warehouses at the regional level for storage of contraceptives and RH commodities;
- A proper system of logistics management and supplies moving from the central to the regional and then to the provincial level; and
- Strengthened M&E for RHCS.

Additional challenges:

- Lack of coordination between donors, partners and government on RH commodities;
- Donor dependency;
- No budget in the government budget line;
- No capacity on logistical management; and
- No regional warehouses for storage of contraceptives and RH commodities.

The way forward

The following next steps have been identified:

- Advocacy with parliamentarians, religious leaders, and community leaders;
- Strengthening the national capacity in the area of RHCS to assume the leadership role in RHCS management at the national level;
- Strengthening coordination among government and partners; and
- Establishment of a proper system of logistical management for the RH community.

Bangladesh

Imams have been sent to schools and have become advocates on issues of reproductive health. Advice and information given by religious leaders is well taken.

Background

The Government of Bangladesh has a policy for resource mobilization and coordination in the area of RH. Major funding is provided under IDA, and excellent cooperation and coordination is found at the central and field levels. Since 1975 the use of contraceptives of different kinds has risen sharply from a CPR of less than 10 per cent to 55.8 per cent in 2007. The MMR stands at 320/100,000 and the IMR at 52/1,000. The TFR is 2.7.

Current strategy

Many programmes have contributed to the drop in MMR. One is the incorporation of imams in training programmes. Some have been sent to schools and have become advocates of RH issues. Advice and information given by religious leaders is well taken. Publications have also been prepared discussing what Islam says about issues such as family planning.

Challenges

Different types of challenges have been identified:

Population related

- Increased demand for RH commodities; and
- 21.7 per cent of the population of reproductive age (15-49 years).

System related

- Lengthy procurement procedures;
- Shortfall of RH commodities;
- Retaining skilled human resources; and
- Capacity building.

The way forward

Programme related

- Develop national strategy on RHCS;
- Institute policy for reaching the unmet need that is target oriented;
- Long- and short-term forecasting;
- Establish a monitoring cell;
- Gradually improve sustainability of RCHS;
- Establish a well-functioning and proactive Procurement Task Group;
- Establish a procurement cell for coordinating all procurement of RH commodities;
- Implement recommendations of the thematic review (GoB) and development partners);
- Allocate more national resources for RH commodities;
- Prepare a national strategy on RHCS;
- Address the skewed method mix (GoB); and
- Strengthen LMIS.

Bhutan

In Bhutan health is a state business.

Background

In Bhutan, the state takes responsibility for health care, which is completely free of charge. The government is highly committed to the health sector (12 per cent), particularly for the health of women and children. There are no private doctors or hospitals, and no NGOs. UNFPA is currently supporting contraceptives, but in the future, this will be supported by the Bhutan Health Trust Fund. Regarding health indicators, the MMR has declined from 560 in 1990 to 255 currently and is on track to reach 140, the MDG target, by 2015. Likewise, the IMR has decreased from 90 to 40 and is on track to meet the MDG target of 30. Under-five mortality has declined from 123 to 62 and will reach the target of 41. Bhutan has learned from Sri Lanka, and experienced a drastic reduction in the MMR after target of 100 per cent institutional delivery was established. Reaching the MDG 5 remains a difficult task, with the easy work having been done. Although accessibility is 90 per cent, people are not using health care facilities as expected and this may be due to the behaviour and motivation of health care workers.

Current strategy

About 2,400 volunteer village health workers have been trained, with dropout rate of half. These are young women who have studied to Class 6 or 7, and are not engaged in other work. They receive a 21-day training programme focusing primarily on prevention, sanitation and hygiene, with some treatment regimes also included. In addition, they distribute RH supplies, and motivate people to use health facilities. They receive no payment, but incentives in the form of five-day refresher training, and some meetings and conferences. They are also given boots, umbrellas, and bags.

Challenges

- Sustaining free health services;
- Ensuring the highest possible standards of RH services; in some cases the way health workers pass judgment on their clients is a barrier to health care services;
- Shortages of human resources in the health sector at all levels of the health system;
- Limited capacity of staff to adequately respond to obstetric emergencies;
- Reaching the unreached; overcoming problems of rough terrain, limited road and communication networks;
- Paucity of research and evidence based planning; and
- Competing priorities.

The way forward

The 10th Five Year Plan strategies include the following:

- Scaling up institutional delivery; ensuring skilled birth attendants at births;
- Expansion of EmOC services;
- Intensify newborn care services;
- Increase ANC/IDC/PNC coverage;
- Increase universal access to FP services;
- Improve and expand PAP smear and VIA services;
- Strengthen research capacity and generate better RH data and information; and
- Intensify RH advocacy and awareness.

India

The most important thing is to put all of our findings into operation.

India's RCH-ll programme is designed to achieve the MDGs and the National Population Policy goals. It is a SWAp based approach based on pooling resources and is characterized by evidence based technical strategies. At present, India's MMR is 254 and the goal for 2010 is reduction to less than 100; the IMR is 77 and the goal is less than 30. The TFR is 2.7, and the goal for 2010 is 2.1; the CPR is 54.1 and the goal is 60.

The current situation of reproductive health commodity security is characterized by the following:

1. RHCS are included in SWAps for RCH-ll to ensure security;
2. Elaborate procurement guidelines are in place;
3. Manufacturing capacity exists for contraceptives and other supplies; there is sufficient production of RHCS for domestic needs and export;
4. Rigorous commodity quality control procedures and systems are in place; and
5. RHCS supplied free through the public health system and at subsidized rates through social marketing organizations, and are also available in the market and private sector.

Current strategy

RCH-ll is a phased approach with the following immediate objectives:

- Improve routine immunization coverage;
- Reduce unmet needs for contraception;
- Promote skilled care during childbirth with appropriate referral linkages for EmOC; and
- Provide integrated service delivery for basic RCH services with special focus on EAG states and the urban poor.

The Medium Term Objective is to reduce the TFR to replacement level by 2010 through coordinated implementation of intersectoral linkages. The Long Term Objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.

Commodity security is to be achieved by ensuring the availability of a wide range of commodities including supplies, drugs and equipment critical for providing quality service through a vast public health delivery system. Contraceptive social marketing is seen as a major supplement to public health services. The emphasis is on meeting the objectives of equity in coverage with service delivery interventions. Regarding the projected contraceptive prevalence by method between 2000 and 2015, more emphasis is being placed on spacing than permanent measures.

The institutional mechanisms used by the MOHFW Procurement Division are forecasting to estimate requirements, ensuring the quality of the commodities, following a procurement strategy, awarding and monitoring contracts, and following a distribution plan. Forecasting is based on various factors:

- State/district requirements;
- Norms set up for supplies of MCH kits to different facilities;
- Current stocks at different levels are considered while making estimations;
- Trends in usage are assessed;
- Storage capacities at different levels are considered; and
- Gaps between actual use and projections are identified.

The quality of the commodities is ensured by mandatory use of Good Manufacturing Practices (GMP) for the pharmaceutical industry. There is a continuous process of issuing GMP certification and post GMP certification audits. In addition, regulatory mechanisms are in place to ensure the quality of the commodities.

An initiative for Strengthening Procurement Implementation through an Empowered Procurement Wing (EPW) was undertaken in 2005. This is designed to:

- Consolidate, streamline and strengthen procurement activities and professionalize procurement of health sector goods;
- Develop and promote policies for improving procurement of health sector goods, drugs and services;

- Help build capacity in states and public sector agencies and monitor their performance;
- Maintain procurement monitoring and complaint database including data on quality; and
- Directly handle procurement of vaccines and contraceptives.

EPW milestones to date include the following:

- Production of a procurement manual with standard bidding documents;
- A database/compendium of generic technical specifications for medical equipment;
- IT based procurement and inventory management tool for use within the EPW, which has since been incorporated into ProMIS;
- Preparation of drug specifications, packaging, model inserts and Quality Assurance (QA) requirements;
- Logistics Improvement Strategic Plan (LISP);
- A review of laboratories controlled by the Central Drug Control Standards Organization;
- Oversight on inspection and testing at the manufacturing source; and
- A specific distribution system has been put in place. Those contraceptives that are part of the national programme are free of cost to the general public.

Challenges

Despite the progress that has been made, various challenges remain:

- Gaps in forecasting, procurement, financing and distribution systems;
- Health Information System and Drug Management Information System;
- Gaps between types of reproductive health commodities demanded and used;
- Issues regarding equity and access to RHCS; and
- Shortage of skilled human resources.

The way forward

- Scope for improvement in LMIS to minimize stock outs and delays;
- Broadening the range of RHCS such as contraceptive choices;
- Increased collaboration with non-governmental and social marketing sector; and
- Strengthening of quality control mechanism.

Maldives

We see this as investment for the future, for the benefit of the people.

Background

The Reproductive Health policy of the Government of Maldives recognizes that RH is a crucial component of health. A developmental and intergenerational RH focus on RH services is a major facilitative service towards achieving the right of individuals and couples to protect their reproductive health and to take responsibility for their reproductive functions.

Maternal mortality has fallen sharply in the past ten years, from 258 in 1997 to 43 in 2008. Similar trends are seen for infant and under-five mortality. The IMR has fallen from 45 in 1992 to the current rate of 14, and under-five mortality has fallen to 11 from a 1992 rate of about 30. Skilled birth attendants are present at 97 per cent of births.

Current strategy

Core areas of reproductive and sexual health recognized in the country's RH strategy are:

- Safe motherhood and newborn care;
- Family planning;
- Sexually transmitted diseases and HIV/AIDS;
- Reproductive morbidities;
- Reproductive and sexual health of adolescents and young adults;
- Partnering with men for reproductive and sexual health; and
- Gender based violence and sexual abuse.

The following conclusions have been drawn regarding an effective RH policy:

- A conducive policy environment coupled with political commitment is crucial;
- Careful planning based on evidence based information is essential;
- An adequate health workforce along with capacity building is central to an effective health system;
- Equity in accessibility to essential health care services must be assured;
- A holistic approach to overall development of the society in terms of education, and attention to the socio-economic development of vulnerable populations is important; and
- Male participation plays a great role in RH.

Challenges

Current challenges include the difficulty of enabling accessibility to EmOC services to peripheral areas due to the nation's geography and the high transport costs involved. Another challenge is the increase in religious fundamentalism that is contributing to larger numbers of child marriages and home deliveries, is keeping girls from attending school, and encouraging refusal to immunize. Rising rates of drug abuse and related problems are leading to an increased vulnerability to HIV/AIDS. Moreover, contraceptives are not officially provided to unmarried people.

The way forward

The way forward requires scaling up comprehensive RH services focusing on the marginalized segment of the society. This re-aligns national goals, government policies, manifestos and emerging issues due to socio-cultural and economic transition. A number of factors are involved:

- Decentralizing health care services through political and administrative decentralization;
- Establishing a transport system along with a systematic referral system;
- Closing the human resource gap through training nurses, doctors, specialists and paramedics. External assistance is required in this area;
- Capacity building of local staff, especially given the high turnover rate of expatriate staff;
- Involving religious leaders in the multi-sectoral approach and looking at RH issues from a moderate Islamic point of view;
- Strengthening linkages for social support between individuals and communities and with the health care delivery system;
- Improving the quality of RH services by strengthening management, improving monitoring and supervision, and establishing and increasing the use of guidelines and protocols; and
- Enhancing accessibility and equity in providing services through health insurance.

Nepal

Reproductive health rights are guaranteed as a fundamental right in the Interim Constitution.

Background

The National Reproductive Health Strategy of Nepal recognizes that RH is a crucial part of overall health and is central to human development. Within the context of Primary Health Care, RH is identified as eight different components which include family planning and emphasize preventing unwanted pregnancies, safe motherhood, care of newborn, prevention and management of STIs, HIV/AIDS and others. The right to RH is enshrined as a fundamental right in the country's Interim Constitution.

Currently in Nepal the MMR is 281 and the IMR is 48. Total fertility rate is 3.1, and the CPR is 44.2. The goal and objective of Nepal's RH policy is to ensure a secure supply and choice of quality contraceptives and other RH commodities to meet every person's needs as required.

Current strategy

A national RHCS strategy was developed for 2007-2011 that includes the following:

- Separate budget line item for contraceptive commodities;
- Inclusion of contraceptives in the Essential Drug List (EDL);
- Establishment of a regular forecasting exercise; and
- Strengthened political commitment for RHCS.

Nepal is committed to strengthening Logistics Management to provide year-round availability of FP/RH and other key health commodities in the more than 4,000 service delivery sites throughout the country. Established in 1996, Logistics Management Information System (LMIS) is key to the success of accurate forecasting, pipeline monitoring and inventory management of FP and other health commodities. LMIS reporting from health facilities each quarter is more than 85 per cent. A web-based LMIS and RH-Equipment Inventory Programme have been implemented.

In the area of human resource development and inventory management, over 16,000 health personnel have been trained in health logistics, and a demand based inventory management system (PULL system) has been introduced in 48 districts. District warehouses have been constructed in 45 districts and the store rooms of health facilities have been strengthened.

Challenges

A number of challenges have been identified:

- External donor partners do not always realize the magnitude of the problem;
- Difficult terrain;

- Providing service to remote, marginalized and underprivileged populations;
- Bringing behavioural changes and a conducive environment for providing services to those in need;
- Store capacity at Central and Regional Warehouses;
- Widening funding gap of Contraceptives in Social Marketing and NGO sectors;
- Setting up lab facilities in the country for testing health commodities; and
- Need for capacity building in quality assurance.

The way forward

- Seek more support from policymakers;
- Further strengthen the coordinating mechanisms with stakeholders to achieve the required supply of health commodities in the country;
- Improve service delivery of health facilities in remote, marginalized, underprivileged populations;
- Construct district warehouses in remaining 29 districts;
- Scale-up demand based supply system (PULL System) in remaining 27 districts by 2010;
- Advocate for MoHP to provide 100 per cent funding for the public sector need for contraceptives;
- Strengthen the procurement system by introducing e-Bidding; and
- Web-based LMIS and RH-Equipment Inventory.

Pakistan

The health of the women is at stake. One life saved is like saving humanity.

The unmet need for family planning in Pakistan is 25 per cent, and growth in the CPR has stalled over the past several years. Over half the population has never used contraceptives and of those who have, almost 20 per cent have stopped. One in three women marries before 18, and a third of these married girls have a child by 19. Average birth spacing among women between 15 and 19 is 21 months. One of the biggest killers of women between 15-19 years of age is pregnancy and birth related issues. Moreover, half of the people newly infected with HIV are between 15-25 years of age. Women of this age don't go to the health services as much as the others do. This age group must be addressed more comprehensively.

Several factors contribute to the high unmet need for FP, including:

- *Access to services:* distance, affordable transport and female mobility;
- *Quality of service:* fear of side effects, treatment by providers, stock outs, etc.;
- *Cost:* contraceptives, services, travel; and
- *Social barriers:* low female literacy, lack of husband and family support, lack of women empowerment and decision-making, pressure for male child, poor knowledge of methods, lack of culture of contraception, misperceptions.

The MMR stands at 276, down from 500 in 1991, and the IMR is 78, down from 108. Many achievements have been made since 1991:

- The contraceptive knowledge rate has increased from 78 per cent to 96 per cent;
- The CPR has increased from 12 per cent to 30 per cent;
- The total fertility rate has fallen from 5.4 to 4.1; and
- The population growth rate has fallen from 2.63 to 1.73.

Current strategy

The following goal for RH has been articulated: Achieve replacement level fertility by 2020 through expeditious completion of demographic transition that entails decline both in fertility and mortality rates. Policy objectives to meet this vision include the following:

- Universal access to modern FP methods by 2010;
- Increase CPR to 60 per cent by 2020;
- Reduction in TFR to 2.1 by 2020; and
- Reduction in PGR to 1.3 per cent by 2020.

Universal access is to be achieved in the following ways:

- Strengthening community-based services;
- Linking with provincial line departments;
- Expanding service delivery outlets with focus on rural/underserved areas;
- Public private partnerships; and
- Ensure quality services with client centered approach.

A strategy of increasing acceptability through religious leaders, a culture friendly media campaign, parliamentarians and decision makers, civil society and social mobilizers has been designed. Various communication methods are being promoted:

- Reposition Family Planning as Birth Spacing for better health outcome;
- Focus on healthy timing and spacing of pregnancies;
- Pregnancy related risks for women < 18 and > 35;
- Remove myths and misconceptions and educate about the effective use of contraceptives;
- Emphasize male responsibility and inter spousal communication; and
- Client – centred approach with focus on informed choice.

The advocacy strategy intends to focus on those areas with maximum impact such as gender, education, the girl child, adolescents and youth. Many methods of communication are being utilized, i.e. TV channels with large numbers of viewers in regional and local languages; sign boards and neon signs at highways, major crossings, interchanges and within cities. Parliamentarians, religious scholars, influential persons and prominent local personalities will be used to promote the concept of the rationalized family.

In recent years, Pakistan has been quite concerned with defence issues, but now due to media and other advocacy social sector spending is rising; the budget for population issues has been increased by 65 per cent.

Challenges

To achieve Pakistan's demographic goals by 2020 the CPR must be increased by 2.3 per cent per year by ensuring RHCS. The national strategy is to achieve the policy goals in the following ways:

- Enhance coverage to facilitate women's access, particularly that of the rural population;
- Strengthen logistics management and performance reporting at the district, provincial and federal levels;
- Succeed at capacity building of logistics managers and their staff;
- Strengthen Monitoring and Evaluation System; and
- Enhance resource mobilization and promote sustainability in order to secure contraceptives for the national programmes.

The way forward

A number of strategies have been identified:

- Improve the status of women;
- Remove gender disparities;
- Reach the un-served community;
- Promote health seeking behaviours;
- Ensure a continuum of quality services and commodity security;
- Ensure a client centered approach;
- Provide online LMIS and information dissemination; and
- Scale-up best practices in the region.

Key Points to Remember

Accessibility

Acceptability

Affordability

Affectivity in Equity

Assurance of Quality

An excellent example of a good practice for ensuring RHCS is the Mobile Service Unit (MSU). This mobile unit provides services to underserved areas where stationery facilities are not available. The custom made vehicle MSU contains a delivery table, TCH/RH equipment and supplies and a tented space for outpatient consultation. All RH services

are provided except surgery, including health education talks, provision of information and education, and closed circuit TV. MSU staff includes a female medical doctor, a paramedic, at least one support staff and a driver. The vehicle and logistic support is managed by the District Population Welfare Officer.

The MSU provides the following services:

1. Distribution of contraceptives including IUCD and injectables after counselling clients according to their choice and needs;
2. Antenatal services and advice on diet, personal hygiene and breastfeeding;
3. Referrals of high risk cases to the nearest health facility;
4. Treatment of minor and common ailments and gynecological problems; and
5. IEC activities.

The success and promise of the MSU is seen in the following achievements:

- Near doubling of family planning clients;
- More than double antenatal clients;
- Five times increase in infant patients;
- More than two times increase in referrals; and
- Health education sessions tripled.

In addition to providing routine services, the MSUs were successfully used during the 2005 earthquake and also during the recent IDP crisis in the NWFP Province.

Sri Lanka

Education and health are our top priorities.

Background

Sri Lanka has had free health services since 1930 and also has excellent health and RH indicators. The MMR has declined from 92 in 1990 to 39.3 in 2006, and the goal for 2015 is 36; IMR has declined from 19.3 in 1990 to 11.2 in 2003 and the goal for 2015 is 9; under-five mortality has declined from 22.2 in 1990 to 13.8 in 2002 and the goal for 2015 is 11. Skilled attendance at birth stands at 99 per cent. CPR was 68.4 per cent in 2007, and the total for 2015 is 76 per cent. The unmet need for FP was 7.3 per cent in 2007. An integrated package of health care at the community, clinic and institutional levels provides a continuum of maternal care that includes FP and other RH services, antenatal and postnatal care and others.

Sustainability at the country level is ensured by social marketing of contraceptives by NGOs along with private sector services. The issue of improved LMIS is being addressed with help from UNFPA. A RHCS Plan of Action is in place. For national coordination,

an RHCS working group links all partners with elements of leadership, advocacy, fundraising, capacity building and sustainability. This is incorporated into RH programming mechanisms. Interface with UNFPA and others is via the Global Initiative.

The current focus of health care has four components:

- Allocation of health resources towards IDPs and populations to be resettled;
- Addressing the quality and coverage of sub-national disparities in health care;
- A comprehensive external Maternal and Newborn Health (MNH) review conducted in 2007 (supported by WHO, UNFPA, UNICEF) leading to MNH strategic plan; and
- External review of HIV/AIDS Programme and development of a national strategy 2007-2011.

Challenges

- District disparities in vital rates – especially in plantation sector and conflict-affected areas;
- Higher proportion of indirect maternal deaths due to medical problems;
- High rate of unwanted pregnancies leading to abortions;
- FP misinterpreted by many political and religious groups;
- High incidence of low birth weight;
- Quality of care; and
- Emerging and re-emerging diseases.

Learning from other Asian Countries

Philippines

Rapid population growth may arguably not directly cause poverty, but it definitely exacerbates poverty and drains government resources that are needed to deal with it.

Background

Despite a drop in the population growth rate to 2.04 from a peak of 3.08 in 1970, the Philippines is facing a population that is impeding the growth of the country's GDP. One third of all births have a spacing of less than two years. In 2008, there were 3.4 million pregnancies, and more than half of them were unintended. This led to 560,000 induced abortions, all of them illegal. If the unwanted pregnancies did not occur, the MMR would decrease by half. At present the MMR is 162, and the trend is "off-track" to meet MDG 5 by 2015. At the present rate, the MMR will reach 140 by 2015, a far cry from 52, the MDG target.

Extreme differences are seen in the RH situation of the wealthy and those living in poverty. The national fertility rate is 3.5; for the rich the rate is 2, while for the poor it is 6. The national percentage of deliveries performed by a skilled health professional is 60 per cent. For the rich it is 92 per cent and for the poor it is a mere 25 per cent. Likewise, the national unmet need for FP is 16 per cent, 12 per cent for the rich and 22 per cent for the poor. Women with an unmet need for FP are the largest contributor to the pool of unintended pregnancies. Finally nationwide, 6 per cent of adolescents between 15 and 19 begin childbearing. For the rich this is 3 per cent, and for the poor 10 per cent. Contraceptive use levels among married women changed little between 2003 and 2006, and the CPR is stagnant at 51 per cent, with the lowest use of modern contraceptive methods among the poorest women.

Comparing the Philippines with other Asian nations, its fertility rate is higher than Bangladesh, Viet Nam, Malaysia and Thailand. It is also higher than other Catholic countries like Brazil and Mexico.

Strategies for change

Facing an unfavourable environment for RH and FP initiatives due to opposition from conservative elements of the Catholic Church, many strategies for advocacy have been developed. The key players in RHCS advocacy are parliamentarians, CSOs, local government units (LGUs), academia, media, UNFPA, the business sector, interfaith groups not including Catholics, and national government agencies. Specific advocacy strategies include the following:

- Partnership with LGUs in providing contraceptive safety nets for the poor and strengthening the LMIS;
- Formulating evidence-based advocacy messages;
- Building alliances with national and local legislators;
- Mobilizing at national and local levels for broad-based support;
- Working towards sustained media coverage and support; and
- Developing coordinated mechanisms for strategizing, monitoring and evaluation.

An example was presented of how the system of decentralization of administration and devolution of services that was designed to give LGUs more power, authority, and responsibility has enabled some LGUs to carry out policies that the national government is often prevented from accomplishing. Quezon City has a population of 2.68 million people, and an average annual population growth rate of 1.92 per cent. Based on a recommendation of the city's Anti-Poverty Integration Task Force, comprised of 12 departments of the city government, a Reproductive Health Ordinance was crafted to address the need for a comprehensive and holistic policy on population and reproductive health. In the absence of a sound national policy on RH and population management,

LGUs have taken up the cause and some, like Quezon City, have started implementing it in their own backyards.

Challenges

Nationwide the Philippines is facing many challenges:

- Weak national leadership on RH;
- Opposition from conservative religious groups;
- Massive distortion and misinformation on RH;
- Competing priorities among RH, hunger and poverty concerns;
- Broadening local united fronts;
- Effective utilization of the Peso 150M (2007) and Peso 1.2B national budget for RH FP commodities; and
- Weak LMIS at the local level.

Lessons learned

- Principled engagement and ownership among advocates;
- Importance of risk mitigation strategies in the overall advocacy plan;
- Build on existing best practices in advocacy;
- Importance of evidence-based advocacy;
- Strengthening linkages between national and local advocacy efforts;
- Do not postpone when the goal is in sight;
- Do not give misinformation; and
- Address the young, the future mothers.

Indonesia

Economic growth is useless unless the population growth rate is brought down.

Background

Indonesia has been working on reducing its population growth rate since the 1970s, and has reduced the rate from 2.32 in 1971 to the current rate of 1.14. The TFR fell from 3.0 in 1991 to 2.6 in 2007, and the target for 2015 is 2.1. A clear relationship is found between the fertility rate and the use of contraceptives. Fertility was reduced from 4.68 in 1980 to 2.6 in 2007; during the same period the CPR rose from 26 per cent to 61.4 per cent. As of 2007 the total unmet need for contraceptives was 9.1 per cent; the target for 2009 is 6 per cent. The root cause for the remaining unmet need is the problem of distribution, especially in remote areas and small islands. Following decentralization, personnel are lacking in the districts for the FP programme, and it is not easy to reach remote areas from the district centres. RH services are free but when people live far from the centres they must pay to get to them and this contributes to the unmet need.

Strategies for change

The objective of Indonesia's strategy for Contraceptive Commodity Security (CCS) is to establish a condition wherein each eligible couple can choose, obtain, and use contraceptives to meet their reproductive needs. Specific goals are:

- Building commitment of decision makers and parliamentarians at the national and sub-national levels;
- Maximizing access and increasing the service network;
- Improving the quality of logistics management through training and other methods;
- Improving the participation of suppliers; and
- Seeking budget sources.

Government takes responsibility for the following:

- Clearly identify the target clients, the poor;
- Find effective ways to reach them;
- Avoid leakage of free or subsidized supplies;
- Use accurate methodology to estimate the need in the near to medium-term of 1-5 years; and
- Assess how to meet this need – from the national budget, donors, etc.

At present 2.9 million new users and 12.6 million active users require free services from government, NGOs and the private sector. Free services are also provided in certain areas of the country. In an effort to reduce the TFR, IUCDs are provided free of charge to all segments of the population. Likewise, condoms are provided free with the aim of increasing male participation and addressing gender disparities among FP users. The use of implants is increasing as a long-term contraceptive method.

The national strategy of CCS has been launched in 33 provinces throughout the country. Orientation to the programme has been given to programme implementers at all levels, and CCS working teams have been established at central, provincial, and district levels. CCS TOTs have been conducted in 23 provinces.

Challenges

- Limited distribution coverage of contraceptives in the private sector;
- Limited local government budget for contraceptive procurement;
- Disparity of support from local government and local FP institutions on CCS;
- CCS working groups not established in all provinces and districts;
- Narrowing the contraceptive method mix to more hormonal methods;
- Limited training for service providers; and
- Limited providers with DMT book.

Problems are found in getting supplies from the district level to the client/user. The FP worker is tasked with getting contraceptives from the district level and bringing them down to lower levels, and to the villages. Too few health workers are in the field, in some cases because local governments have removed the FP workers and assigned them to different positions. In some areas contraceptive supplies are running out because of the lack of effective mechanisms in the field. This is a problem related to decentralization. After decentralization, there are no personnel for FP at the district level.

Lessons learned

- Availability of contraceptives at sub-district levels at an accessible price;
- Free contraceptives only for the poor;
- Increased local budget for contraceptives;
- Dissemination of CCS materials to all districts;
- Advocacy of all kinds, to the media, religious leaders, etc.;
- Support from all related sectors on CCS;
- Extension of TOT at the provincial level; and
- Evaluation and development of CCS tools.

Mongolia

The government provides incentives to young couples to have children.

Background

Unlike the other countries represented at the Conference, Mongolia has a policy that seeks to increase population growth. Mongolia has been making progress in the area of RHCS. The current MMR is 49, and the IMR is 19.6. CPR is 40.4,[9] and the TFR is 2.6. A dramatic reduction has been seen in MMR due to the policy of promoting institutional delivery. Mongolia still has a traditional nomadic lifestyle. A strategy has been designed to ensure that women get to the hospital for delivery. Women go to the delivery centre, the rural district hospital about two weeks before the due date. Only 0.2 per cent of deliveries are without medical assistance. At present antenatal care coverage is 99.8 per cent, with first trimester coverage of 83.7 per cent. Antenatal syphilis screening is 80.2 per cent.

9 This figure is from the RHS; the MOH figure is 52.6 per cent but the presenter felt the RHS figure was more accurate.

Strategies for change

Mongolia is one of the nine Stream 1 countries of the Global RHCS Programme and is due to receive up to US$5 million during 2008-2012. Currently the government funds 80-83 per cent of essential RH drugs and equipment; UNFPA and other donors make up the difference. The National RH Commodity Security Strategy was approved by the Parliament in April 2009. A joint UNFPA/WHO mission to review the current status in access to a core set of critical, life-saving maternal/RH medicines was held between 18 June and 2 July 2009.

Looking ahead, the following steps are planned:

- Ensuring that funding for Maternal and Child Health is not reduced due to the economic slowdown;
- Strengthening the Public Logistics Management System for essential health commodities that require state coordination;
- Optimizing the financing mechanism of health commodities for the primary health care package;
- Providing policy support for the private sector and for NGOs that have been providing sustained and credible service;
- Strengthening the quality assurance system and capacity for drugs and medical supplies to ensure drug safety; and
- Implementing the National RHCS Strategy.

Challenges

Many challenges remain, however. Mongolia is one of seven countries in the Western Pacific Region with high MMR, and disparities are found throughout the country. Maternal mortality at rural hospitals is 1.6 times higher than at *aimag*[10] general hospitals and double that of Ulaanbaatar. Of the women who died, 35.8 per cent were unemployed and 30.9 per cent were herdswomen. Maternal mortality has increased during the first half of 2009, especially in Ulaanbaator. Two reasons have been postulated for this. Over the past 10 years the number of deliveries in UB has increased by 25 per cent while the number of beds at maternity hospitals has decreased by 25 per cent. In addition, the in-migrant population has limited access to health services.

Abortion is a sensitive issue in Mongolia. The government policy is to increase the population but the incidence of abortion remains high. People's knowledge of RH and FP is very high but practice is very low.

Other challenges include the following:

- The unmet need for family planning at 14.4 per cent is 2–4 times higher than 5 years ago;
- There has been no decrease in induced abortions;
- Because of privatization no government institution deals with the supply and distribution of drugs and medical supplies;

10 An administrative division between rural and district hospitals.

- There is a lack of sufficient coordination among the many private companies procuring and distributing drugs, and capacity building is needed in this area; and
- No special support is being given to the private sector to motivate them to enhance RHCS.

Lessons learned

- It is useful to have policies and programmes in place;
- Advocacy is needed at all levels, especially the Ministry of Finance, which should be involved from early stages;
- Capacity building is required;
- Government leadership is required;
- There should be close collaboration with UNFPA;
- Public-private partnerships promote sustainability; and
- Involvement in the UNFPA RHCS Global programme is important.

Lao PDR

Youth represents major part of population in Lao PDR and is a force that can be educated. How can we utilize that human resource not only for RHCS, but also for poverty reduction?

Background

Lao PDR has made great progress in the area of RH during the last two decades. The MMR decreased from 750 in 1990 to 405 in 2005, and the national target for 2015 is 260; the IMR declined from 82 to 70 between 2000 and 2005, and the national target for 2015 is 45. The under-five mortality rate declined from 170 in 1990 to 97 in 2005, and the national target for 2015 is 55. The CPR has increased from 13 per cent in 1990 to 35 per cent in 2005, and the national target for 2015 is 55 per cent. Between 2000 and 2005 the unmet need for FP declined from 49 per cent to 27 per cent. The TFR declined from 4.9 to 4.5 between 2000 and 2005.

Strategies for change

- To improve maternal health:
  - Commit to mobilizing resources to cover health investment amounting to US$16.58/person/year;
  - Strengthen the FP and Maternal Health services;
  - Develop competent midwifery workforce and improve emergency obstetric care and services; and
  - Commit to support implementation of Skilled Birth Attendant development plan.

- To ensure RHCS achievement:
  - Ensure free of charge long-term FP methods;
  - Ensure free of charge long-term FP information and services for people in rural and remote areas through community-based FP;
  - Strengthen demand creation for RH-FP; and
  - Exploit the potential of the private sector to provide FP services through social marketing.

Several strategies have been proposed as the way forward. Working through the Health Sector Working Group, the following should be accomplished:

- Achieve universal access to RH through the implementation of MNCH package and SBAs;
- Build functional unified logistic system for the health sector by taking LMIS as the core;
- Build forecasting and procurement capacity;
- Build sustainable health financing;
- Build health information system to monitor performance and to identify areas of focus; and
- More interaction of LAPPD within the National Assembly with the government and within constituencies.

Challenges

- Insufficient workforce that is poorly distributed and a serious shortage of midwives;
- Lack of accurate data for decision-making;
- Inadequate capacity for commodity need forecasting and procurement;
- A vertical programme approach with limited MNCH programmatic coordination and planning;
- In many communities, particularly in remote areas, contraceptives are still new and misperceptions and fear of side effects are insufficiently addressed;
- The poor, especially in rural and remote areas of ethnic populations, cannot afford FP and delivery services; and
- Low investment in the health sector (2.13 per cent in FY 2008-2009).

Lessons learned

- High-level political will and commitment of government demonstrated through budget allocations;
- Commitment of development partners, both financial and technical;
- Strong sector-wide coordination to improve efficiency and effectiveness; and
- Support for strengthening the capacity of parliamentarians to advocate for RH, population, and development issues.

Country Plans

Preparation of individual country Plans of Action began with the presentation of the format and plenary group discussion. Each SAARC country prepared a PoA consisting of one or two major activities, sub-activities, focal points, partners, and estimated budget sources to be carried out during the time frame of August to December 2009. The UNFPA APRO committed to provide US$2,000 to each country office to support carrying out these plans. Country delegations worked in teams to prepare the Action Plans. Each country's plan is included in the Annexes to this report.

A list of the major activities identified by the country teams follows:

1. Consult with parliamentarians/members of provincial assemblies so that they become sensitized to the advantages of RHCS;

2. Engage media by promoting more reportage on RH issues, and by preparing messages to be broadcast;

3. Dialogue with the Ministry of Health and Population, and with the Ministry of Religious Affairs;

4. Participate in round table discussions with key stakeholders and members of the media;

5. Assess the impact of growing fundamentalism and promote advocacy through moderate religious leaders;

6. Revise budget allocations for RH advocacy;

7. Review national population policy;

8. Form a caucus group on RH in parliament;

9. Conduct high-level advocacy workshops for policymakers and other stakeholders; and

10. Explore the possibility of establishing a SAARC media forum.

Lessons Learned

Lessons from SAARC countries

Overall, five factors are required for success of RHCS:

1. Political and operational leadership and community engagement;
2. Disaggregated data;
3. An identified quality minimum package with components that are available;
4. Removal of barriers to access; availability is one thing, accessibility is another – do people know about it? Do providers provide to everyone?; and
5. Skilled and motivated health workers in right place and right time, along with the required infrastructure.

Other specific lessons learned include the following:

- South-south cooperation is required for sharing programmes among SAARC countries, for seeing what is working and what is not, and for sharing success stories;
- Raising the status of women is part of a poverty strategy plan. Until the status of women is improved, no country will be able to address poverty or control the population growth rate. The problem of maternal mortality cannot be addressed only by looking at the population issue. Also involved are matters related to women's empowerment, education, human rights, and other gender issues. Attention from parliamentarians and broad work across sectors is required to address these concerns;
- Education is of major importance in improving CPR and reducing unmet need for contraception. More and better education for the girl child contributes to decreases in the total fertility rate. A holistic approach to overall development of the society in terms of education, and attention to the socio-economic development of vulnerable populations is important;
- Programmes must be developed for young people as this group represents a major part of the population and suffers from a high risk of maternal mortality as well as infection by HIV and other STIs. Allocations of funds and advocacy are needed on this point. The biggest killer of 15 to 18 year olds is pregnancy and birth related, and half of all HIV infections occur in the 15 to 25 age group. In certain South Asian countries, the age of marriage is quite young. In Pakistan, for example, one in three women marries before the age of 18. There must be programming directed at young people;
- The role and leadership of parliamentarians is important in each country. Rather than focusing on the general population, conclusive policies are required for individual constituencies. One suggestion proposes a multipurpose centre for each parliamentarian where contraceptive and commodity security issues could be addressed;

- Budgetary allocation is an important policy issue in which parliamentarians can make a difference. Monitoring of results is important for accountability. Sustainability and donor dependency are issues to be faced by some countries;

- A caucus of women parliamentarians to take up gender issues, including FP, MMR and others might be an effective advocacy tool to support RHCS programmes. Women's empowerment could be another focus.

- Reproductive health must be fully integrated into development plans, sector policies, and budgets. A conducive policy environment coupled with political commitment is crucial. Budgetary allocation is important policy issue in which parliamentarians can make a difference;

- Decentralization has a positive impact on RHCS in every aspect except for procurement. Success is indicated from decentralization, when communities are involved. Distribution and other mechanisms are good under decentralization, but a centralized mechanism is needed for procurement. Skill in buying is low at the local level. Corruption levels can be reduced by automating the entire system of procurement;

- Gross country wide data masks variations and disparities that are found within countries. Disaggregation of data is required. For example India currently has an overall CPR of 54.1 per cent, in certain parts of country it is only 10 per cent. Equity in accessibility to essential health care services must be assured;

- Variations in population density within countries can lead to local administrations being more or less favourable to promoting FP, particularly in situations of indigenous populations. This is the case with Papua New Guinea, where the local administration does not favour FP;

- An adequate health workforce along with capacity building is central to an effective health system. Skilled birth attendants are crucial for preventing maternal and infant mortality, and more need to be trained. Possible public/ private partnerships could take the form of using private services for training of motivated health workers;

- A policy of increasing institutional delivery is found to drastically decrease the MMR;

- The problem of morbidity as well as maternal mortality must not be forgotten. Allocations of funds and advocacy are required in this area;

- Village level midwives, local women who have been trained for two to three years, can be very effective in winning the trust of their communities. They can also serve to distribute RH supplies at the local level;

- Volunteer village health workers may not work well because they need an income to sustain their families. The model of having these workers both distributing and selling RH products to subsidize their salaries is a good one;

- Mobile service units are an effective way to reach remote and underserved communities, and also to provide services during natural disasters and other emergency situations;

- Extended families, including men, must be involved in RH issues, and educated in practices such as the importance of good nutrition to avoid anaemia in pregnant women. A healthy birth should be seen as a festive occasion. The involvement of men in general is important as part of advocacy efforts in support of RHCS;

- Religious, community and political leaders must be part of any advocacy effort. Recently some level of religious opposition is coming up. Educating religious as well as other community leaders is an effective strategy for overcoming; and

- Careful planning based on evidence based information is essential and monitoring and evaluation of results is required for accountability.

Lessons from non-SAARC countries

- Principled engagement and ownership among advocates;
- Importance of risk mitigation strategies in the overall advocacy plan;
- Build on existing best practices in advocacy;
- Importance of evidence-based advocacy;
- Strengthening linkages between national and local advocacy efforts;
- Do not postpone when the goal is in sight;
- Do not give misinformation;
- Address the young, the future mothers;
- It is useful to have policies and programmes in place;
- Advocacy is needed at all levels, especially the Ministry of Finance, which should be involved from early stages;
- Capacity building is required;
- Government leadership is required;
- There should be close collaboration with UNFPA;
- Public-private partnerships promote sustainability; and
- Importance of involvement in the UNFPA RHCS Global programme.

Closing Ceremony

How many women's lives have been lost during this three-day conference?

Every minute one woman dies from complications related to pregnancy and childbirth. No one speaks for these women, so advocacy on their behalf is our responsibility. The Declaration that came out of this Conference is only the first part of the work. The real work begins now. Europe and the developed world have solved the problem of maternal mortality. It is time for South Asia to solve this problem as well. This is doable, requiring only dedication and political commitment. Every time we hear that a woman has lost her life while giving life we should find out why, investigate and take the story to the media.[11]

The lack of funding for contraceptives takes a serious toll on the women and children of Nepal: each US$1 million shortfall in contraceptives results in: (1) 360,000 more unwanted pregnancies, (2) 150,000 more induced abortions, (3) 800 maternal deaths, (4) 11,000 infants deaths, and (5) 14,000 additional deaths of children under five.[12]

Governments in developing countries are inclined to seek support for RHCS from donors but donor support has been declining over the years. This situation is even more alarming because the size of the population seeking RH services and commodities is increasing due to a large cohort of young people entering into the reproductive age groups.

Parliamentarians should vow to meet the needs of their people, including access to RH commodities and services. The national governments in South Asia are signatories to the PoA adopted at the ICPD in September 1994. Paragraph 76 of the ICPD PoA states: "All countries should strive to make accessible through the primary health care system reproductive health to all individuals of appropriate ages as soon as possible and not later than the year 2015".

2015 is fast approaching, but progress is not satisfactory and questions are being raised about whether this goal will be achieved. If we fail to effectively advocate to our national governments in partnership with other stakeholders, we will fail to meet our commitments and will disappoint the expectations of our people.

Though the primary and ultimate responsibility for achieving the MDGs and ICPD goals lies with national governments and related organizations, they cannot work in isolation. Therefore, we must create a favourable environment and build pressure for greater commitment by government among civil society, media, and health professionals. Such commitment will take the form of allocating resources from national budgets, accessing support from donors and international agencies, strengthening health systems, calling for public-private partnerships, and the like.

---

11 From remarks by Jagdish Upadhyay, Chief, Commodity Security Branch, UNFPA, New York.

12 The next several paragraphs are taken from remarks by Rt. Hon. Subas Chandra Nembang, Chairman of the Constituent Assembly of the Federal Democratic Republic of Nepal.

UNFPA's overall goal is to drastically reduce maternal mortality and thereby save women's lives. The causes of so much misery and tragedy are easily eliminated. The need is for cadres of trained professionals, robust health systems that can bring services to women in remote and difficult to reach communities, and a sustainable supply of RH commodities. All of this requires enormous work as outlined in the Declaration of Commitment prepared at this Conference.[13]

The major concerns of the UNFPA Regional Office are few but they are major:

- The funding gap. With generous support from the UK a long-term and comprehensive plan is being developed;
- Health systems are weak, both in terms of the deliverability of health services and the shortfall of supplies; and
- Emergency situations. Since the Asian tsunami, UNFPA has been working on contingency plans to address the RH of women even during emergencies and disasters.

13 The next several paragraphs are taken from remarks by Najib M. Assifi, Regional Director, a.i., of Asia and the Pacific Regional Office, Bangkok.

The major strategies for the years to come include:

- Creating a politically supportive environment. This Conference is part of that effort and the signing of the Declaration by parliamentarians for each South Asian country expresses their clear commitment;

- Creating a commitment for action. Implementation is the challenging aspect of commitment, and there must be commitment for action at the country level. To this end and to assure sustainability we will work to ensure that RH supplies are included in national budgets. Donor support has been generous, but signs of donor fatigue have now emerged;

- Building capacity for forecasting and logical management systems; and

- Developing strong and functional systems in all countries, including adequate storage, distribution capacity and LMIS.

The Asia and the Pacific Regional Office remains fully committed to achieving these broad goals.

Annex I

DECLARATION BY DELEGATES OF THE ASIA REGIONAL CONFERENCE FOR THE SAARC COUNTRIES PARLIAMENTARIANS ON ADVOCATING FOR UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH SERVICES AND COMMODITY SECURITY

28-30 July 2009, Kathmandu, Nepal

Ensuring every pregnancy wanted, every birth safe, every newborn healthy: "no woman should die giving life"

Background

1. With less than seven years to go in the countdown to 2015, the target date set by the United Nations Millennium Declaration, for achieving various development goals and targets, countries in the South Asian Region are concerned with the slow progress on reducing maternal mortality. The Millennium Development Goal (MDG) 5, for improving maternal health, with targets for reducing maternal mortality (target 5A) and achieving universal access to reproductive health (target 5B) provides an opportunity to review key policy and operational constraints and advocate for actions to accelerate progress. Key considerations are to ensure that good quality reproductive health services and commodities are accessible to all.

Current status and achievements on MDG 5 in the region

2. Although some progress has been made, in many countries in our region, coverage for family planning and access to comprehensive reproductive health services and commodities is still inadequate. A number of countries experience a high unmet need for family planning, low facility-based deliveries and deaths or disabilities associated with pregnancy or childbirth. Overall, women continue to experience an unacceptably high rate of sexual and reproductive health problems from preventable causes and issues associated with gender and social status. Significant inequities and disparities remain in achieving universal access to services within countries.

Declaration

3. **RECALLING** the 2005 World Summit outcomes and commitments made by Heads of State and Government to fully implement the MDGs;

   RECALLING the integration in 2007, by the UN Secretary General, of a new target within the MDG framework, to "achieve, by 2015, universal access to reproductive health";

CONCERNED by the relatively slow progress being made in the region, in particular, in reducing maternal mortality and ensuring equitable access to services;

RECOGNIZING that the attainment of the MDGs and other international goals and targets require, as a priority, a strong investment and political commitment to, and advocacy for, improving sexual and reproductive health;

ACCEPTING that as legislators, parliamentarians, policy makers, representatives of national organizations, religious leaders, civil society and media professionals, we have a responsibility, together with our governments, to ensure the health of our women, men and young people in our countries by providing high quality, accessible, affordable and sustainable reproductive health care at all levels;

NOTING, with concern, that the impact of the HIV pandemic in our countries puts at risk some of our health gains, particularly those that pertain to women, young people, and children and threatens to overwhelm the resources needed to improve reproductive health services;

RECALLING and recognizing the Programme of Action of the International Conference on Population and Development (ICPD Cairo, 1994) and key actions for the further implementation of the Programme of Action of the ICPD, adopted by the twenty-first special session of the United Nations General Assembly;

ACKNOWLEDGING the importance of achieving universal access to reproductive health services and commodity security in meeting international goals for reducing maternal mortality and morbidity;

FURTHER RECALLING the *Global reproductive health strategy to accelerate progress towards the attainment of international development goals and targets* adopted in 2004 by Health Ministers at the World Health Assembly;

RECOGNIZING the links between improved sexual and reproductive health, provision of universal education, especially of girls, women empowerment and socio-economic development, poverty reduction, environmental protection and overall health and development;

4. **URGE** various stakeholders, including ministers, parliamentarians, health programme managers, service providers, donors, the media and others in all countries in our region, as a matter of urgency to:

4.1 devote sufficient priority, commitment and resources to interventions, policies and strategies for reducing maternal mortality, including among others ensuring a continuum of care; access to quality family planning counseling, information, services and commodities that promote informed choice; emergency contraception; prevention of unsafe abortion and provision of post-abortion care; access to antenatal and post-natal care; provision of emergency obstetric and newborn care; ensuring availability of transport, access to skilled birth attendants, and safe blood and blood products;

4.2 provide a separate annual incremental budget line for reproductive health within the health budget that adequately supports services, and strengthen national capacity in management and security of commodities, support forecasting, procurement and distribution of essential commodities including contraceptives on the basis of sound logistics, service and demographic data;

4.3 ensure that sexual and reproductive health and rights, and research, which includes family planning, maternal health, prevention and control of sexually transmitted infections and HIV, and prevention of mother to child transmission, are integrated within national health strategies and action plans, to the fullest extent possible;

4.4 establish policies and programmes that care for vulnerable groups, such as adolescents, underprivileged groups, the urban poor, ethnic minorities, marginalized communities, populations in conflict, post conflict and disaster situations, and address their reproductive health needs;

4.5 engage parliamentarians, sensitize the media, involve men and mobilize the extended family, community groups, religious and civil society leaders, the private sector, social marketing and relevant organizations to participate in the introduction and scaling up of interventions for improving sexual and reproductive health, and the elimination of gender based violence;

4.6 introduce programmes and policies that support HIV prevention and care, including comprehensive condom programming; and support HIV and reproductive health education in upper primary and secondary schools;

4.7 train and retain health care providers for the delivery of an integrated and comprehensive range of reproductive health, including family planning services; and increase coverage for services, including through community based initiatives;

4.8 develop and implement national strategies for rapid production, deployment and retention of skilled health care providers and midwives and incorporate Emergency Obstetric and Newborn Care in pre-service training at all levels of health care delivery system;

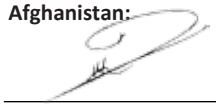
4.9 ensure that national essential medicines lists include reproductive health commodities; and support quality assurance in the production and supply chain;

4.10 institutionalize monitoring and evaluation (M&E) and allocate adequate human and financial recourses, including the identification through M&E, and sharing, of best practices.

In conclusion, we want to reiterate and commit to improving the health of women, men and young people in our countries. As parliamentarians, policy makers and media professionals, we wish to advocate for greater awareness and a stronger commitment to achieving the MDGs, in particular MDG 5, which shows the least progress.

Signed by:

Afghanistan:



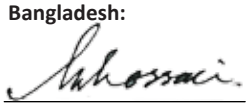
Ms. Nadera Hayat Burhani
Head of the Delegates
Hon. Deputy Minister
Ministry of Health

Ms. Fatema Aziz Atahi
Hon. Member of Parliament
Parliament

Mr. Mohammad Ali Sitigh
Hon. Member of Parliament
Parliament

Ms. Fawzia Ihsan
Media
Radio Liberty

Bangladesh:



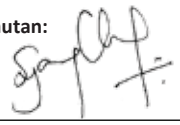
Mr. Md. Mozammel Hossain
Head of the Delegates
Hon. Member of Parliament

Prof. Dr. M. Amanullah
Hon. Member of
Parliament

Mr. Barun Dev Mitra
Additional Secretary
Ministry of Health & Family
Welfare

Mr. AKM Rashidul Hasan
Staff Correspondent
The Daily Star

Bhutan:



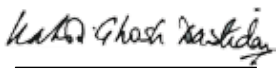
Ms. Sonam Yangchen
Head of the Delegates
Hon. Member of Parliament
National Council

Dr. Ugen Dophu
Director, Public Health
Ministry of Health

Mr. Yeshi Pelzang
Planning Officer
Gross National Happiness
Commission

Mr. Neten Dorjee
Media
Bhutan Broadcasting Service

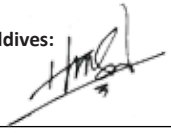
India:



Dr. Kakoli Ghosh Dastidar
Head of the Delegates
Hon. Member of Parliament
National Parliament

Ms. Kumkum Chadha
Editor National News
Hindustan Times

Maldives:



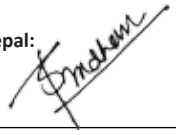
Mr. Hamdhun Abdulla Hameed
Head of the Delegates
Hon. Member of Parliament
Inguraidhoo Constituency

Ms. Rugiyya Mohamed
Hon. Member of Parliament
Mahinadhoo Constituency

Mr. Abdul Bari Abdulla
Hon. Minister of State for
Health and Family

Ms. Asiyath Mohamed Saeed
Broadcast Development Executive
Haveeru Daily

Nepal:



Ms. Sapana P. Malla
Head of the Delegates
Hon. Member of Parliament
Constituent Assembly

Ms. Ang Dawa Sherpa
Hon. Member of Parliament
Constituent Assembly

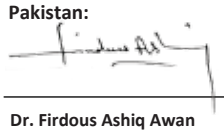
Ms. Gayatri Shah
Hon. Member of Parliament
Constituent Assembly

Dr. Mingmar G. Sherpa
Director
Logistics Management Division, DOH
Ministry of Health & Population

Mr. Kabiraj Khanal
Under Secretary
Ministry of Health & Population

Mr. Prem Dhakal
Special correspondent
Republica

Pakistan:



Dr. Firdous Ashiq Awan
Head of the Delegates
Hon. Federal Minister
Population Welfare

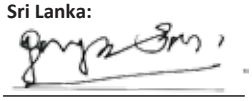
Mr. Sardar Saif-ud-din Khosa
Hon. Member of Parliament
National
Assembly/Parliamentarian

Mr. Shahzad Ahmed Malik
Chief
Planning Commission
(Population)

Dr. Mumtaz Eskar
Director General (Technical
Wing)
Ministry of Population Welfare

Mr Parvez Jamil Mir
Anchor person
ARY TV

Sri Lanka:



Mr. Chandima Weerakkody
Head of the Delegates
Hon. Member of Parliament
Member of Parliament

Mr. S.M. Peshala Jayaratne
Bandara
Hon. Minister of Provincial
Health of North

Dr. Deepthi Perera
Director
Family Health Bureau

This declaration is issued by the delegates of the Asia Pacific Regional Conference for the SAARC countries Parliamentarians on Advocating Universal Access to Reproductive Health Services and Commodity Security, organized by UNFPA and AFPPD.

Signed on 30th day of July in the year 2009
Kathmandu, Federal Democratic Republic of Nepal

Annex II

Address by Rt. Hon. President Dr. Ram Baran Yadav, Conference on Advocating Universal Access to Reproductive Health Services and Commodity Security 28-30 July 2009, Kathmandu

Distinguished Guests
Participants
Ladies and Gentlemen,

I would like to thank United Nations Population Fund (UNFPA) and the organizing committee of this important conference here in Kathmandu. I feel honored and happy to be with you all this morning.

We all know that the pace of progress in achieving Millennium Development Goal 5 which is reduction of maternal mortality by three quarters by the year 2015 is being slow or even disappointing. In South Asia near about two hundred thousand women die each year due to pregnancy-related complications. South Asia is accounted for more than 50 per cent of the Asia's maternal deaths in 2005. An irony is that these deaths are avoidable, if we are committed have effective mechanisms in place backed by favourable government policies and functioning health systems.

To achieve MDG 5 by 2015, improving health care for women and providing universal access to reproductive health services must be prioritized. This includes access to family planning, prevention of unplanned pregnancies and provision of high-quality pregnancy and delivery care, including emergency obstetric care and availability of reproductive health commodities including contraceptives.

This conference is happening at an important time when international communities are organizing several events to look back and review what we have achieved, how much more to be done before 2015. Slow progress achieving MDGs including MDG 5, which is the topic of this conference, is often due to a gap between commitment and implementation. The MDG process will become fragmented and lose momentum unless there is a coordination approach to the partnership for a strong advocacy component. Delegates to the conference can deliberate on effective ways of advocacy, through a series of regional and sub-regional forums to create opportunities for different kinds of networking, NGOs and representatives of community organizations to form new alliances and work together more effectively.

I understand that Nepal is trying her best to achieve goals in the area of child health and maternal health as well as preventing major infectious diseases. We are hopeful that the MDG 4, 5 and 6 will be achieved by 2015. I sincerely hope that this conference will provide you a learning forum, learning from your own colleagues or counterparts from other countries, to improve capacity to advocate in coordinated approach to their respective national governments for stronger commitment to achieving MDG 5 for

increased resources, integrated framework approach and coordination. During the conference, you will take an opportunity to review the progress on reproductive health and commodity security and determine how much each of us have yet to do and contribute to this cause.

I would like to wish all of you fruitful and productive deliberations in the coming days and look forward to an excellent outcome of this conference.

Thank You, Thank you all.

Annex III

Philippines Testimonial from Hon. Joseph P. Juico, Councilor of the First District of Quezon City Proponent of the RH Bill in Quezon City

I am standing before you today to tell you a story. To others, this might be something you have heard of before, to some, this might be the first time you will hear of it. Like most stories, what I will share with you today started out as a journey and ended up as one of the most unforgettable and fruitful lessons of my life as a policymaker, and as a person. The story of the Reproductive Health ordinance in Quezon City may well be the best example of the adage: The Journey is the Destination. It was not a journey I took alone. The ordinance since its inception, has been under intense scrutiny from the various stakeholders in Quezon City, and rightly so, because this ordinance is the first of its kind in the metropolis.

All Politics is Local

"All politics is local" is a statement that is often used to describe the political dynamics in the Philippines. More than anything, it describes the struggles of national policymaking and implementation vis-à-vis the more direct, more personal, although small-scale local-level.

The reality of the dynamics of national and local governments is that while both have their respective strengths and challenges to overcome, the national front, especially in areas of legislation and policy implementation is fraught with problems, such as political deadlocks that bog down progressive legislation and policy formulation.

Local Government Autonomy

In the interest of genuine and meaningful local autonomy, and to empower LGUs to attain their fullest development as self-reliant and more effective partners in the achievement of national goals, a system of decentralization of administration and devolution of services was instituted to give more power, authority and responsibilities to LGUs.

Over the years, we can observe a trend in the development and local government units especially in the metropolis. One is the uneven development of LGUs – some are financially better off and more socially progressive than others, others are bogged down by political conflicts, and some still have major challenges to overcome. In the metropolis, highly urbanized cities are among the trailblazers for economic, social welfare and administrative reforms. It can even be said of some LGUs that they are able to do what the national government is often restricted from fully accomplishing.

One clear-cut example that I can give you is the formulation of a national policy for reproductive health and population management – a highly contentious issue spanning decades, and still without a solution.

National Reproductive Health and Population Management Policy

Philippine population continues to grow exponentially, with a projected population of 92.23M Filipinos as of 2009. Time and again, we are reminded that a burgeoning population is a hindrance to our development goals. Viewing the issue through the moral lens of a single abbeit dominant perspective, that is, the view of the Catholic Church blurs the demarcation lines between Church and State, and reveals the extent one dominates or subjugates the other in critical areas or policymaking. Opposition by the Catholic Church against any form of modern method of family planning is, to put it mildly, fierce.

The attitude of the sitting administration vis-à-vis influential players such as the Catholic Church, greatly affects the formulation and implementation of population policy.

Fluctuating National Executive Policies on Population Management

For example, during the terms of former Presidents Marcos, Ramos and Estrada, a strong population programme was in place despite the staunch opposition of the Church. Thus, there was access to much-needed RH goods and service, thanks to the political will and support of the national government.

It is well to note that despite the very close ties of Pres. Aquino to the Church, there were responsive Family Planning and Population Management Programs in place. To avert the Church backlash, the strategy of the Executive Branch, particularly the Health Department, made it into a general and holistic HEALTH ISSUE, which was integrated into the National health program. This RIGHTS-based approach, which focused on the people's right to health proved to be effective because it led to the institutionalization in the 1987 Constitution of the right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood.

However, reversal of national policy on population be selectively promoting natural family planning methods only and cutting budgetary allocation for RH commodities occurred during the current administration of President Gloria Macapagal-Arroyo, attributed to the Administration's attempts to salvage its precarious relationship with the influential Catholic Church, and concomitantly prevent a backlash.

The House of Representatives is a perpetual battleground of diametrically opposing beliefs among legislators, policymakers and the Catholic Church; and these deadlocks have resulted in irreconcilable differences, thus, the absence of a national RH law. Nevertheless, the hope of a strong, consistent and development oriented national population and reproductive health policy lies in national legislation. Legislation transcends political and religious differences, it allows various policy perspectives to converge and harmonize, and it provides the standards by which a national population policy will be carried out.

Strategies for Provisional Measures

Meanwhile, absent the successful passage of national legislation, insertions in the national budget for family planning is a provisional remedy for now, a stop-gap measure. Thus, in the 2007 General Appropriations Act (GAA), P150 million was allotted for the procurement of contraceptives. Under the 2008 GAA, another P2 billion was allotted for the purpose; sadly portion of it remains unused up to this time because of the delay in the formulation of the implementing rules and guidelines by the Department of Health (DOH).

Reproductive Health and Population Management: The Quezon City Experience

On the local level, introducing a Reproductive Health ordinance in a country where majority of the citizens are Catholic and where the lines are blurred when it comes to the separation of Church and State was no easy task. Now, you might be asking yourself why someone who was born and raised in the Catholic faith, even studied at an educational institution ran by Christian brothers, and whose parents are very active in church and community services, decided to go against the tide? Well, that part of my story is something I considered as both a learning and transformative experience.

As one of the youngest Councilors of Quezon City, my role as a public servant has given me the opportunity to meet different kinds of people. In a developing country like the Philippines, poverty is a persistent social problem that any public servant would like to reduce, if not eliminate altogether. My immersion in the depressed areas in our district opened my eyes to harsh realities. Families there have more children than they can provide and care for. They want to practice family planning but they don't have enough information, as well as access to resources and services to enable them to do so. They can barely afford to feed, clothe, and house their children, let alone give them a proper education. These parents are aware that when their children grow older, they are similarly deprived of opportunities for a better life. This scenario is not hard to imagine in Quezon City where an estimated 2.68 million people reside. The City's population is considered the biggest among all the Philippine cities with an average population growth rate of 1.92 per cent annually. Even the wealthiest city in the country is severely limited in the services it can provide to a steadily increasing population. Rapid population growth affects various dimensions of local and national development, namely education, health, employment, shelter, food security and the environment. Rapid population growth may arguably, not directly cause poverty, but it definitely exacerbates poverty and drains government resources that are needed to deal with it.

In my conversations with couples, they ask me how the government intends to help them. More than handing dole outs, I know that the key to their empowerment lies in giving them ample information, resources and services to help them make informed choices which would, in turn, help them determine what's best for their family. They would have the means and knowledge to decide how big they want their family to be, and how they can prepare for the coming of each child.

RH Journey in Quezon City

Working hand in hand with the Anti-Poverty Task Force in QC and the various stakeholders in the city, a Reproductive Health Ordinance was crafted to address the need for a comprehensive and holistic policy on population and reproductive health. It is important to note that even prior to the RH ordinance, Mayor Sonny Belmonte adopted a program that encouraged family planning and provided budgetary support for family planning services and commodities, which drastically reduced maternal deaths in QC.

All these facts and figures convinced me as a lawmaker that it is sound policy, and also urgent, to come up with legislation that will institutionalize RH and Population management. I honestly believed that it was part of my oath as a public servant to answer the clamor of our people.

RH Journey in Quezon City: Timeline

Since its filing in July 2007, we made sure that we gave all sectors, both for and against, equal opportunities to air their side. Everyone was invited for a dialogue as we tried to be as inclusive, participative and democratic as possible. During the public hearing in December of 2007, again both sides were free to voice their arguments. From all their inputs, amendments were made to make the ordinance truly reflective of and responsive to the needs of our people.

For those of you who do not know, I faced a lot of challenges with regard to the RH Ordinance. I have been subjected to various accusations and threats, which caused not only me but my family distress and anxiety. All this would have been easier to handle had the attacks been limited to the actual contents of the Ordinance. Critics went as far as to call me an abortionist. It naturally affected my family and took its toll on them. They probably could not understand why critics were calling their son an abortionist when they firmly believe that they have raised their son well. My mother was so affected that she even wrote to an archbishop asking why her son was being criticized this way and even said and I quote "If Jesus were alive, would he do this to his own?" She never got a reply. Looking back, the fear of not being allowed to wed in the church or worse, not being given the Holy Communion seems ridiculous, but during that time, the fear was very real.

It did not stop there. Newspaper columnists devoted whole columns attacking the Ordinance. Rallies were mobilized against it. Streamers were put up in churches urging people to oppose it. Homilies contained exhortations not to re-elect me and to reject the Ordinance at all costs. House-to-house signature campaigns were conducted against it.

Contentious to groups that oppose the ordinance is the provision on Adolescent Health Education, to be taught in an age-appropriate manner – mandatory for public high schools and voluntary for private educational institutions. Despite the safeguards and guidelines provided in the ordinance for teaching of the subject. I was accused of authoring an ordinance that will teach the young how to have sex and engage in promiscuous behavior, by corrupting or polluting their minds. Institutionalizing AHE is a step towards teaching the youth of today on responsible parenthood. It is an avenue for young people to have a structured leaning and access to accurate information because they are bombarded everyday with images and unfiltered information from other sources

such as their peers, media and the internet. It is only through proper education of the youth that we can guard and protect them against unwanted pregnancies, sexually transmitted diseases and AIDS. Even though studies have shown that subjects like AHE tend to make the youth more cautious and likely to abstain from sex, sadly, the mere mention of reproductive health automatically connotes immorality.

To say that those were really dark and long days was an understatement. It would have taken some of the experts in the field of press relations to "clear" my name. On a more personal level, it made me question whether pushing through with the Ordinance was really worth it. There was even a point when I questioned my faith because the vitriolic attacks of the Catholic Hierarchy. However, I never lost my faith in my GOD.

From a political point of view, it seemed the costs far outweigh the benefits. But then I realized that I am more than a politician. I am a public servant mandated to serve the people. I know that this issue had clearly gone beyond politics, beyond any religion or ideology. It is about the people, what they need now and what will help them build better lives. And also, this is an important point, we were, indeed, very lucky to have a very supportive Mayor and a local city council ready to set aside politics and instead pushed for something which will benefit the majority. It is truly a triumph of the will to have passed this groundbreaking ordinance.

I would like to believe that my story will get its happy ending. Last March 2009, Mayor Belmonte approved the Implementing Rules and Regulations of the RH Ordinance. Again, it was a product of a long process of consultation with a multi-sectoral working group composed of experts and representatives from various sectors such as: religious denominations/organization, civil society, medical practitioners, demographers, women's groups/NGOs, men's groups/NGOs, reproductive health rights advocacy groups, and community-based organizations. Immediately after signing the IRR, the local government launched a program entitled MP4 or *Pamilyang Pinaplano, Malusog, Masaya, Matatag at Masagana:* Quality Family in our Quality City as an affirmation of the local government's effort to put into practice the provisions outlined in the ordinance. At this early stage, we have received feedbacks of heightened awareness or reproductive rights and an increase in the attendance at local health centers of families wanting to know their family planning options and to avail of the RH services. In my capacity as a Councilor, I have started conducting information dissemination campaigns and seminars in my district targeting women and the youth.

Now, I boldly say again, "All politics is local". In the absence of a sound national policy on reproductive health and population management, the LGUs have taken up the cause and some have started implementing it in their very own backyards. Such is the case of Quezon City, one of the largest LGUs, a trailblazer in gender-based governance and now, population and reproductive health. While we cannot wait for the national government to get its act together, we are hoping that it will follow suit.

Indeed, it has been a long, grueling and LEARNING journey, I may have incurred some scars along the way, but the impact of the Ordinance will speak for itself for generations to come and I am only too happy to have been part of its story.

Mabuhay po tayong lahat!

Annex IV

Conference on Advocating Universal Access to Reproductive Health Services and Commodity Security 28-30 July 2009, Kathmandu, Nepal

Agenda

Day	Item	Responsible Person(s)	Remarks
28th July			
09:00 – 09:45	1. Opening (45 mins)	**Chair:** Hon. Mr. Khadga Bahadur Basyal Sarki, State Minister, Ministry of Health and Population, Nepal	
	– Welcome	Mr. Ian McFarlane, UNFPA Representative to Nepal	
	– Remarks	Mr. Najib Assifi, Regional Director a.i., UNFPA APRO Mr. Jagdish Upadhyay, Chief, CSB/TD, UNFPA, New York	
	– Address to Delegates by UNFPA Executive Director	Ms. Thoraya Obaid, UNFPA Executive Director	Through Video
	– Remarks	Hon. Mr. Khadga Bahadur Basyal Sarki, State Minister, Ministry of Health and Population, Nepal	
	– Key note address and Opening by Chief Guest	Right Hon. Dr. Ram Badan Yadav, President of the Federal Democratic Republic Nepal	
	– Vote of thanks	Mr. Jayanti Tuladhar, Regional Technical Advisor, UNFPA APRO, Bangkok	
09:45 – 10:15	**Opening reception**		
10:15 – 11:15		**Chair:** Hon. (MP) Dr. Kakoli Ghosh Dastidar from India	
	Security Briefing 2.1 Achieving the new MDG target: Universal Access to Reproductive Health (15 mins presentation)	UNDSS Dr. Michael Mbizvo, Director of RHR a.i., WHO-Geneva	
	2.2 UNFPA Global Policies on Reproductive Health Commodity Security (15 mins presentation and 20 mins discussion)	Mr. Jagdish Upadhyay, Chief, CSB/TD, UNFPA, New York	
11:15 – 12:00	3. Partnering with Media – Panel discussion (India, Indonesia and Philippines)	Moderator: Mr. William Ryan, Regional Communication Officer, APRO, Bangkok	
12:00 – 13:00	4. Country presentations – Afghanistan, Bangladesh, Bhutan (10 mins each and 30 mins discussion)		

Day	Item	Responsible Person(s)	Remarks
13:00 – 14:00	**Lunch (60 mins)**		
14:00 – 15:40	5. Country presentations – India, Maldives and Nepal (10 mins each and 30 mins discussion)	**Chair:** Hon. (MP) from Bangladesh, Dr. M. Amanullah	
	6. Country presentations – Pakistan and Sri Lanka (10 mins each and 20 mins discussion)		
15:40 – 15:55	**Break (15 mins)**		
15:55 – 17:00	7. Meeting MDG – RHCS Advocacy: Sharing experiences (30 mins presentation and 30 mins discussion)	**Chair:** Hon. (MP) from Bhutan, Ms. Sonam Yangchen The Philippines Panelists	
17:00 – 18:00	8. Why did Mrs. X Die? – The Road to Maternal Death	Video Presentation	
29th July			
8:30 – 10:45	9. Commitment – RHCS Advocacy: Sharing experiences (30 mins presentation and 30 mins discussion)	**Chair:** Hon. (MP) from Maldives, Mr. Hamdhun Abdulla Hameed The Indonesian Panelists	
	10. Meeting Resources – RHCS Advocacy: Sharing experiences (15 mins presentation and 30 mins discussion)	The Mongolian Panelists	
10:45 – 11:00	**Break (15 mins)**		
11:00 – 13:00	11. Commitment – RHCS Advocacy: Sharing experiences (30 mins presentation and 30 mins discussion)	**Chair:** Hon. (Minister) from Pakistan, Dr. Firdous Ashiq Awan The Lao PDR Panelists	
	12. UNFPA-WHO Initiative: Critical Life Savings Medicines (15 mins presentation and 30 mins discussion)	Dr. Kabir Ahmed, Technical Adviser, CSB, UNFPA, New York	
13:00 – 14:00	**Lunch (60 mins)**		
14:00 – 15:30	13. Sharing of Initial DRAFT of Commitment of Declaration (15 mins presentation and 30 mins discussion) – Formation of sub-committee to finalize the "Declaration"	**Chair:** Hon. (MP) from Nepal, Ms. Sapana P. Malla Dr. Michael T. Mbizvo to present for discussion	Drafting Committee starts working on the draft (Drs. Michael T. Mbizvo and Kabir Ahmed to facilitate)
	14. Preparation of Country Plan (15 mins presentation of format and 30 mins discussion)	Dr. Kabir Ahmed to present objectives and the format	

Day	Item	Responsible Person(s)	Remarks
15:30 – 15:45	**Break (15 mins)**		
15:45 – 17:00	15.1 Drafting sub-committee works on "Declaration"		
	15.2 Country group for preparing workplan and at least one advocacy activity in 2009		Only countries from SAARC region
30th July			
9:00 – 10:30	Continue group work (90 mins) and sub-committee		
10:30 – 10:45	**Break (30 mins)**		
10:45 – 13:00	16. Presentations of workplan (10 mins each and 30 mins discussion)	**Chair:** Hon. (MP) Mr. Chandima Weerakkody from Sri Lanka Individual country	Drafting committee continue working on the draft
	17. Sharing of initial draft of "Declaration" and discussion	Dr. Michael T. Mbizvo, Mr. Jagdish Upadhyay, Dr. Kabir Ahmed and Mr. Jayanti Tuladhar	Drafting committee continue working on the draft
13:00 – 14:00	**Lunch (60 mins)**		
14:00 – 15:00	Signing of "Declaration"		Agreed "Declaration"
15:00 – 17:00	**Break**		
17:00 – 19:00	18. Concluding session (starts at 5 PM) – Remark – Summary of 3-day activities and outcomes – Key note address and Opening by Chief Guest – Asia Regional Perspectives and Priorities on RHCS Address and vote of thanks on behalf of delegates	**Chair:** Mr. Najib Assifi, Regional Director a.i., APRO Mr. Jagdish Upadhyay, Chief, CSB/TD, UNFPA, New York Mr. Jayanti Tuladhar, Regional Technical Adviser, UNFPA APRO, Bangkok Rt. Hon. Mr. Subas Chandra Nembang, Chairman of Constituent Assembly of the Federal Democratic Republic Nepal Mr. Najib Assifi, Regional Director, a.i. of UNFPA Asia and the Pacific Regional Office (APRO), Bangkok (5 mins) Hon. Member of Parliament Ms. Sonam Yangchen, National Council, Bhutan	
	19. Cocktail Reception		

Annex V

Conference on

Advocating Universal Access to Reproductive Health Services and Commodity Security
28-30 July 2009, Hotel Soaltee Crowne Plaza, Kathmandu, Nepal

List of Delegates

No.	Country	Name	Position	Designation Office	Contact Address	E-mail	Telephone No.
	Delegates						
1	Afghanistan	Ms. Nadera Hayat Burhani	Hon. Deputy Minister	Ministry of Health		hcsp@moph@gov.af	230 2391
2	Afghanistan	Ms. Fatema Aziz Atahi	Hon. Member of Parliament	Parliament		dr.fatema_02i2_atahi @yahoo.com	93 70071 4444
3	Afghanistan	Ms. Noshafarin Shahab Dawlati	Hon. Member of Parliament	Parliament			
4	Afghanistan	Mr. Mohammad Ali Sitigh	Hon. Member of Parliament	Parliament		dr.sitigh@yahoo.com, dr. sitigh@gmail.com	079 941 4008
5	Afghanistan	Ms. Fawzia Ihsan	Media	Radio Liberty		saghar_ihsan@yahoo.com	004 3700 2191996
6	Bangladesh	Mr. Md. Mozammel Hossain	Hon. Member of Parliament	Parliament			001 7155 49590
7	Bangladesh	Prof. Dr. M. Amanullah	Hon. Member of Parliament	Parliament		aman_u@livedol.com	0171 507 8696
8	Bangladesh	Mr. Barun Dev Mitra	Additional Secretary	Ministry of Health and Family Welfare		bdmitra@hotmail.com	880 271 65067
9	Bangladesh	Ms. Afsana Taher	Operations Manager and Focal Point for RHCS	UNFPA Bangladesh	IDB Bhaban (15th Floor), E/8-A Begum Rokeya Sharani, Sher-E-Bangla Nagar, Agargaon	taher@unfpa.org	+880 17115 43424
10	Bangladesh	Mr. AKM Rashidul Hasan	Staff Correspondent	The Daily Star			
11	Bhutan	Dr. Ugen Dophu	Director, Public Health	Ministry of Health	Thimphu, Bhutan	udophu@yahoo.com	+00975 2 326 454
12	Bhutan	Ms. Sonam Yangchen	Hon. Member of Parliament	National Council	National Council of Bhutan	sonamyangchen@ nationalcouncil.bt	+975 1761 0260
13	Bhutan	Mr. Yeshi Pelzang	Planning Officer	Gross National Happiness Commission	Thimphu, Bhutan	ypelzang@gnhc.gov.bt	+975 02 325192

Annex V *(continued)*

No.	Country	Name	Position	Designation Office	Contact Address	E-mail	Telephone No.
	Delegates						
14	Bhutan	Mr. Neten Dorjee	Media	Butan Broadcasting Service			
15	Bhutan	Mr. Yeshey Dorji	Asst. Representative	UNFPA Bhutan	UN House, Samten Lam, G.P.O. Box 162	yeshey.dorji@unfpa.org	00975 1762 9208
16	India	Dr. Kakoli Ghosh Dastidar	Hon. Member of Parliament	National Parliament			
17	India	Dr. Prakash R. Deo	State Programme Coordinator	UNFPA Madhya Pradesh State Office	UN House, 40140 Shamla Hills. Bhopal (MP)	deo@unfpa.org	91 942 560 2591
18	India	Ms. Kumkum Chadha	Editor National News	Hindustan Times			
19	Maldives	Ms. Rugiyya Mohamed	Hon. Member of Parliament for Mahibadhoo Constituency	Mahinadhoo Constituency, People's Majlis Secretariate	People's Majlis Secretariat, Medhuziyaaraiy Magu, Malé, Maldives	rugym@hotmail.com	+(960)-7907984; 3313216
20	Maldives	Mr. Hamdhun Abdulla Hameed	Hon. Member of Parliament for Inguraidhoo Constituency	Inguraidhoo Constituency, People's Majlis Secretariat	People's Majlis Secretariat, Medhuziyaaraiy Magu, Malé, Maldives	raawouth@gmail.com	+(960)-7772333; 3313216
21	Maldives	Mr. Abdul Bari Abdulla	Hon. Minister of State for Health and Family	Ministry of Health and Family, Malé, Maldives	Ministry of Health and Family, Ameeneemagu, Malé, Maldives	bari@health.gov.mv; or bari7785403@yahoo.com	+(960)-7785403; 3332510
22	Maldives	Ms. Asiyath Mohamed Saeed	Broadcast Development Executive	Haveeru Daily	Haveeru Daily, Ameenee Magu, Post Code 20354, Malé, Maldives. P.O.Box 20103	asiyath@haveeru.com.mv; or asiyath.mohamedsaeed @gmail.com	+(960)-3301162; 7784661
23	Maldives	Ms. Kumiko Yoshida	International Programme Coordinator	UNFPA Maldives Country Office	UN Building, Rahdhebai Higun, Malé, Maldives	yoshida@unfpa.org	+(960)-7901455; 3316940
24	Nepal	Hon. Ms. Ang Dawa Sherpa	Member of Parliament	Constituent Assembly	Kathmandu, Nepal	ang-media@yahoo.com	9841395294
25	Nepal	Hon. Ms. Gayatri Shah	Member of Parliament	Constituent Assembly	Kathmandu, Nepal	onlinegayatri@hotmail.com	
26	Nepal	Hon. Ms. Sapana P Malla	Member of Parliament	Constituent Assembly	Kathmandu, Nepal	sapana@fwld.wlink.com.np	9851023630
27	Nepal	Dr. Praveen Mishra	Secretary	Ministry of Health and Population	Kathmandu, Nepal	praveen.mishra73@ yahoo.com	9851030100
28	Nepal	Mr. Kabiraj Khanal	Under Section Policy, Planning and International Cooperation Division	Ministry of Health and Population	Kathmandu, Nepal	krk.maha@gmail.com	+98412 56772

Annex V *(continued)*

No.	Country	Name	Position	Designation Office	Contact Address	E-mail	Telephone No.
	Delegates						
29	Nepal	B.R. Dotel	Senior Health Public Administrator	Family Health Division/ DoHS/MoHP	Kathmandu, Nepal	brdotel@gmail.com	+977 1 426 2273
30	Nepal	Dr. Mingmar Sherpa	Director	Logistics Management Division/DoHS/MoHP	Kathmandu, Nepal	doctor_mingma@ hotmail.com	+977 1 44 22627
31	Nepal	Mr. Prem Dhakal	Special Correspondent	Republica	Kathmandu, Nepal	premdhakal@gmail.com	
32	Nepal	Mr. Ian McFarlane	UNFPA Representative	UNFPA Nepal	UNFPA CO, Kathmandu	mcfarlane@unfpa.org	5523880
33	Nepal	Dr. Peden Pradhan	Asst. Representative	UNFPA Nepal	UNFPA CO, Kathmandu	pradhan@unfpa.org	5523880
34	Nepal	Mr. Ramji Dhakal	Consultant	UNFPA Nepal	UNFPA CO, Kathmandu	dhakal@unfpa.org	5523880
35	Pakistan	Dr. Firdous Ashiq Awan	Hon. Federal Minister	Population Welfare			
36	Pakistan	Mr. Sardar Saif-ud-din Khosa	Hon. Member of Parliament	National Assembly/ Parliamentarian	F Block PAK Sex Islamabad	dr.firdousashiqawan @hotmail.com	+0092 300 8511638
37	Pakistan	Dr. M Hulki Uz	Deputy Representative, UNFPA, Pakistan	UNFPA Pakistan	UN House, #12, St-17, F/7-2, Islamabad, Pakistan; P.O. BOX 1051	hulki.uz@un.org.pk	92 51 835 5741
38	Pakistan	Mr. Shahzad Ahmed Malik	Chief	Planning Commission (Population)			
39	Pakistan	Mr Parvez Jamil Mir	Anchor person	ARY TV			
40	Pakistan	Mr. Malik Ahmed Khan	Logistics Analyst (RHCS Focal Person)	UNFPA Pakistan	UN House, #12, St-17, F/7-2, Islamabad, Pakistan; P.O. BOX 1051	malik.ahmed@un.or.pk	
41	Pakistan	Dr. Mumtaz Eskar	Director General (Technical Wing)	Ministry of Population Welfare, Islamabad		mumtazes@gmail.com	051-924 6016
42	Sri Lanka	Mr. Chandima Weerakkody	Hon. Member of Parliament	Member of Parliament, Galle District of Sri Lanka	Rosewood Estate, Hapugala, Galle, Sri Lanka	chandimaw@sktnet.lk	94-11-777-747005
43	Sri Lanka	Mr. S.M. Peshala Jayaratne Bandara	Hon. Minister	Minister of Provincial Health of North Central Province	278, 3rd Cannal Road, Polonnaruwa, Sri Lanka		94-11-27-2226565
44	Sri Lanka	Dr. Deepthi Perera	Director	Family Health Bureau	231, de Saram Place, Colombo 10, Sri Lanka	fhb_dir@sit.lk	94-11-2696508
45	Sri Lanka	Ms. Lene K. Christiansen	UNFPA Representative Sri Lanka	UNFPA Sri Lanka	202, Bauddhaloka Mawatha, Colombo 7, Sri Lanka	christiansen@unfpa.org	94-11-2580840

Annex V *(continued)*

No.	Country	Name	Position	Designation Office	Contact Address	E-mail	Telephone No.
	Resource Persons/UN Staff:						
46	Indonesia	Dr. Sumaryati Arjoso	Hon. Member of Parliament	Parliament	UNFPA Country Office Indonesia 7th Floor Menara Thamrin Jl. M.H. Thamrin Kav. 3 Jakarta 10250, Indonesia	Aarjoso@yahoo.com	Ph: +62 21 3141308 Fax: +62 21 31927902
47	Indonesia	Ms. Maria Hartiningsihh	Journalist	Kompass Daily	UNFPA Country Office Indonesia 7th Floor Menara Thamrin Jl. M.H. Thamrin Kav. 3 Jakarta 10250, Indonesia	maria@kompas.co.id	Ph: +62 21 3141308 Fax: +62 21 31927902
48	Indonesia	Ms. Satya Nugraheni	National Programme Associate	UNFPA Indonesia	UNFPA Country Office Indonesia 7th Floor Menara Thamrin Jl. M.H. Thamrin Kav. 3 Jakarta 10250, Indonesia	nugraheni@unfpa.org	Ph: +62 21 3141308 Fax: +62 21 31927902
49	Indonesia	Ms. Siti Fatonah	Head	West Kaliamantan Provincial BKKBN	UNFPA Country Office Indonesia 7th Floor Menara Thamrin Jl. M.H. Thamrin Kav. 3 Jakarta 10250, Indonesia	fsiti01@yahoo.com	Ph: +62 21 3141308 Fax: +62 21 31927902
50	Lao PDR	Prof. Phonethep Pholsena	Hon. Member of Parliament (Vice Chair of committee)	Social and Cultural Committee		P-phonethep@gov.la	856 20 2214792
51	Lao PDR	Mr. Somchith Inthamit	Director of International Cooperation Department	Ministry of Planning and Investment		somchit57@yahoo.com	856 20 5526 604
52	Lao PDR	Dr. Somchith Akkhavong	Deputy Director of Hygiene and Prevention Department	Ministry of Health		suilayraus@yahoo.com	856 21 952 911
53	Lao PDR	Dr. Douangchanh Xaymounvong	National Programme Officer	UNFPA Lao PDR	UNFPA P.O. Box 345, Vientiane, Lao PDR	douangchanh.unfpa@undp.org	856 21 315 547 Ext. 109
54	Mongolia	Mr. Ganbaymba Navaansamdan	Hon. Member of Parliament	Parliament		soyol2007@yahoo.com	
55	Mongolia	Mr. Jyekyei Khalidalda	Hon. Member of Parliament, Chair of Standing Committee on Justice	Parliament		bauko_z1212@yahoo.com	

Annex V *(continued)*

No.	Country	Name	Position	Designation Office	Contact Address	E-mail	Telephone No.
56	Mongolia	Mr. Shinetugs Bayanbileg	RH Adviser	UNFPA Mongolia	UN House, 12 United Nations Street, Ulaanbaatar	bayanbileg@unfpa.org	976-11-323365 x 196
57	Philippines	Mr. Joseph Emile Juico	Hon. Member of Parliament	Congress			
58	Philippines	Ms. Teresa Abesamis	Columnist	Business Women		ctsdbesamis0114@yahoo.com	+63 32 0918 936 8498
59	Philippines	Mr. Benjamin de Leon	Media	FORUM			
60	Philippines	Ms. Suneeta Mukherjee	UNFPA Representative	UNFPA Philippines	30th Floor, Yuchengco Tower, RCBC Plaza, 6819 Ayala Avenue, Makati City	mukherjee@unfpa.org	+63 2 901-0302
61	Resource person	Dr. Michael T. Mbizvo	Director a.i., RHR	WHO Geneva	20 Avenue Appia, CH-1211 Geneva 27, Switzerland	mbizvom@who.int	+41 22 791 5059
62	Resource person	Mr. Jagdish Upadhyay	Chief, CSB	UNFPA Headquarter	220 East 42nd Street, New York 10017, USA	upadhyay@unfpa.org	+1-212-297-5228
63	Resource person	Dr. Kabir Ahmed	Technical Adviser	UNFPA Headquarter	220 East 42nd Street, New York 10017, USA	kahmed@unfpa.org	+212 297 5199
64	Resource person	Mr. William Ryan	Regional Communications Adviser	UNFPA APRO	UNFPA, 12th Floor, UN Building Rajdamnern Nok Avenue Bangkok 10120, Thailand	ryanw@unfpa.org	+66 2 6870118
65	Organizer	Mr. Najib Assifi	UNFPA Representative Thailand/Deputy Regional Director, APRO	UNFPA APRO	UNFPA, 12th Floor, UN Building Rajdamnern Nok Avenue Bangkok 10120, Thailand	assifi@unfpa.org	+66 2687 0102
66	Organizer	Mr. Jayanti Tuladhar	Technical Adviser	UNFPA APRO	UNFPA, 12th Floor UN Building Rajdamnern Nok Avenue Bangkok 10120, Thailand	tuladhar@unfpa.org	+66 2687 0114
67	Organizer	Mr. Steffano Palazzi	Regional Security Adviser	UNFPA APRO	UNFPA, 12th Floor UN Building Rajdamnern Nok Avenue Bangkok 10120, Thailand	palazzi@unfpa.org	+6626870105
68	Organizer	Ms. Naveeda Khawaja	Technical Adviser	UNFPA SRO	UNDP, United Nations House, Pulchowk, Lalitpur, Nepal		

Annex V *(continued)*

No.	Country	Name	Position	Designation Office	Contact Address	E-mail	Telephone No.
69	Organizer	Mr. Raj Gakhar	International Operations Manager	UNFPA Nepal	UNDP, United Nations House, Pulchowk, Lalitpur, Nepal	gakhar@unfpa.org	977-1-5523880
70	Organizer	Mr. Shyam Dongol	Sr. Admin/Finance Associate	UNFPA Nepal	UNDP, United Nations House, Pulchowk, Lalitpur, Nepal	dongol@unfpa.org	977-1-5523880
71	Organizer	Ms. Geeta Shrestha	Programme Associate	UNFPA SRO	UNDP, United Nations House, Pulchowk, Lalitpur, Nepal	shrestha@unfpa.org	
72	Organizer	Mr. Shiv Khare	Executive Director	AFPPD	Phyathai Plaza Building, Suite 9-C., Phyathai Road, Ratchathewi Bangkok 10400, Thailand	afppd@afppd.org	+66 2219 2903-4
73	Organizer	Ms. Sharmila Shewprasad	Programme Associate	AFPPD	Phyathai Plaza Building, Suite 9-C., Phyathai Road, Ratchathewi Bangkok 10400, Thailand	afppd@afppd.org	+66 2 219 2903
74	Consultant	Ms. Judith Amtzis	Report Writer	UNFPA	UNDP, United Nations House, Pulchowk, Lalitpur, Nepal		
75	Consultant	Mr. Marc Westhof	Video Producer	UNFPA	UNFPA, 12th Floor UN Building Rajdamnern Nok Avenue Bangkok 10120, Thailand	mcwesthof@kinocell.com	+6626620421
76	Observer	Mr. Pangday Yonzone	Programme Specialist	USAID			
77	Observer	Mr. Steve Hodgins	Director	NFPA, Nepal			
78	Observer	Ms. Wilda Campbell	Team Leader	SSMP/DFID, Nepal			
79	Observer	Mr. K.P. Bista	Director General	FPAN, Nepal			
80	Observer	Mr. Krishna B. Rayamajhi	Managing Director	Nepal CRS Company, Nepal			
81	Observer	Mr. Andrew Boner	Country Representative	PSI, Nepal			
82	Observer	Mr. Prakash Mani Sharma	Executive Director	Pro Public			
83	Observer	Mr. Cryanendra Chandhany	PA for Minister of Health	NFPHP	MoHP	gyanes38@hotmail.com	+9841 008342
84	Observer	Mr. Heem Sakya	JSI	NFPHP		hsakya@nfhr.org.np	

Annex VI: Country Action Plans

Action Plan for Advocacy on RH/RHCS

Country: Afghanistan **Time frame: August-December 2009**

Dr. Nadera Hayat/Dr. Sitigh/Dr. Fatema/Mrs. Fawzia

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/ Sources	Time Period
1. To involve Parliamentarian in Advantage of Quality Commodity Security (RHCS) for education of MMR and Population Development	1.1 Preparing Presentation and documents According Health RHCS Need 1.2 Present the RHCS Objective, goal and its benefit on MMR Reduction and Population Development to parliament	MoPH	UNFPA Parliament Member	US$800 UNFPA	One month – August 2009
2. To involve Media for Increasing Awareness of Community Regarding Availability of Quality RH/FP Commodity Security of their Choice from the MOPH managed facilities	2.1 Preparing Massages, TV and Radio spots through RH and IEC/BCC unit 2.2 Broadcast of the massages and spots through media	MoPH, IEC, PR, RH, FP	UNFPA Media	US$1,200 UNFPA	2 months – September-December 2009

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Bangladesh **Time frame: August-December 2009**

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/Sources	Time Period
1. Advocacy to key Parliamentarians on RHCS issues	1.1 Consultative meeting with the MPs of Parliament Standing Committees on Ministry of Health and Family Welfare, Ministry of Finance and Ministry of Religious Affairs on Family Planning and ensuring access to RHCS for all	Mr. Md. Mozammel Hossain and Dr. Amanullah, (Hon.) MP, Bangladesh National Parliament	MOHFW/UNFPA Bangladesh	US$2,000	August 2009
	1.2 Dialogue with Chairman of Parliamentary Standing Committee on MOHFW, Finance and Religious Affairs, GoB official of concerned ministries, other key stakeholders, religious leaders and UNFPA on Family Planning and ensuring access to RHCS for all	Dr. Mozzammel Hossain and Dr. Amanullah, (Hon.) MP, Bangladesh National Parliament	MOHFW/UNFPA Bangladesh/BTV		September 2009
2. Round Table meeting with key stakeholders and media personnel (Editors)	2.1 Round Table meeting on Family Planning and ensuring access to RHCS for all	Mr. AKM Rashidul Hasan (Daily Star)	UNFPA Bangladesh		October 2009

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Bhutan **Time frame: 2009**

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/ Sources	Time Period
1. Advocacy	1.1 Sensitizing parliament	Rep. Parliament, UNFPA, and GNHC	MoH, RH programme	US$1,200	Mid-October 2009
	1.2 Engaging media on RHCS	Rep. Parliament, UNFPA, and GNHC	MoH, RH programme	US$800	August 2009

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: India

Time frame: August-December 2009

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/Sources	Time Period
1. Orientation/ sensitization of MDG Parliamentarian Committee and also Population Policy Committee members	1.1 Briefing Hon. Health Minister 1.2 Preparing a brief note and sharing this note with members with draft agenda for their inputs and then finalizing the agenda 1.3 Organizing one day sensitization workshop focusing on MDG5, regional disparities, gaps, and role of parliamentarians 1.4 Follow up with Hon. Health Minister to discuss key advocacy issues in parliament and programme managers	Dr. Mrs. Kakoli Ghosh Dastidar, Hon. Member of Parliament	Department of Health and FW – GOI, UNFPA and AFPPD	US$2,000	August 2009 – October 2009
2. Sensitization and mobilization of media on advocating key RH issues	2.1 Developing a brief note on media advocacy issues in consultation with UNFPA and advocacy wing of MOH and FW 2.2 Sharing note with key media representatives to get their inputs, selecting a core group of media (print and electronic) 2.3 Organizing media workshop 2.4 A declaration signed by media representatives, shared with all media representatives	Ms. Kumkum Chhaddha, Hindustan Times	Advocacy wing of Department of Health and FW – GOI and UNFPA	US$2,000	August 2009 – October 2009

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Maldives **Time frame: August-December 2009**

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/ Sources	Time Period	Output Indicators
1. Assess impact of growing fundamentalists thoughts on RH, FP and gender equality, promote advocacy through moderate religious leaders	1.1 Establish policy dialogue mechanism between MIA and MOHF and Majilis Social Committee, or National Development Committee	MOHF	MIA, Majilis committees	n/a	August	– Declare policy guidelines through media
	1.2 Prepare status report and statistics on trend on fundamentalist behaviour towards RH/FP	MOHF, UNFPA		US$3,000	August-September	– Report and statistics available
	1.3 Conduct advocacy programmes by moderate religious leaders through media	MOHF	MIA, media	US$5,000	August-December	– At least 1 advocacy programme on TV, radio, newspaper quarterly (2 by the end of 2009) – At least 5 televised Friday sermons with advocacy messages on RH
2. Review 2009 UNFPA Country Programme and revise budget allocation for RH advocacy	2.1 Evaluate current Country Programme	MOHF, UNFPA	DNP	n/a	August	– Evaluation and recommendations
	2.2 Reallocate budget to prioritized programmes in this Action Plan					– Revised AWP 2009

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Maldives *(continued)*

Time frame: August-December 2009

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/ Sources	Time Period	Output Indicators
3. Review National Population Policy and revise or adapt to the present situation/ policies	3.1 Coordinate dialogue between DNP, MOHF and UNFPA and confirm/reassign roles and responsibilities in implementing CP	MOHF	UNFPA, DNP, population policy committee (to be reinstalled)	n/a	August	– Synergized National Population Policy and the Government Manifesto
	3.2 Prepare AWP	MOHF, UNFPA		n/a	August	– Funds allocated for sub-activity 3.1
4. Develop Maternal care continuum (MCC)	4.1 Develop the ANC/PNC guidelines specific to Maldives context	UNFPA, MOHF		Already in the AWP	August	– Finalized ANC/PNC guidelines
	4.2 Improve Maternal death audit procedures, share info with media	MOHF		WHO consultant is planned	August-December	– Improved MDA – The results will be available to the media as cases arise
	4.3 Mapping of RH/FP services in the country	MOHF		US$2,000	September-October	– Report is available
	4.4 Community-based CPR assessment to capture the real situation	MOHF		US$10,000	October-November	– Report is available
5. Sensitize media to report more on RH/FP and get the right message across	5.1 Conduct a workshop to sensitize media personnel	MOHF	Maldives Journalist Association	US$5,000		
	5.2 Create a corner in print media to write articles on RH/FP	MOHF	Maldives Journalist Association	n/a		– Once a month article in the corner

Total estimated budget: US$25,000.

Annex VI *(continued)*

Suggested Major Activities:

- Advocate for creating/establishing a budget line with allocation for RHCS – *for those who don't have BL and allocated resources*. Where it already exists: advocate to increase the budget allocations as well as mobilize more resources to ensure the availability of affordable reproductive health commodities.
- Advocate to review of the MDG targets (4 and 5 specifically) and advocate for facilitating/expediting the progress (specific actions, may be 2-3 actions) toward achieving these targets.
- Advocate to organize advocacy meetings/workshops for key stakeholders – for engaging parliamentarians-sensitize media-develop or establish policies and/or strategies, etc.
- Advocate to strengthen/establish/ensure functioning of in-country coordination mechanisms for RH/RHCS – few specific activities for 2009.
- Advocate to maximize/facilitate media coverage – publishing routine/periodic updates, sensitization, advocacy, etc.
- Advocate for few specific activities toward repositioning FP – increase CPR, reduce unmet needs, etc.
- Advocate for specific activities on demand creation: BCC/IEC, target specific population and sub-groups, etc.
- Review/revise/adapt existing national EML to include essential RHCS.

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Pakistan **Time frame: August-December 2009**

Major Activities	Sub-activities	Focal Point/Initiator	Other Partners(s)	Estimated Budget/Sources	Time Period
1. Advocacy for Parliamentarians	1.1 Advocacy to selected MNAs/Senators (Representative of all Provinces)	DG (Tech), (Programme) and (M&S) Ministry of Population Welfare	UNFPA/Member Parliament	US$3,000	September
	1.2 Creating **Parliamentarians' Caucus** to add voice to RH and Population Development	DG (Tech), (Programme) and (M&S) Ministry of Population Welfare	UNFPA/Member Parliament	US$1,500	October
	1.3 Advocacy to CMs and Members of the Provincial Assemblies to add voice to RH and Population Development	DG (Tech), (Programme) and (M&S) Ministry of Population Welfare	UNFPA/Member Parliament	US$4,500	November
2. Advocating for Pakistan Forum of Media for Population and Development	2.1 Work Plan/Road Map	DG (Tech), (Programme) and (M&S) Ministry of Population Welfare	UNFPA/Media	US$500	November
	2.2 Advocacy to media personals (Male/Female) for better RH and Population Services	DG (Tech), (Programme) and (M&S) Ministry of Population Welfare	UNFPA/Media	US$4,000	October
	2.3 Explore possibilities of establishing SAARC Media Forum	DG (Tech), (Programme) and (M&S) Ministry of Population Welfare	UNFPA/Media	US$2,000	December

Total Budget US$15,500.

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Nepal **Time frame: August-December 2009**

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/Sources	Time Period
1. Form a caucus group of Population and Reproductive Health in the Parliament of Nepal to advocate universal free access from MoHP, NGOs/INGOs to RH services and commodity security	1.1 Interact with parliament members of different political parties, confer with Speaker and Secretary General for the formation of the caucus group	Hon. parliament members Ms. Sapana Malla and Ms. Ang Dawa Sherpa, Ms. Gayatri Shah	Parliament members of diverse political parties	–	July – 15 August 2009
2. Conduct a high-level advocacy workshop to sensitize RH needs and RH advocacy among policymakers and the people	2.1 Form a working group among Nepal delegates and partners to support caucus group	UNFPA	Parliament members, MoHP, UNFPA, USAID, JSI/NFHP, CRS, FPAN, Media House (Republica)	–	29 July 2009
	2.2 Prepare a list of invitees e.g., Parliament members, Ministry of Health and Population, Ministry of Finance, USAID, UNFPA, CRS, FPAN, Media people, and other stakeholders	Caucus group of Population and Reproductive Health in Nepal Parliament	MoHP, MOF, USAID, UNFPA, JSI/NFHP, CRS, FPAN, Media people, and other stakeholders	US$2,000/UNFPA	October 2009
	2.3 Identify policy level RH gaps link with MDGs and National RH policies and advocacy activities				

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Sri Lanka

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/Sources	Time Period
Meeting in Parliament to convince Parliamentarians and Provincial Ministers regarding the need to achieve universal access to RH services and commodity security *Chaired by:* **Hon. Minister of Health Care and Nutrition** *Participants:* Parliamentarians (#100) Provincial Ministers (#50) Media personnel (#TBD) Officials from MOH Colombo and UNFPA) *Venue:* Committee Room at Parliament (gratis)	(a) Develop (identify) and advocacy video targeting parliamentarians on the subject; copy video for handout Subject to include unwanted pregnancy, sexual abuse, maternal and infant mortality, targeting underserved populations including IDPs and estate sector (b) Develop/print booklet with relevant data and illustrations on the subject	Mr. Chandima Weerakkody, Hon. MP for Parliament	Family Health Bureau/MOH UNFPA CO Provincial Ministry/NCP Secretary to Parliament	Video: US$2,000 (funding source TBD) Booklet: US$750 Lunch for provincial participants: US$250	First Tuesday in October 2009
Meeting in Anuradhapura in North Central Province to convince regarding the need to achieve universal access to RH services and commodity security *Chaired by:* **Governor of North Central Province** *Chief Guest:* Hon. Minister of Health Care and Nutrition *Guest:* Mr. Chandima Weerakkody, Hon. MP for Parliament	(a) Street drama (b) Copy video (above) (c) Print booklet (above) (d) Hire venue (e) Lunch and refreshments	Mr. Peshala Jayaratne Bandara, Hon. Minister of Health and Social Welfare, NCP	Hon. Minister of Health Care and Nutrition Mr. Chandima Weerakkody, Hon. MP for Parliament Provincial Health and Social Welfare Ministry, NCP	Street drama: US$200 Copy video: US$50 Print booklet: US$100 Venue: US$200 Lunch etc.: US$450	3rd Tuesday of October 2009

Annex VI *(continued)*

Action Plan for Advocacy on RH/RHCS

Country: Sri Lanka *(continued)*

Major Activities	Sub-activities	Focal Point/ Initiator	Other Partner(s)	Estimated Budget/Sources	Time Period
Participants: Chief Minister and Ministers (#5) Provincial Councilors (28) Chief Secretary Secretary to Governor Secretaries to Provincial Ministries (#5) Local Government Heads (#30) Provincial Director of Health Services Provincial Director of Education Regional Directors of Health Services (#2) Medical Officers of Health (#30) Zonal Directors of Education (#8) Media Personnel (#TBD) (Officials from MOH Colombo and UNFPA)			Family Health Bureau/MOH UNFPA CO		
Total				US$2,000 (+ US$2,000 to be identified)	

Asia and the Pacific Regional Office
Bangkok, Thailand
September 2009