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List of ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CCP	Comprehensive Condom Programming
CHWs	Community Health Workers
DCE	Drugs, Commodities and Equipment
DHS	Demographic and Health Survey
EOC	Essential Obstetric Care
EmOC	Emergency Obstetric Care
FBO	Faith Based Organizations
FP	Family Planning
HEOs	Health Extension Officers
HIB	Health Improvement Branch
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HRM	Human Resources Management
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
LLG	Local Level Government
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NDOE	6 National Department of Education
NDOH	National Department of Health
NGOs	Non-Governmental Organizations
PICT	Provider initiated counselling and testing
PLHIV	People Living with HIV/AIDS
PPTCT	Prevention of Parent To Child Transmission of HIV.
PoA	Program of Action
RHCS	Reproductive Health Commodity Security
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YAH	Youth and Adolescent Health

	worker when to ready (alert) and when to take the action into save the life that is utero.
Policy:	A written statement used to guide and determine present and future decision about standards of care
Pregnancy at term:	From 37 completed weeks to less than 42 weeks (259 to 293 days) of gestation
SRH care	The provision and access to quality sexual and reproductive health care services including; adolescence health services, family planning, safe motherhood, PPTCT, STI & HIV, cancer screening services for cervical and breast cancer and prostate screening services and gender-based violence.
Standard of care:	Professionally developed detailed written statements used to guide procedures
Supervised childbirth	Birth of a newborn baby by the assistance of a health worker trained and competent in childbirth
Skilled Birth Attendant	WHO defines an SBA as someone “trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns
Unsafe abortion	An <i>unsafe abortion</i> is the termination of an unwanted pregnancy by persons lacking the necessary skills, or in an environment lacking minimal medical standards or both.
Women of reproductive age:	Usually refers to all women aged 15-49 years. In PNG we have reported maternal deaths from the age of 12.
Stakeholders	Those who may be interested in, potentially affected by, or influence the implementation of the SRH policy. In the context of this policy it applies to human resources for health, development partners, the partner government ministries, NGOs and civil society
Person with disabilities	Persons with disabilities have the same sexual and reproductive health (SRH) needs as other people. Yet they often face barriers to information and services including; family planning, maternal health, HIV and AIDS, adolescence, and gender-based violence.

Foreword

The International Conference on Population and Development (ICPD) held in Cairo in 1994, marked a critical shift in the focus of population programs and underscored the need to meet the sexual and reproductive health needs of individuals and couples, throughout the life-cycle, as a key approach to improving quality of lives of people and stabilizing the world population. Papua New Guinea was among the over 180 countries that approved the historic Program of Action that was the outcome of the ICPD.

Thus, Papua New Guinea committed itself to the operationalization of this concept and the achievement of the ICPD targets in the interest of the health and development of its citizens.

Sexual and Reproductive Health (SRH), as a concept, is a more comprehensive and effective approach than that of maternal and child health and family planning, and actually represents a paradigm shift. Thus, it requires not only a re-direction in programming and service delivery methods, but also needs appropriate policies. It is in this regard that Papua New Guinea has developed this Sexual and Reproductive Health Policy to provide the necessary guidance and framework for the promotion and implementation of reproductive health programs and activities. The ultimate aim of this policy is to serve as an effective national platform for strengthening reproductive health activities in the country and facilitating the achievement of relevant global and regional goals in the interest of improved health, well-being, and overall quality of lives of all peoples in Papua New Guinea. This policy is a further demonstration of Papua New Guinea's commitment to the achievement of the ICPD goals and targets including the MDGs within its national boundaries.

This policy has been developed through a highly consultative process involving various groups of stakeholders at many levels, and thus represents the aspirations of the people and government of Papua New Guinea to achieve an improved reproductive health status. The policy is in consonance with the country's national commitments and development goals as enunciated in the National Health Policy, policies on Maternal and Child Health, National Youth Policy, National HIV/AIDS Policy, and the National Population Policy including that on School Health.

It is our sincere hope that in presenting this policy, we encourage all Papua New Guineans from all walks of life to actively support the implementation of the policy and ensure that the national goals in the area of sexual and reproductive health are attained within the shortest possible time period.

Hon. Michael Malabag, MP, OBE, CBE
Hon. Minister for Health and HIV/AIDS

Acknowledgment

The National Department of Health owes its thanks to many individuals and organizations for their hard work toward the creation of this National Sexual and Reproductive Health Policy. Only through the collaborative efforts of these partners could a document such as this have come to fruition. This policy will provide clarity to the health sector and its partners on sexual and reproductive health information, services; programs and activities in PNG.

I would like to acknowledge the NDoH Health Improvement Branch staff, National Reproductive Health Technical Advisory Committee for their commitment and contributions throughout the process of thinking through and writing this document. AusAID, UNFPA, UNICEF and WHO provided much valuable technical assistance and guidance in the preparation of this document. The staff of the National Department of Health and the national specialists and medical and nursing officers involved in sexual and reproductive health services in government, church and NGO sectors deserve our gratitude for their invaluable insights and contributions. I extend my appreciation also to the former secretary, Dr Clement Malau and former minister, Hon. Sasa Zibe for their leadership and support in the initial formulation of the policy.

The Policy is supported by the work of the Ministerial Taskforce on Maternal Health which recognizes the pivotal role a well implemented sexual and reproductive health policy will play in ensuring that proper standards and quality service are available for women, men, youth and adolescents.

Finally, I look forward to the implementation of the Sexual and Reproductive Health Policy in Papua New Guinea through the health sector of PNG for the benefit of our people, the majority of whom live in the rural areas.

Pascoe Kase (Mr)
Secretary

Facility-based maternal deaths review	when deaths are initially identified at the facility level but such reviews are not only concerned on the treatment and care provided at health facility level, but also with identifying the combination of factors at the facility and in the community that contributed to the death, and which ones were avoidable
Family Planning:	Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility.
Long term family planning methods	Long-term methods (intrauterine devices, implants and sterilization), usually used to limit childbearing, and short-term methods (pills, condoms, spermicides, injectable, other modern methods and all traditional methods), better suited for women who want to delay but not forfeit having a child.
Permanent family planning methods	Vasectomy, and tubal ligation
Gender:	The social constructed roles, behaviours, activities and attributes that are considered by a society to be appropriate for its men and women. People are born female or male but learn to be girls or boys who grow into women and men. This learned, socially reinforced, and often legally enforced behaviour delineates gender roles and relationships.
Gender based violence	The United Nations defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.
Maternal death:	The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any causes related to or aggravated by the pregnancy or its management but not from accidental or incidental causes
Maternal mortality ratio	Number of maternal deaths during a given period per 100,000 live births during the same time period.
Direct obstetric complication	Pregnancy related complications. Which are leading causes of death in developing countries are such as severe bleeding, hypertension in pregnancy, sepsis, unsafe abortion, and obstructed labour. For them simple, life-saving, and cost-effective treatment exists.
Partogram:	A graphic record of the course of labour. It shows the health

ANNEX TWO: GLOSSARY

Abortion	Abortion is the termination of pregnancy by the removal or expulsion from the uterus of a foetus or embryo prior to viability. An <i>abortion</i> can occur spontaneously, or can be induced in which case it is usually called a miscarriage, or it can be purposely induced.
Attitude:	A person view (values and beliefs) about a thing, process or person that often lead to positive or negative behaviour.
Behaviour	A person way of relating or responding to the action of others or to an environmental stimulus.
Communitybased-maternal death reviews <small>based maternal</small> death reviews	A qualitative, in-depth investigation of the causes of and circumstances surrounding maternal deaths occurring at community level, the factors that contributed to the maternal death are discussed, avoidable caused recognized and recommendation provided.
Competence	Sufficient knowledge, psychomotor, communication and decision-making skills and attitudes to enable the performance of actions and specific tasks to a define level of proficiency.
Coordination of care:	A service characteristic resulting in coherent treatment plans for individual patients. Each plan should have clear goals and the necessary and effective interventions.
Counselling	Refers to a process of interaction, a two way communication between a skilled provider, bounded by a code of ethics and practice, and a client/s. It aims to create awareness of and to facilitate or confirm informed and voluntary sexual and reproductive health decision-making by the client it requires empathy, genuineness and the absence of any moral or personal judgment.
Early recognition of risk factors	Recognizing the risk factors at the early stage so as to prepare in advance to treat or refer to higher level facility for proper assess and management to avoid complication.
Early referrals	Refer on time to a higher level facility for proper management before the complications deteriorate.
Essential medicine and equipment:	Emergency medical devices are essential for safe and effective prevention, diagnosis, treatment and rehabilitation of illness and disease.

Executive Summary

This document represents the first National Sexual and Reproductive Health Policy.

The goal of the Sexual and Reproductive Health Policy is to find appropriate solution to the current fragmentation of reproductive health activities and improve the limited impact of existing programs in reducing sexual and reproductive ill health while improving reproductive health and well-being for the PNG population. This policy aims to encourage men's involvement in sexual and reproductive health matters and address the increasing high-risk behaviour of adolescents leading to premarital sexual encounters, early marriage, unintended pregnancies, unsafe abortions and the social consequences such as school dropout with subsequent negative effects;

The following are the SRH policy statements that will guide its implementation:

- Every mother should be given proper comprehensive free of charge antenatal care and nutrition education from first trimester of pregnancy.
- Every child-birth must be assisted by a skilled birth attendant in a health facility.
- Every maternal death should be registered, notified, reported and reviewed at facility level, District level and by the Provincial Maternal Death Review Committee.
- Women/girls and men/boys should have access to modern contraceptives every day of the week to prevent unplanned/unwanted pregnancies and its consequences in all health facilities, free of charge.
- All the population in need should receive correct information, be tested and treated for Sexually Transmitted Infection (including HIV) as per national approved standard guideline.
- There is zero tolerance to all forms of gender-based violence and other harmful practices.
- Men/boys and women/girls should have equal access to quality sexual and reproductive health services.
- Early detection and management of cancers of the reproductive system and breast should be encouraged and promoted.
- Infertility management services shall be promoted and provided in all provincial health care facilities by an appropriately trained provider.
- Men and boys should be encouraged to actively engage in reproductive health.
- Evidence base research recommendation should form the basis for improvement of SRH services delivery.
- NDoH shall maintain central coordination of SRH services and seek political commitment at all levels of government and development partners to implement this policy.

Some of the strategies which will be applied to implement the SRH policy:

Increase access to affordable, high quality maternal and newborn health services including supervised childbirth and post-abortion care while increasing the access to factual sexual and reproductive health integrated (comprehensive of FP) quality services and information .

Ensure that all the maternal deaths are notified and registered and all the stories beyond the numbers are reviewed and recommendations are presented to policy maker for actions. Reduce unplanned and unwanted pregnancy, among adolescents increasing the access to FP while providing sexual and Reproductive Health education and awareness in all schools.

Increase awareness and information to the community on prevention of STI and HIV transmission and Increase the proportion of pregnant women (and partners) that are screened and treated for HIV and syphilis

Provide education and awareness on gender based violence to the community, supporting the establishment of Family Support Centres in all provincial hospitals where appropriate treatment, care and support including counselling will be provided to survivors of gender based and domestic and sexual violence. Enforcement of existing laws and promote enactment of laws to increase the minimum age for marriage and decrease the minimum age for legal consent is paramount. Create gender sensitive management systems in the health sector to enhance gender responsive policies and programs through the application of gender health mainstreaming analysis.

Promote and support awareness activities to increase knowledge on Cancer prevention. Increase the screening sites by Visual Inspection/Acetic acid programs for early detection of cervical cancer, while establishing effective referral system for the management of reproductive tract cancer patients. Reduce the mortality and morbidity from reproductive health cancers through HPV vaccination for young adolescents.

Reduce the incidence and prevalence of infertility through proper management of sexually transmitted infections, post-abortion and post-partum sepsis.

Use of research recommendation's to change policies, planning and improve the implementation of sexual and reproductive health programs. Conduct policy oriented and operational research on sexual and reproductive health throughout the life cycle.

Mother and newborn are, before childbirth and after it, to be considered as one entity, but, to stress the prominence of neonatal care to decrease the IMR in PNG, a Neonatal Health Care policy (NCHP) is to be developed. The NHCP and will guide the National Health System to care for the newborns.

The NDoH will ensure processes are in place to monitor and evaluate the impact, process, outcomes and responsiveness of the reproductive health system in order to know whether the strategies adopted for the implementation of the present policy are producing the expected outcomes and impact. At each level of the system a set of indicators will be developed with, data collected and analysed on a periodic basis. The time frame of this SRH policy will be 10 years.

The NDoH will be the leading agency responsible for the implementation of the SRH policy in collaboration with development partners, NGOs, faith based organization and private sector.

- Dialoguing with the NDOH to ensure their involvement in complementing the government's effort in reducing maternal and child mortality and morbidity rates.

The Medical Schools, Schools of Nursing and Midwifery and other schools of health sciences shall reflect in their curricula, the philosophy of SRH and shall provide appropriate practical training in these areas.

The Medical and allied health Schools in collaboration with the National Department of Health shall incorporate Emergency Obstetric and Neonatal Care in the continuing education curriculum of medical practitioners as CHW and allied professionals so that they can give the needed support to Midwives, where midwives are not available.



4.1.3 District/Local Level Government shall be responsible for:

- Motivate the community by carrying along traditional chiefs, religious leaders, other influential persons, and groups, cultural organizations, elicit the support of formal and informal leaders, for community action in favour of SRH.
- Involve key individuals and groups in the planning and implementation of SRH programs taking special cognizance of women and youths.
- Provide health information to the community in SRH and in such other matters that can enhance the SRH status of all.
- Train the village health volunteers in the delivery of SRH services as per national standards.
- Organize and maintaining linkages and support between VHV and community health/Aid posts serving in their areas.
- Ascertain the availability and maintenance of basic SRH infrastructures.

4.1.4 Non-Government Organizations and Communities:

In collaboration with the national, Provincial and Local Level Governments **shall be responsible for:**

- Providing technical assistance to LLGs on fund raising activities, resource mobilization and utilization, planning, implementation, monitoring and evaluation;
- Identifying the SRH needs of the communities, through studies to provide relevant data;
- Using agreed innovative approaches in addressing SRH needs of the communities;
- Assisting in developing Information, Education and Communication and Behaviour Change Communication materials and programs;
- Training the Village Health Volunteers to delivery SRH services as per National Policy;
- Assist in Supervision, Monitoring and Evaluation programs;
- Mobilizing the community to embark on awareness campaigns to eradicate Harmful Practices such as incest, domestic and other forms GBV;
- Assisting in the development and maintenance of a functional referral system;
- Assisting in the collation and updating of relevant data about SRH;
- Assisting in the retraining of various levels of health workers involved in SRH duties as per national standards.

4.1.5 Mass Media shall be responsible for:

- Creating and maintaining awareness of issues concerning SRH;
- Disseminating of information and accurate reporting on SRH issues;
- Be involved in the networking activities of Non-Governmental Organizations, CBOs, FBOs and relevant health professional bodies.

4.1.6 Professional Groups shall be responsible for:

- Training of professionally competent human resources capable of providing high quality SRH care in community and health facilities;
- Enforcing effective monitoring of the providers at all levels to ensure efficient, effective and quality service within the framework of acceptable ethical standards;
- Support qualified midwives, nursing officers and CHWs to retrain on EmONC in order to reduce maternal and neonatal mortality and morbidity;

CHAPTER ONE - BACKGROUND

The components of the Sexual and Reproductive Health are:

- Prenatal care, safe delivery, essential and emergency obstetric care, perinatal and neonatal care, postnatal care and breastfeeding;
- Family planning counselling, information and services;
- Prevention and management of infertility and sexual dysfunction in both men and women;
- Prevention and management of complications of abortion;
- Provision of safe abortion services **where the law permits**;
- Prevention and management of reproductive tract infections, especially sexually transmitted infections (STIs), including HIV infections;
- Promotion of healthy sexual maturation as from pre-adolescence, responsible and safe sex throughout the lifetime; gender equity and equality;
- Elimination of harmful practices, such as female genital mutilation (FGM), early marriage, domestic and sexual violence against women;
- Management of non-infectious conditions of the reproductive system, such as vesico-vaginal fistula, cervical cancer and reproductive health problems associated with menopause.

1.1 Intent of Policy

The intent of the Sexual and Reproductive Health (umbrella) Policy is to create an enabling environment for appropriate actions aimed at providing the necessary impetus and guidance to national and local interventions and initiatives in all areas of Sexual and Reproductive Health.

The Policy will aim to foster changes in line with the needs of sustainable development that would lead to improvement in the quality of life of all Papua New Guineans and thus resulting in decreased morbidity and mortality among the sexually active target population.

1.2 Historical Context

From 9th to 13th September 1994, Papua New Guinea was among countries at the International Conference on Population and Development (ICPD), which took place in Cairo, Egypt. The ICPD marked the beginning of the paradigm shift from the concept of Maternal and Child Health and Family Planning (MCH/FP) to Reproductive Health, later called Sexual and Reproductive Health. At this conference which was a follow-up of others held in Tehran, Mexico, Budapest; the nations of the world reached an understanding on the key concepts of reproductive health and reproductive rights. All agreed that reproductive health is a right for all men, women and adolescents. The *global* community, at the ICPD, further agreed that reproductive health and rights are indispensable to people's health and development, and set the goal of achieving universal access to reproductive health information and services for the year 2015.

"Reproductive Rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community."(Principle 7.3 of the ICPD PoA)

All the above were re-emphasized at other conferences such as that in Beijing and were moulded together as a development platform at the Millennium Summit. The last (Millennium Summit) led to the formulation of the Millennium Development Goals (MDGs) which all countries agreed to work towards achieving with eight goals and eighteen targets.

1.3 Audience

The policy has been written for all Health care service providers throughout PNG serving in:

- Health Training institutions
- The NDoH
- Provincial Health Authorities
- Provinces
- Public Hospitals
- Non - Government Organisations
- Research Institutions
- Private and Corporate Organisations
- Managers of health care facilities
- Leaders at community, provincial and national levels.

d) Finance:

- Collaborate with national and international agencies and NGOs to secure financial and technical assistance for implementation of SRH programs.

e) Research:

- Encourage the development of a research culture within the National Department of Health, Provincial Health Divisions, up to community level, training and research institutions, private organizations and the mass media, including small scale studies relevant to sexual and reproductive health programs ensuring the full application of acceptable ethical standards.

f) Health promotion Information Education and Communication (IEC):

- Responsible of the adoption of a multidisciplinary approach in disseminating information to relevant national institutions, Provinces, Districts and communities, NGOs, donors, CBOs and other stakeholders on Sexual and Reproductive Health issues;
- Declare a day to create awareness on sexual and reproductive health issues;
- Develop suitable materials for IEC for effective coverage of RH programs.

4.1.2) Provincial Health Authority shall be responsible to:

a) Training:

- Ensure that appropriately qualified and adequately skilled health personnel are available for provision of SRH services;
- Ensure that health personnel update their knowledge and skills on a continuous basis to perform functions relevant to the country's SRH priorities.

b) Services:

- Ensure effective implementation of SRH programs in public and private health institutions;
- Review and provide recommendation to the related Departments on the distribution of existing health care facilities in order to promote equity and access;
- Facilitate intra and inter collaborative approaches to SRH care;
- Lead and coordinate development partners and professional organizations in planning and implementation of SRH services;
- Strengthen a two-way referral system

c) Drugs and Equipment:

- Ensure the regular and timely distribution of drugs; ensuring inclusion of SRH drugs are in the 100 percent health kits;
- Ensure maintenance culture with regard to infrastructure, equipment and vehicles.

d) Finance:

- Explore and implement appropriate mechanism for mobilizing and allocating resources for SRH care including appropriate budgeting and annual activity plan development.

e) Information, Education and Communication& Behaviour Change Communication

- Promote health education and promotion through health personnel, mass media Non-governmental organizations, communities, families and individuals.

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ANNEX ONE: ROLES AND RESPONSIBILITIES OF IMPLEMENATORS AND PARTNERS

The following constitute the major thrusts of the strategic approach to achieving the goals and objectives of the SRH policy.

- Advocacy and social mobilization
- Partnership arrangements
- Promotion of healthy sexual and reproductive behaviours
- Equitable access to quality' health services
- Capacity building
- Research promotion

Further details about strategies and implementation approaches are given in the Sexual and Reproductive Strategic plan which is to be used with this policy concurrently. Please refer to the SRH Strategic plan 2013-20120 for the main activities to be implemented at the central, Provincial and District level of the national Health System. Here below highlighted the responsibility, at the different levels of the health system, for the policy implementation:

4.1.1 National Department of Health is responsible for:

a) Training:

Establish guidelines for planning, organizing, conducting and supervising in service training of all SRH health personnel at all levels. It will provide when required, the appropriate technical support for curriculum development, training, and continuing education modules.

b) Provision of SRH Services:

- Regularly assess the country's SRH profiles;
- Define and ensure standards with respect to the delivery of sexual and reproductive health services ;
- Issue guidelines to assist Provincial and Local Governments to plan, Implement, monitor and evaluate their SRH programs;
- Facilitate and lead intra and inter collaborative approaches to reproductive and sexual health care;
- Initiate and maintain a multi-sectoral approach to SRH care, It shall involve for example, Departments of Agriculture and Water Resources, Education, Communication, Community Development and Women Affairs; Youth Development and Sports Development, Non-Governmental Organizations.

c) Reproductive Health Commodity Security (Drugs, Commodities and Equipment):

- Set guidelines and provide an enabling environment for the procurement of drugs and their supply through a sustainable mechanism to Provinces, Districts and up to the lowest levels of utilization, including NGOs and CBOs;
- Facilitate the procurement and supply of equipment and materials for smooth running of activities relevant to sexual and reproductive health programs in identified health facilities/institutions.

1.4 Policy Development Process

In the formulation of this National Sexual and Reproductive Health Policy, full recognition was given to the sensitivities (cultural and otherwise) that would be involved in its implementation. As the success of the policy will be contingent upon changes in individual behaviour and attitudes, the policy has been formulated keeping in view the essence of PNG cultural and traditional values.

This policy has been developed through an extensive process including:

- Literature review of the evidence base in PNG and internationally on sexual and reproductive health services and development.
- Several stakeholder consultations meetings.
- Several drafts presented by the National Sexual and Reproductive Health Consultative Committee.
- The process has been supported by specialist technical assistance – within PNG and internationally and Development Partners.
- Guided by the Sexual and Reproductive Health Meeting in Madang in February, 2008 and the recommendations arising from the working group discussions.

The final draft was reviewed by a sub-group of the National Reproductive Health Committee in a 1 day retreat, and peer reviewed by the NDoH policy officers.

The Policy was then reviewed and approved by the Senior Executive Management (SEM) of the NDoH. The National Health Board approved the policy and it was presented to the National Executive Committee of the GoPNG in 2010 and due to the new requested format, it was reformatted and re-presented to SEM at the beginning of the year 2013.

CHAPTER TWO - POLICY CONTEXT AND DIRECTIONS

2.1 Goal

The main goal of the Sexual and Reproductive Health Policy is to find appropriate solution to the current fragmentation of reproductive health activities and the limited impact of existing programs in reducing sexual and reproductive ill health toward the improvement of the reproductive health and well-being of the PNG population.

This SRH policy refers specific areas as YAH, Gender, Family Planning and Neonatal health to the respective Policies recently developed.

2.2 Vision and Mission

Vision: A healthy and prosperous nation where sexual and reproductive health services are enhanced to promote healthy and satisfying sexual and reproductive lives of the population.

Mission: Improve and promote quality sexual and reproductive health services that embraces Christian and cultural values through making informed sexual and reproductive health choices within a safe and supportive environment.

2.3 Objectives of the Sexual and Reproductive Health Policy

The principal objective of the policy is to ensure that all Papua New Guineans can achieve better sexual and reproductive healthy lives.

This can be achieved by;

1. Reducing maternal morbidity and mortality due to pregnancy and childbirth.
2. Reducing the level of unplanned pregnancies.
3. Reducing the incidence and prevalence of sexually transmitted infections, including HIV/AIDS.
4. Reducing the incidence and prevalence of infertility.
5. Eliminating all forms of gender-based violence, reducing the gender imbalance in availability of sexual and reproductive health services though men’s involvement in SRH programs.
6. Reducing the incidence and prevalence of reproductive cancers and improve the treatment and care.
7. Promoting research on sexual and reproductive health issues.

CHAPTER FIVE - MONITORING AND EVALUATION

In addition to the general monitoring of indicators of social and economic development, specific indicators for the evaluation of Sexual and Reproductive Health shall be developed by the Technical Advisory Committee in collaboration with the Department of Health Planning and Research of the National Department of Health. Periodic monitoring of each sector shall be carried out to ensure each sector meets its set targets. The National Department of Health shall have the overall responsibility of compiling the reports of the activities of the various sectors, sharing them and itemizing lessons learned and best practices.

5.1 The National Department of Health shall:

- a) Establish a regular channel of communication and information sharing between the National Health Information System (NHIS) and the Public health Division. This to provide information at all levels on progress made in reducing mortality and morbidity arising from sexual and reproductive health issues. NDoH will support the NHIS to provide information at all levels on progress made in all areas of the SRH program including changes in morbidity and mortality arising from sexual and reproductive health problems.
- b) Support the supervision, monitoring, and evaluation of sexual and reproductive health programs at Provincial and District levels. These information will be utilized for annual planning purpose

5.2 The Provincial Health office/PHA shall:

- a) Facilitate data collection, analysis, use and dissemination of information on sexual and reproductive health at District level.
- b) Support the supervision, monitoring, and evaluation of SRH programs at District levels, ensuring and facilitating data collection and processing, use and dissemination of SRH updated information. This information’s will be utilized for annual planning purpose.

5.3 The District and Local Level Government shall:

- a) Monitor the data collection and recording and collate and analyse relevant data about the SRH status and resources, the health status of the population and their utilization of available health services. This information will be utilized for annual planning purpose.

5.4 Non-Governmental Organizations and private sector shall:

- Provide regularly the collected data to the District data managers and assist updating of relevant data about the sexual and reproductive health resources, health status of the population and the utilization of available SRH services.

CHAPTER FOUR - IMPLEMENTATION PLAN

This policy requires effective coordination and collaboration from all relevant stakeholders including the users of the SHR services. Because SHR directly impacts development status of PNG, this policy will be implemented by the different levels of government collaborating with all health service partners in the following manner:

The DoH is the steward for the health sector will coordinate the implementation of this policy based on the Sexual Reproductive Health Strategic Plan 2013-2020 which will be operationalized at the central level through the Corporate Plan and the Annual Implementation Planning process.

The Public Health Division of the DoH will be responsible for coordination and developing overarching partnerships agreements between the state and other relevant partners in implementation SHR services in PNG. Specific requirements of individual partnerships with provinces and districts will be modified, within the framework of overall government policies and legislative requirements.

The Medical Standards Division and Public Health Divisions of the DoH will be responsible for monitoring compliance with the National Health Service Standards and the registration and accreditation of health facilities. The Medical Board of PNG will be responsible for licensing of facilities and health workers. Both the Public Health and Medical Standards will outline referral mechanisms and pathways within the health sector.

The implementation of this policy will be informed and guided by other complementary and subsidiary policies for specific strategies implementation such as the Health Sector Human Resources Policy and the Health Sector Workforce Development Plan.

Provinces and the various partners operating in specific provinces will implement this policy through the Province, Provincial Health Authority and Public Hospitals Service Planning process. Annual Implementation Planning and Budgeting will guide and resource implementation on an annual basis. This will maximize the utilization of limited resources for optimum outcomes.

The total cost of implementing this policy is captured in the Sexual and Reproductive Health Strategic Implementation 2013-2020.

2.4 Principles

The following principles serve as the foundation on which the SRH policy and its programs will be developed and implemented

1. **Human Rights**, where all the clients are respected, protected and have right to be healthy.
2. **Equitable access**, where every client regardless of social status, cultural background, tribal ethnicity as well as geographical setting and urban or rural livelihood is given the same quality of care.
3. **Community Participation**, where men, women and other community members are involved in planning and implementation of the SRH care activities.
4. **Holistic and Integrated approach**, where every client is receiving comprehensive care combining provisions of services for female in the continuum of care from pre-pregnancy, pregnancy, birth/delivery, and post-partum period, for male along all their sexual life span .
5. **Evidence based services**, where every client receiving health interventions that are proved to be effective, documented, and nationally and internationally recognized.
6. **Good Governance**, where implementations of SRH care programs and activities comply with relevant government processes and legislations.
7. **Transparency**, where information on SRH programs and activities are openly shared amongst all relevant stakeholders and partners.
8. **Accountability**, where SRH activities are monitored and relevant stakeholders are liable for their implementation results.
9. **Leadership and ownership**, where the State takes responsibility for the overall coordination and implementation of SRH care program.
10. **Sustainability**, where programs and interventions, after initial support from development partners and other stakeholders, can be successfully continued and maintained with available resources and capacity available in the country.
11. **Cost Effectiveness**, where allocated funds and other resources justified results are achieved.
12. **Partnership**, where SRH care programs and activities are implemented through effective dialogue and collaboration with all relevant stakeholders.
13. **Friendly services**, where all girls and boys, women and men are receiving health care services in supportive, no cost, empathetic and hospitable environment.
14. **Professionalism**, where all SRH care services are provided according to highest possible standard between various professional groups.

2.5 Core Government Legislations and Policies

This policy is in line with the following core Government commitment and policies:

Laws and Acts

- Papua New Guinea Constitution; 1975
- Public Finance Management Act; 1995
- Public Service Management Act (1994)
- NationalMedicineDrugPolicy;of2014Papua New Guinea; 1998
- National Health Administration Act; 1997
- Organic Law for Provincial and Local Level Governments; 1998
- HIV Management and Prevention Act; 2003
- Provincial Health Authority Act 2007
- Public Hospital Act 1994
- Criminal Code of PNG
- Criminal Law (Compensation) Act
- National Council of Women Act
- Sorcery Act
- Equality and Participation Bill
- Family Sexual Violence Act (2012)
- Public Service General Order (2012)
- Lukautim Pikinini Act (2011)
- HIV/AIDS Management Prevention Act (2005)

Policies and Standards

Policies and Standards

- Vision 2050, 2009
- NationalVision2050,Health2009Plan 2 vol. 2011-2020; 2010
- Family Planning Policy; 2009
- Minimum Standards for Village Health Volunteers in Papua New Guinea; 2003
- National Policy on Health Promotion; 2003
- National Policy on Partnerships in Health Sector for Papua New Guinea; 2002
- National Tobacco Control Policy; 2003
- National Policy for Expanded Program on Immunization; 2004
- National Policy on Medical Equipment for Papua New Guinea; 2004
- Child Health Policy; 2010
- National Population Policy 2001-2010; 1999
- National Health Plan 2001-2010; 2011-2020
- Medical and Dental Stores Catalogue; 2002
- Minimum Standards for District Health Services in Papua New Guinea; 2003
- National Family Planning ;Standards2014 Policy for Papua New Guinea; 1995
- Papua New Guinea National Nutrition Policy; 1985
- Health Sector Human Resource Policy -2012
- National Nutrition Policy (1995)
- HealthSectorPartnershipPartnershipPolicyPolicy;(2002)2014
- National Policy on Health Promotion (2003)
- National Youth Policy 2008-2012
- Child Health Policy 2009
- National Gender Policy(2011)
- Mental Health Policy (2011)

- 2. Ensure a regular coordination (with proper monitoring and evaluation mechanisms) is established with other Ministries, Professional Organizations, development partners for a consistent implementation of the SRH policy;
- 3. Ensure that all development partners providing SRH services report the collected data to the National Health Information System.

3.4 Resource, staffing and service implications

Issues related to number and to the quality of the human resources for health which are weakening the implementation of the SRH policy have been highlighted in chapter 3.

Financial implication of the SRH policy implementation is captured in the NHP 2011-2020 and in the Ministerial Task Force 2009 Report discussion on budget. The human resources component will be further developed in the HR Policy and development plan which is to be submitted to the next SMC meeting. The proper implementation of the SRH policy is related as well to the allocation of the Health functional grant in particular for activities related to MCH outreach, facility operation and medical supply. It has to be underlined that any decrease in fund allocation will have implication in staffing and SRH service provision.

Considering the importance of having the SRH strategic plan 2013-2020 costed the exercise has been finalized along with the finalization of the SRH policy by the NDoH Family Health Branch.

Objective Seven: To reduce the prevalence of infertility and sexual dysfunction.

Policy Statement: Infertility management services shall be promoted and provided in all provincial health care facilities by an appropriately trained provider.

Strategy:

1. Reduce the incidence and prevalence of infertility through proper management of sexually transmitted infections, post-abortion and post-partum sepsis;
2. Provide adequate training for health care providers for counselling and management of infertility;
3. Develop national standards for Infertility management;
4. Advocate for the establishment of at least one properly equipped Infertility Management Centre.

Objective Eight: To increase the involvement of men in sexual and reproductive health programs.

Policy Statement: Men and boys should be encouraged to actively engage in reproductive health.

Strategies:

1. Increase male utilization of sexual and reproductive health services;
2. Promote male support for the utilization of sexual and reproductive health services by women and adolescents;
3. Increase male involvement in the promotion and upholding of reproductive rights of women and adolescents;
4. Promote and facilitate, starting from in-service training, up to all level of services, the active involvement of husbands and partners in the support of the pregnant woman during the gestational period (ANC) and the childbirth (in the labour ward).

Objective Nine: To promote research on sexual and reproductive health issues.

Policy Statement: Evidence base research recommendation should form the basis for improvement of SRH services delivery.

Strategies:

1. Develop a SRH research agenda;
2. Build capacity of staff at all levels to conduct research on SRH;
3. Encourage the use of research recommendation to change policies, planning and improve the implementation of sexual and reproductive health programs;
4. Conduct policy oriented and operational research on sexual and reproductive health throughout the life cycle.

Objective 10: To lead and co-ordinate all development partners in the planning, implementation, monitoring & evaluation of SRH activities

Policy statement: NDoH shall maintain central coordination of SRH services and seek political commitment at all levels of government and development partners to implement this policy.

Strategies:

1. Ensure to provide technical advice to province, district, LLG in implementing SRH programs and activities;

- National Disability Policy (2012)
- Youth and Adolescent Health Policy (2013)
- National Health sector Gender Policy (2013)
- Family Planning Policy (2013)
- National FSV Strategy

CHAPTER THREE - POLICIES AND STRATEGIES

3.1 Current Situation& Issue Analysis

1. Sexual and Reproductive Health status of the Population

Available statistics show that the sexual and reproductive health situation in Papua New Guinea is not only poor but appears to be declining from previous levels. Moreover, there is wide regional and geographical disparity in the country. The deteriorating reproductive health situation in the country was confirmed by the Independent Health Sector Review that took place in October 2005. PNG has the highest rate of HIV and AIDS in the Pacific.

Services such as prevention of parent to child transmission of HIV and voluntary counselling and testing services are generally improving, but only about 65% of pregnant women received at least 1 antenatal visit. Only 35% of births (SPAR 2012) are attended by trained health personnel. Family Support Centres have been established only in 11 Provincial and District hospitals where they provide comprehensive services for survivors of Gender based and domestic violence.

1.1 Maternal (and neonatal) morbidity and mortality

Maternal mortality in Papua New Guinea is very high. Forty percent of pregnant women it is estimated that experience pregnancy-related health problems during or after pregnancy and childbirth. The 2006 Demographic and Health Survey (DHS) results showed an increase of MMR from a high of 370/100,000 to a very worrisome 733/100,000 live births. There is a wide geographical disparity with the highest being in the Highlands region. More than 70 percent of all maternal deaths are due to the usual major complications: haemorrhage, infection, hypertensive disease of pregnancy, and obstructed labour, with 15 percent of mothers suffering serious or long-term complications such as pelvic inflammatory disease and infertility. Thirty percent of maternal deaths are reported to be amongst teenage mothers. The number of supervised deliveries in the country has declined between 1991 and 2011 from 52 percent to 35 percent (SPAR 2012) with the majority of deliveries still taking place un-supervised in the communities. Pre-, intra- and post-partum care is generally low, and, considering the high number of sepsis leading to maternal deaths, a special attention has to be dedicated to post-partum care. Up to date there are no official data on unsafe abortion in PNG, but among the maternal death reports received several deaths are due to complication of unsafe abortion.

1.2 Family Planning

The total fertility rate (TFR) has remained high in PNG. The TFR fell from between 4.8 in 1996 to 4.4 in 2006 (an 8% decline); to 4.0 in 2010 (a further 9% decline). Women in urban areas have a lower TFR (3.6) than women in rural areas (4.5), and there are marked differences by region – ranging from 3.9 in the highlands to 4.6 in the Islandsⁱ. In addition, the adolescent birth rate is high. Women aged 15–19 have an estimated birth rate of 70 births per 1000; 22 percent of 19 year olds have at least one child and 6 percent have two or more children.

The utilization of modern contraceptives in Papua New Guinea is still very low with the Contraceptive prevalence (modern methods) at 26 percent for women (15-49 years) in unions, despite a high level of awareness, indicating a potentially large unmet need (DHS 2006). The level of contraception among sexually active adolescents is particularly low, contributing to the high level of teenage pregnancy, unsafe abortions and maternal mortality, among other problems in this age group. On the whole, the total demand for FP is still relatively low as only 35.7 percent of women demanded for family planning according to the 2006 DHS report.

- 6. All blood and blood products as well as other biological products are properly screened for syphilis, HIV and hepatitis B prior to transfusion;
- 7. Ensure the access to SRH services to persons living with disabilities.

Objective Four: Eliminate all forms of gender-based violence and other practices that are harmful to the health of women and children.

Policy Statement: There is zero tolerance to all forms of gender-based violence and other harmful practices.

Strategies:

- 1. Ensure the timely implementation of the National health gender policy ;
- 2. Ensure there is GBV Zero Tolerance policy enforced at work place through the implementation of the Health Sector Gender Policy;
- 4 Promote the enactment of laws to increase the minimum age for marriage and decrease the minimum age for legal consent.

Objective Five: To reduce gender imbalance in availability of sexual and reproductive health services.

Policy Statement: Men/boys and women/girls should have equal access to quality sexual and reproductive health services.

Strategies:

- 1. Set gender sensitive National standards of care based on best practices with emphasis on male involvement in SRH;
- 2. Promote the respectful provision of SRH services to all individuals regardless of their sexual orientation.

Objective Six: To reduce the Incidence and prevalence of cancers of the reproductive system and breast.

Policy Statement: Early detection and management of cancers of the reproductive system and breast should be encouraged and promoted.

Strategies:

- 1. Promote screening programs for early detection of cervical, , breast and prostate cancer;
- 2. Training of SRH service providers in Visual Inspection/Acetic acid to increase the number of screening sites;
- 3. Establish effective referral system for the management of cancer patients;
- 4. Strengthen data base for reproductive health cancers i.e. cancer registries;
- 5. Promote and support awareness activities to increase knowledge on Cancer prevention;
- 6. Reduce the mortality and morbidity from reproductive health cancers through HPV vaccination for young adolescents.

Policy Statement: Every maternal death should be registered, notified, reported and reviewed at facility level, District level and by the Provincial Maternal Death Review Committee

Strategies:

1. Ensure that the National Maternal deaths Review committee meet quarterly to review selected reported maternal deaths, provide feed-back to the provinces and produce bi-annually the National maternal deaths report;
2. Ensure that all the Provinces establish the Maternal Health Task Force and the Maternal Deaths Review Committee and conduct the revision of all the maternal deaths reported;
3. Ensure that all the maternal deaths are reported and reviewed and recommendations are made for actions targeted to improve preventive and curative interventions to prevent avoidable deaths.

Objective Two: To reduce the level of unplanned and unwanted pregnancies

Policy Statement: Women/girls and men/boys should have access to modern contraceptives every day of the week to prevent unplanned/unwanted pregnancies and its consequences in all health facilities, free of charge.

Strategies:

1. Increase the demand of contraceptive use;
2. Increase access and availability to FP information and services to all population in need (including adolescents);
3. Provide pre-service and in-service competency based training on Family Planning;
4. Provide pre-service and in-service training for CLMS to Central level and Provincial level Logistic Officers;
5. Contribute to the implementation of updated SRH education and awareness teaching curricula in all schools;
6. Actively involve VHVs in the information and provision of selected FP methods to the communities;
7. Increase the accessibility to FP services for persons living with disabilities;
8. Strengthen the program in long term and permanent contraceptive methods training for SRH health care providers.

Objective Three: To reduce the incidence and prevalence of STI and HIV.

Policy Statement: All the population in need should receive correct information, be tested and treated for Sexually Transmitted Infection (including HIV) as per national approved standard guideline.

Strategies:

1. Increase the proportion of pregnant women and partners who are screened and treated for HIV and syphilis;
2. Increase awareness and information to the community on prevention of STI and HIV transmission;
3. Increase the proportion of people, including adolescents, who have access to accurate and comprehensive STI information and services;
4. Ensure pre-service and in-service competency based training on management of STIs and HIV for sexual and reproductive health care providers;
5. Establish at least one PPTCT centre in each district of the country;

Couple year protection nationally is 86/1000 women in 15-44 years child bearing age group and, it gives us the amount of contraception necessary to protect one couple per year. Generally, family planning use in PNG decreased between 2007 and 2011. Rates are very low in SHP and Enga provinces. Regionally, there is very low family planning use in the most populous region (Highlands) of the country.

1.3 Sexually Transmitted Infections

National HIV prevalence 2012 is estimated to be 0.9 percent among general population aged 15-49 at the end of 2012, which means there are about 36,000 people estimated to be living with HIV. The trend of the epidemic is showing a slow decline. The Prevalence of HIV at PMGH increased between 2007 and 2010, but in theyear2011, the rate dropped from 2.4 percent to 1.7 percent. It is also interesting to note that prevalence among antenatal mothers at the labor ward is higher than those attending ANC clinics. According to hospital data (PMGH, Goroka Base Hospital etc.), PNG has the highest rate of syphilis in the Pacific, while rates of gonorrhoea and 'other ' STIs, including chlamydia, genital herpes, warts and trichomoniasis, are equally high. Between 25percent and 45percent of HIV positive women pass on the virus to their babies during pregnancy, delivery, or through breastfeeding (in the absence of appropriate care including the administration of antiretroviral drugs), and thus the HIV situation has severe implications for neonatal and child health. From the DHS it was found that 52 percent of men who had sex with one or more non cohabiting partner within the last12 months reported using a condom at the last intercourse while that for women in the same study was 33 percent.

1.3 Youth and Adolescent SR Health

The reproductive health status of the adolescent is poor in PNG. From the DHS (2006) study, the median age at first sexual intercourse was 19 years, with women initiating sex at a much earlier age than men. In Papua New Guinea, the HIV sero-surveillance of Antenatal clinics in 2011 reported HIV infections among antenatal women aged 15-24 years to be 0.74 percent in 2008 and 0.71 percent in 2011. As stated earlier, young people especially girls are the ones most affected by the HIV/AIDS epidemic. Current teenage pregnancy rate is 13 percent and about 30 percent of maternal deaths are reported to be amongst teenage mothers.

1.4 GBV - Harmful practices and reproductive rights

Various harmful practices, which may be encountered throughout the life span, contribute to reproductive ill health in Papua New Guinea and constitute a violation of reproductive rights. Harmful practices that may be encountered in some settings include early marriage, rape and gang rape, incest, puberty initiation rites, labour and delivery practices. The most common forms of gender based violence are wife battering, rape, child sexual abuse, abduction and illegal detention. These practices violate the right to the enjoyment of the highest attainable standard of physical and mental health.

Gender-based violence is widespread throughout the country. Studies have shown the rate of violence against women range from 67 percent to 75 percent. In real terms, many women in PNG (two out of three) have experienced domestic violence and 50 percent have experienced forced sex.ⁱⁱOf those who reported rape, nearly half were under age 15 and 13 percent under age 7. These figures are considered to be among the highest in the world and this is under-reported.

A subtle form of harmful practice is the discriminatory upbringing and socialization of girls and boys to the disadvantage of the girls. This has often led to malnutrition and anaemia in the girl child which can adversely affects their reproductive health during adolescence progressing into their childbearing years.

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2. Male participation

There is a low level of male participation in promoting positive attitude and behaviour and SRH services for men are very limited, usually concentrated to STIs and HIV/AIDS.

3. Community participation

Communities are not well informed on matters concerning their health and thus cannot take ownership of the decision making process.

4. Cancer of cervix

There are no updated national statistics relating to cancers of the reproductive system. In 1982 at the National Health Symposium Dr Mola reported that cervical cancer was reported to be 15 percent of all female cancer and 62 percent of all the gynaecological cancers. Seventeen years later in the very same Symposium the cervical cancer counted for 48 percent of all cancers in female. Evidence exists not only on the increasing incidence of the cancer of the cervix but of its occurrence in a much younger age group.

With increasing life expectancy the reproductive cancers in the elderly male and female will become increasingly evident in PNG.

5. SRH care and human resources

In the year 2009, the health system employed about 13,000 staff and its infrastructure comprises 19 provincial hospitals, 94 urban clinics, 2,192 Health Centres and 447 Health Sub-Centres and about 2,000 AID Posts -- but many more were previously operational (300 closed between 1995 and 2000) affecting those in lower-asset quintiles and those living in remote areas. The number of doctors has increase significantly over the past 11 years (80%), but the number of nurses (which provide SRH care) increased 24 percent over the last 11 years but over the last 5 years there has been a 5 percent decrease in numbers. Similarly community health workers (CHWs) over the last 11 years numbers increased 13 percent, but in the last 5 years declined 17 percent. Availability showed that there are inadequate numbers of all categories of health workers, but midwives cadre is particularly affected with only less than 300 registered midwives in all country.

In PNG the population living in rural area counts for 85 percent of the total , but overall, 52 percent of staff (6,801) are engaged in urban areas (including NDOH, hospitals and urban clinics) and 48 percent (6,262) are deployed to rural areas . The distribution of staff varies considerably by province, with some provinces being significantly less well staffed than others. Fifty four percent of the current workforce is at retirement age or will retire in the next decade.

3.2 Policy Response

The policy objectives and strategies are reflective of specific objectives and strategies of the 2011-2020 National Health Plan and are as follows:

Objective One: To reduce maternal morbidity and mortality due to pregnancy and childbirth.

Policy Statement: Every mother should be given proper comprehensive free of charge antenatal care and nutrition education from first trimester of pregnancy.

Strategies:

- 1. Increase access to correct and evidence based sexual and reproductive health information and services;
- 2. Increase access to, high quality Ante Natal Care (ANC) services with emphasis in supporting the implementation of the MCH integrated outreach program;
- 3. Reduce the prevalence of anaemia and other micro-nutrients deficiencies among women in Reproductive age;
- 4. Ensure that all pregnant women are seen early (during the first trimester) and regularly (at least 4 ANC visits) during their pregnancy;
- 5. Ensure that the routine ANT tests such as Syphilis, HIV, proteinuria and Haemoglobin are available at all sites.

Policy statement: Every child-birth must be assisted by a skilled birth attendant in a health facility.

Strategies:

- 1. Increase access to basic and comprehensive emergency obstetric care (human resources, drugs, equipment, referral ;
- 2. Increase the number and quality (knowledge, attitude, skills) of Health care providers trained in essential obstetric care;
- 3. Ensure that all the facility use the partograph to allow early detection of obstetric and neonatal complication and timely referral;
- 4. Ensure pre-service and in-service competency based training on EONC for SRH health care providers (including CHW);
- 5. Revise the training curriculum to stress the role of the VHV as health promoters and educators for the women their families within the communities;
- 6. Ensure that the delivery rooms comply with the National health services standards;
- 7. Ensure that a functional referral system 24/7days/week provides proper support to the facility designated to deliver supervised childbirth;
- 8. Advocate for the establishment and develop guideline for the establishment of Delivery Waiting Homes close to Health facility that can provide Basic Emergency Obstetric and Neonatal Care (BEONC) and referral or Comprehensive Emergency Obstetric Neonatal Care (CEONC).
- 9. Ensure that all established Community Health Post are staffed with a skilled birth attendance.