

**Republic of Marshall Islands**  
**Ministry of Health**

**National Reproductive Health Policy and Strategy**  
**2016 -2018**



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## ABBREVIATIONS:

AIDS	Auto Immune Deficiency Syndrome	MNH	Maternal and Neonatal Health
ANC	Antenatal Care	MOH	Ministry of Health
ASRH	Adolescent Sexual and Reproductive Health	NCD	Non-communicable Diseases
BCC	Behavior Change Communication	NGO	Non-Governmental Organization
bEmONC	Basic Emergency Obstetric and Newborn Care	OID	Outer Island
CBD	Community Based Distribution	PAP	Prevention of Adolescent Pregnancy
cEmONC	Comprehensive Emergency Obstetric and Newborn Care	PEP	Post Exposure Violence
CEDAW	Convention for the Elimination of All Forms of Violence Against Women	PMTCT	Prevention of Mother to Child Transmission
CEP	Continuing Education Program	PNC	Postnatal Care
CPR	Contraceptive Prevalence rate	PSRO	(UNFPA) Pacific Sub Regional Office
FLE	Family Life Education	RH	Reproductive Health
DHS	Demographic Health Survey	RHCS	Reproductive Health Commodity Security
EmONC	Emergency Obstetric and Newborn Care	RTI	Reproductive Tract Infections
FBO	Faith Based Organization	RMI	Republic of Marshal Islands
FP	Family Planning	SDG	Sustainable Development Goals
FGM	Female Genital Mutilation	SGBV	Sexual Gender Based Violence
GBV	Gender Based Violence	SMS	Short Message Service
HCP	Health Care Provider	SOP	Standard Operating Procedure
HIV	Human Immunodeficiency Virus	SPC	Secretariat of the Pacific Community
ICPD	International Conference on Population and Development	SRH	Sexual Reproductive Health
IEC	Information Education and Communication	STI	Sexually Transmitted Infection
IMR	Infant Mortality Rate	TB	Tuberculosis
LBW	Low Birth Weight	TFR	Total Fertility Rate
MCH	Maternal and Child Health	UNFPA	United Nations Population Fund
MDG	Millennium Development Goal	UNICEF	United Nations Children's Fund
MISP	Minimum Initial Service Package	VLBW	Very Low Birth Weight
MMR	Maternal Mortality Ratio	WHO	World Health Organization
		WUTMI	Women United Together Marshall Islands
		YTYIH	Youth to Youth in Health

## FOREWORD

### MESSAGE FROM THE MINISTER OF HEALTH & SECRETARY OF HEALTH

Sexual and Reproductive health (SRH) which is a development issue contributing to death and disability that affect many families is a priority area for the Republic of Marshall Islands. The Republic therefore recognizes that high quality SRH services are a must for all the people of the Republic. The adoption and launching of the National Sexual and Reproductive Health Policy demonstrates government's commitment in providing optimum SRH services to its population.

This policy, complemented by a strategy providing details on how the policy provisions will be implemented, recognizes the country's vast SRH needs and forms the basis and mandate for all SRH activities, outlining the national policy direction for improving SRH in the Republic of the Marshall Islands. It therefore outlines Government's approach to SRH and articulates the framework within which high quality SRH services will be provided to those in greatest need and most vulnerable countrywide in partnership with communities, national and international partners. It will therefore also facilitate creation of an environment that is conducive to addressing SRH needs in the country including funding and resource allocation to facilitate implementation of the policy.

It has been developed at an opportune time when the ICPD Agenda is being reaffirmed globally and reflects the Republic's commitment to the achievement of the ICPD goals including the new Sustainable Development Goals endorsed in September 2015 to replace the Millennium Development Goals. The policy is also aligned to key National frameworks.

The SRH policy and strategy, with clearly defined outcomes and expected results, is expected to foster a mutual focus on results and accountability. It is my hope therefore that the articulation of the SRH policy will not be an end in itself and that progress with implementation will be closely monitored and reported on a regular basis.

It is important that we not only sustain the progress that the Republic of the Marshall Islands has made over the last two decades but we need to also rid our country of all preventable SRH morbidity and mortality and ensure that the vision of this policy is achieved.



A handwritten signature in black ink, appearing to read 'Kalani Kaneko', written over a white background.

Honorable Kalani Kaneko  
Minister of Health



A handwritten signature in black ink, appearing to read 'Kennar Briand', written over a white background.

Dr. Kennar Briand  
Interim Secretary of Health

## **ACKNOWLEDGEMENT**

The Ministry of Health would like to express its deep appreciation to all who contributed to the development of the Reproductive Health Policy and strategy document which will guide reproductive health service provision in the country. We are indebted to all who worked tirelessly throughout the whole development process. The leadership and guidance of the Ministry of Health is highly appreciated.

We extend special appreciation to all stakeholders for their inputs which enabled finalization of this important document. Special thanks are extended to the Sexual and Reproductive Health Committee members for drafting the Reproductive Health Policy and Strategy and ensuring timely completion of this crucial document.

Lastly but not least, special recognition and thanks goes to the United Nations Population Fund which provided technical guidance and financial support for the whole policy development process without whom the document could not have been finalized.

## 1. INTRODUCTION

The Government of the Republic of the Marshall Islands (RMI) recognizes reproductive health not only as a right, but also as a pillar of sustainable social and economic development. That is why RMI is signatory to the International Convention on Population and Development (ICPD) Programme of Action and other key international resolutions and conventions that strive to improve Sexual and Reproductive Health (SRH), such as, the Millennium Development Goals (MDGs), the Convention for the Elimination of All Forms of Violence Against Women (CEDAW), and more recently the Sustainable Development Goals (SDGs). RMI is committed to fulfilling its commitments to the SRH of its citizens. It therefore goes without saying that the availability of good quality SRH services is a critical social and economic investment benefit to the family and to the country.

The World Health Organization (WHO) defined RH as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Reproductive health addresses reproductive processes, functions and systems at all stages of life. Thus, RH does not only focus on diseases, it is about human responsibility, safety, satisfaction, capability, and the freedom to decide when to have children.

In the context of primary health care, the International Conference on Population and Development (ICPD) defined RH care components as follows:

- a. Family planning;
- b. Antenatal, safe delivery, and post-natal care;
- c. Prevention and appropriate treatment of infertility;
- d. Prevention of abortion and management of the consequences of abortion;
- e. Treatment of reproductive tract infections;
- f. Prevention, care and treatment of STIs and HIV/AIDS;
- g. Information, education and counselling, as appropriate, on human sexuality and reproductive health;

- h. Prevention and surveillance of violence against women, care for survivors of violence and other actions to eliminate traditional harmful practices, such as Female genital mutilation (FGM).

The ICPD projects the concept of RH care as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive and sexual health problems, whilst the MDGs included and integrated references to RH social and cultural determinants as well as specifying targets in maternal and reproductive health.

Review of both the ICPD and MDG in 2014 showed that the RMI has made significant progress towards achieving both the ICPD and MDG goals over the last two decades. Access to basic health services throughout the country is generally good despite many challenges such as geographical and topographical related. Despite progress made, RMI like most other countries, enters the post 2015 era with unfinished business of the MDGs.

This RH Policy accompanied by the implementation strategy for the Republic of Marshall Islands draws from ICPD program direction, the new Sustainable Development Goals which replaced the MDGs in September 2015, the Republic of Marshall Islands National Health Plan (years); the Family Planning and Reproductive Health Needs Assessment, 2014; and Achievement of Universal Access to Reproductive Health Services and Commodities and the Pacific Policy Framework 2008-2015.

The SDGs, whilst more ambitious and bolder than the MDGs, augur well with the forward looking Vision 2018 of the RMI developed 2003, which focuses on major development priorities including the eradication of poverty, hunger, and gender inequality.

Vision 2018 states: “ to become a country within an inter-dependent world, with an enhanced socio-economic self-reliance, an educated, healthy, productive, law-abiding and God-loving people in which individual freedom and fundamental human rights are protected and culture and traditions are respected and development and environmental sustainability are in harmony”

It is for this reason therefore that RMI has embraced the relevant SDGs into this Policy. This policy document is also the outcome of an exhaustive exercise, involving all key stakeholders, led by the Reproductive Health Unit with technical assistance from the UNFPA Pacific Sub Regional Office (PSRO).

## **2. CONTEXT**

### **2.1 Geography and demography**

The Marshall Islands are located in the Central Pacific Ocean, approximately 2,000 miles southwest of Hawaii and 1,300 miles southeast of Guam. They are comprised of 29 scattered chains of remote atolls, the Eastern Ratak (Sunrise) and Western Ralik (Sunset).

The total land area is 181 square kilometers and has some 370 km of coastline (less than 0.01 percent of the total surface area). The Marshall Islands face great challenges in the delivery of basic health services. Transportation and communications are limited by the isolated nature of many of the islands and atolls.

Two-thirds of the population lives on the two major urban atolls, Majuro and Kwajalein (including Ebeye Island). Population densities in some of the urban settlements exceed 28,000 people/km<sup>2</sup>. More than half of the RMI total population lives in Majuro.

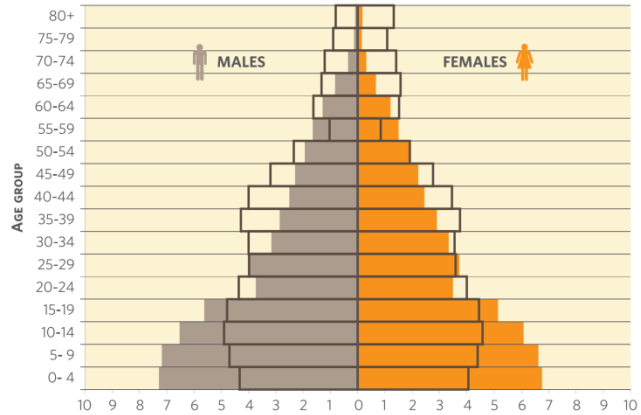
The total population count of the 2011 census is 53,158; which increased only by 2,300 people since the last census in 1999. The slow growth of the population in the country is primarily caused by the emigration of the Marshallese to the United States and elsewhere. (UNFPA, 2014)

**Table 1: Population composition in Marshall Islands, UNFPA Estimated, 2014**

**Age composition (2014)**

Age composition	Value
Population 0- 14 (%)	40
Population 15- 24 (%)	18
Population 25- 59 (%)	37
Population 60 and older (%)	5

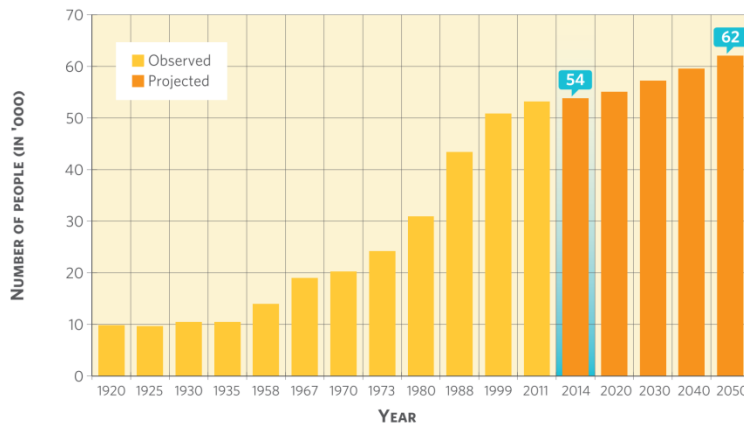
**Figure 1: Population in RMI by age and sex: 2015 (Shaded area) and 2050 (Outlined)**



Source: Population and Development Profiles: Pacific Island Countries. UNFPA Population projection, 2014)

The Total Fertility Rate (TFR) which has declined slowly over the last three decades stands at 4.1 nationally, with urban areas recording 3.9 and 4.5 in the rural area (2009-2011). The RMI has the highest teenage fertility rate in the region. As a result of high levels of fertility, the Marshall Islands has one of the youngest populations in the region. Forty percent (40%) of the population age is below 15. (UNFPA, 2014)

**Figure 2: Population Trend in Marshall Islands, 2014**



(Source: Population and Development Profiles: Pacific Island Countries. UNFPA Population projection, 2014)

## 2.2 Health Status

The life expectancy at birth in RMI is 71.3 for males, and 72.5 for females. The average maternal mortality ratio is 80 deaths per 100, 000 live births. Over ninety percent (94.1%) of pregnant women are managed by skilled attendants at the delivery.

The RMI has a high teenage fertility rate, and this is much more prevalent in the outer islands. Over eighteen percent (18.68%) of teenage mothers have low birth weight (LBW) babies. Trends with teenage pregnancy and outcomes of births in teenage mothers from 2008 to 2012 are provided in the table below.

According to the Ministry of Health's statistics, unmet need for contraception was 8.1 in the 2007, but had decreased to 2.4 in 2009. The HIV prevalence rate is low at 0.031%. However, the prevalence rate for chlamydia trachomatis infection remains high. (UNFPA, 2014).

**Table 2: Teenage Pregnancy: Mother's age is less than 20 years old (2012 MOH Report)—**

Description	2008	2009	2010	2011	2012	2013
Teen Pregnancy	253	232	198	122	182	177
VLBW for Teen Pregnancy	5	2	3	4	3	0
LBW for Teen Pregnancy	53	43	37	40	34	28
Premature Teen Pregnancy	31	18	10	9	3	
% of Teen Pregnancy from all birth	17%	14%	14%	15%	14%	14%
Teen Pregnancy rate per 1,000 population	39	36	31	41	34	33

## 2.3 Health System

The RMI has a well-developed public health system. There are two main hospitals, Majuro Hospital and Ebeye Hospital, and 56 health centers. Both hospitals offer out-patient, in-patient, Public health clinics, and other services. There are also two private clinics and one pharmacy

located in Majuro. Special health care services, called 177 Health Care Programme, have been set up for the four atolls affected by the nuclear testing.

The two main hospitals provide primary/secondary and some tertiary care services to the urban areas including surrounding islands through referrals and medical evacuation. Moreover, patients are also referred to off-islands hospitals in the Philippines and Hawaii for tertiary care.

### **3. THE POLICY DEVELOPMENT PROCESS**

Following the recommendation from international and regional development agencies; the government of RMI is very active in improving the safe motherhood/making pregnancy safer, family planning and other services in the country.

The RMI Reproductive Health Policy and Strategy development was led by the Ministry of Health with technical and financial support from UNFPA. This involved consultations with key stakeholders in September, 2014. The representatives from government and non-government organizations attended the meeting (see annex 1: List of participants).

The causality analysis was made prior to set up of the policy statements. The analysis helped to identify the strengths and weaknesses, and other factors affecting Reproductive Health Services in RMI. The policy statements are derived from the experiences from implementation of the current intervention as well as addressing of the gaps.

The overall policies and commitment are stated toward improving health care, particularly to Reproductive Health Services.

#### **3.1 Guidance principles and Values**

The description of the values and principles of this policy are based on the following parameters:

- **National ownership and country leadership.** Ensuring government-driven leadership for effective interventions that are planned and implemented according to national priorities and the specific needs of the population;
- **Rights bases approach** and respect for the reproductive rights for all individuals recognizes the fundamental right to health and the particular needs of underserved

populations, especially those of women, youth and populations in rural and remote areas, in the provision of services;

- **Gender and culturally sensitive** participatory, aim to put emphasis on gender mainstreaming, equal opportunity to all citizens (including the marginalized) irrespective of their social status, religion, or beliefs.
- Ensure **universal coverage of comprehensive evidence based quality SRH services** including coverage for essential **SRH services in crisis situations** from the outset of an emergency situation.
- **Service integration.** Service provision will be integrated to maximize the effectiveness of resource utilization
- **Multidisciplinary approach-** Involve all sectors linked to health such as education, Law and Order, Justice, labor, and other disciplinary partners.

#### **4. POLICY AND STRATEGY FOR REPRODUCTIVE HEALTH**

The policy is based on the specific context of RMI and aims to assist the RMI's health system to provide quality Reproductive Health care for all. The policy document does not only focus on diseases but also ensures that the people of the RMI receive complete comprehensive care including support for physical, mental, and social wellbeing.

This policy has been formulated within the remits of various consultations with key stakeholders, it is aimed to enable the RMI meet its commitment to achieving SDGs particularly SDGs 3 and 5 and also contribute to the achievement of all the other SDGs.

##### **4.1 Vision**

This policy envisions a highest level of Health and well-being for all the people of the Republic of Marshall Islands population with universal access to quality Sexual and Reproductive Health and Rights services.

## 4.2 Mission

The mission of this policy is to create a conducive environment for reduction of morbidity and mortality by ensuring universal access to quality sexual and reproductive health and rights provided in an equitable and sustainable manner.

## 4.3 Key Policy Areas, Policy Statements and Strategic Areas

In order to achieve the stated vision and mission, Key Policy Areas (KPA) on the priority SRH elements that the Government of the Republic of Marshal Islands shall implement with partners are provided. These include:

- Key Policy Area 1: Maternal and Neonatal Health Care
- Key Policy Area 2: Provision of Family Planning
- Key Policy Area 3: Adolescent Sexual and Reproductive Health
- Key Policy Area 4: The control of STIs/HIV and on integration with other SRH programs
- Key Policy Area 5: Other gynecological morbidities: abortions, infertility, and menopause
- Key Policy Area 6: Cervical, Breast and Colon Cancer
- Key Policy Area 7: Gender and Reproductive Health
- Key Policy Area 8: Men involvement in Reproductive Health
- Key Policy Area 9: Reproductive Health Commodity Security

For each of the KPAs, Policy statements and Strategic Areas on the priority SRH elements that the Government of the Republic of Marshal Islands shall implement with partners are described.

### 4.3.1 Key Policy Area 1: Maternal and Neonatal Health

**POLICY STATEMENT:** Quality Maternal and Newborn health information and services shall be available and accessible at all levels of care for improved Pregnancy and Neonatal Outcomes

The intention is to ensure that all women receive appropriate health care throughout pregnancy and childbirth including proper nutrition and lead a healthy life style during pregnancy with appropriate antenatal care, prevention of complications, early and effective diagnosis and the

treatment of complications. The objective is to ensure women and their babies are safe throughout pregnancy, during and after delivery.

Strengthened quality of antenatal care services at peripheral health centres and increased number of qualified midwives are needed to meet the current high demand of antenatal services. Women should be encouraged to receive antenatal services from community clinics. Facilities should be equipped to ensure private consultations and relevant screening and treatment. All facilities should have running potable water.

#### **STRATEGIC AREAS AND ACTIVITIES:**

<b>STRATEGIC AREA 1.1:</b> Ensure that every pregnant woman is provided with quality antenatal care
1.1.1 Promote early ANC booking (before 12 weeks) and initiate pre-natal classes at first booking at all service delivery points
1.1.2 Develop, introduce, implement and monitor implementation of antenatal and postnatal guidelines and protocols for all centers
1.1.3 Define and adopt a full package of ANC (including PMTCT) interventions as defined in the guidelines and protocols.
1.1.4 Define and monitor use of the referral system for emergency antenatal mothers
1.1.5 Increase coverage of ANC service provision in hard-to-reach areas through outreach
<b>STRATEGIC AREA 1.2:</b> Ensure that all pregnant women have access to emergency obstetric and newborn care

- 1.2.1 Develop a Continuing Education Program (CEP) for the on-going up skilling of health care providers in emergency obstetric and neonatal care competency and skills
- 1.2.2 Develop human resource strategy to ensure appropriate number of midwives are placed in all facilities expected to conduct deliveries
- 1.2.3 Upgrade health care facilities to comply with the signal functions of bEmONC and cEmONC standards
- 1.2.4 Strengthen on-going training of traditional birth attendants (TBA) for promotion of ANC and early referral of pregnant women
- 1.2.5 Update, implement and monitor use of clinical guidelines and obstetrics protocols including labour and delivery, use of partographs, active management of third stage of labour and post-delivery care
- 1.2.6 Strengthen communication and referral strategies amongst all levels of care
- 1.2.7 Develop clear referral system, facilitate prompt referrals of high risk cases to the main hospitals
- 1.2.8 Establish waiting areas/houses adjacent to health care facilities for near-term expectant mothers from remote areas for improved access to skilled attendance at delivery
- 1.2.9 Strengthen laboratory services to ensure that blood bank is operational at all hospitals

**STRATEGIC AREA 1.3:** Strengthened access and availability of quality Neonatal Care and Post-natal care

- 1.3.1 Review and update existing policies, guidelines and tools
- 1.3.2 Strengthen the capacity of the health system at all levels for efficient and effective delivery of services for the newborn, including resuscitation, thermal regulation, infection prevention and promotion of early and exclusive breastfeeding
- 1.3.3 Strengthen on-going training of TBAs for promotion of PNC and early newborn care including early referral of pregnant women
- 1.3.4 Advocate for resource allocation for PNC programme ensure funding for supplies
- 1.3.5 Strengthen notification of all births to the nearest health facility

**STRATEGIC AREA 1.4:** Strengthen quality of maternal and newborn care, monitor and evaluate practice.

- 1.4.1 Regular monitoring to ensure that service delivery points comply with a basic and/or comprehensive obstetric and newborn care standards as appropriate
- 1.4.2 Strengthen support supervision and mentoring of staff in the districts/provinces and outer islands
- 1.4.3 Put measures in place for maternal and perinatal death tracking and reviews, including maternal and newborn mortality audits (MPDSR) in health facilities
- 1.4.4 Establish/strengthen notification of all maternal and perinatal deaths to the appropriate authorities at all levels of the MOH

**STRATEGIC AREA 1.5: Community awareness and participation on Maternal and Neonatal Health**

- 1.5.1 Engage communities on their role in supporting MNH to ensure birth preparedness and complication readiness including assisting with transport, early identification and referrals of complications, postnatal care and registration of births
- 1.5.2 Raise awareness and promote Maternal and Neonatal Health to ensure communities are informed about pregnancy and the need to ensure pregnant women receive appropriate antenatal, EmONC and postpartum care

**4.3.2 Key Policy Area 2: Provision of Family Planning**

**POLICY STATEMENT:** Quality Family planning information and services shall be available at all levels of care and accessible to every individual (regardless of sex, gender, age, status, sexual orientation and religion) or couple according to their needs.

Family planning reduces health risks in women and gives them more control over their reproductive lives. It allows people to attain their desired number of children and determine the spacing of pregnancies. Meeting unmet need for family planning will lead to reduction in maternal mortality and teenage pregnancy.

Family Planning is the means by which individuals and couples can freely and responsibly choose the number of children they want, when they want them for the health and well-being of themselves and their family.

Confidentiality, privacy and promotion of human and reproductive rights for each client seeking contraceptive service should be respected, as consistent with the constitution of RMI.

All clients have the right to information about each method and should be supported to make informed decisions about family planning, free of coercion in a private and comfortable environment that ensures confidentiality. Contraceptive methods should be prescribed on the basis of informed choice with effective counselling.

**STRATEGIC AREAS AND ACTIVITIES:**

<b>STRATEGIC AREA 2.1:</b> Strengthen counselling of clients to ensure informed decision in determining their contraceptive method of choice	
2.1.1	Develop FP counselling guidelines and training manual for the FP/RH/Maternity/PH/Dispensaries staff
2.1.2	Develop CEP for HCP to improve counselling skills to facilitate selection of appropriate contraceptive methods, and ensure proper documentation at all visits
2.1.3	Provide regular support supervision visits
2.1.4	Conduct regular monitoring and evaluation of services including getting feedback from clients
2.1.5	Assess client satisfaction with counselling services provided
<b>STRATEGIC AREA 2.2:</b> Strengthen the community awareness on Family Planning and where to access services	
2.2.1	Strengthen strategic health communication on FP to the community
2.2.2	Advertise access points for FP services and commodities
2.2.3	Build capacity of community health workers and school health advocates of the FP clinic
2.2.4	Facilitate community dialogues on Family planning
<b>STRATEGIC AREA 2.3:</b> Strengthen the availability and access to a full range of modern contraceptive methods at all levels of care including the community level	
2.3.1	Increase access to existing FP methods and method mix including condoms

- 2.3.2 Review and update the essential medicines list to include newly adopted modern contraceptive methods
- 2.3.3 Provide technical guidance and provide tools (standards, guidelines and protocols) to facilitate provision of FP services at all levels
- 2.3.4 Conduct training of service providers (including CBDs) and equip facilities to deliver quality comprehensive family planning services
- 2.3.5 Supply wide range of quality family planning services and methods at all service delivery areas/points including the community level
- 2.3.6 Increase access to family planning services by strengthening community based and school based family planning provision
- 2.3.7 Provide regular support supervision visits
- 2.3.8 Conduct regular monitoring and evaluation of services
- 2.3.9 Assess client satisfaction with services

**STRATEGIC AREA 2.4: Law and policy review to facilitate rights based family planning services**

- 2.4.1 Review of scope of practice of midwives and nurses to provide FP interventions such as Jadelle and vasectomy
- 2.4.2 Advocate for access to services by young people without parental consent
- 2.4.3 Protection of health care providers for providing services to young people
- 2.4.4 Community based distribution of FP commodities

**4.3.3 Key Policy Area 3: Adolescent Sexual and Reproductive Health**

**POLICY STATEMENT:** Family Life Education, information and integrated SRH services shall be provided to all children, adolescents and young people in RMI at all levels of health care delivery systems and other relevant settings according to their age and need.

An adolescent is at a transitional stage of change from childhood to adulthood. In this stage, young people undergo different changes in their life which include physical, emotional, social, and also gain a sense of identity and values. During this period attention to the sexual and reproductive health, and the prevention of sexually transmitted infection including HIV/AIDS is

very important. Addressing adolescent sexual and reproductive health may delay first pregnancy, reduce maternal and child mortality, and facilitate adolescents reaching their full potential in life. Adequate access to the full range of adolescent SRH services should therefore be ensured.

Adolescent Sexual and Reproductive Health (ASRH) includes prevention of teenage pregnancy, STI/HIV; the provision of Information, Education and Communication including family life education; the provision of youth friendly services; the review and development of youth friendly policies and youth participation.

**STRATEGIC AREAS AND ACTIVITIES:**

<b>STRATEGIC AREA 3.1: Ensure the rights of young people are protected</b>
3.1.1 Create awareness on existing laws and policies which enable access to adolescent health services
3.1.2 Facilitate implementation of policies and laws – e.g. Patients privacy laws, Domestic Violence Act
3.1.3 Review and adopt policies that will enhance the services for Adolescent Sexual and Reproductive Health
3.1.4 Advocating for Social Services under the Ministry of Health
<b>STRATEGIC AREA 3.2: Strengthen youth-friendly ASRH educational program that offer school-based and teacher-facilitated information for different age groups</b>
3.2.1 Create awareness on Family Life Education to parents and communities
3.2.2 Advocate for introduction of FLE program with Ministry of Education
3.2.3 Introduce mandatory Family Life Education in Schools but with an option to opt-out
3.2.4 Closely monitoring and evaluate program from the development to implementation
3.2.5 Integrate adolescent SRH/STI/HIV issues into schools and youth programs
3.2.6 Set up a referral system from schools to public health programs (STD/HIV, FP, TB, Immunization and other programs)
<b>STRATEGIC AREA 3.3: Ensure the availability of and access to youth-friendly services that address the needs of young people</b>

- 3.3.1 Support expansion of the number of health facilities offering youth friendly reproductive health services
- 3.3.2 Roll out youth friendly outreach services to outer islands
- 3.3.3 Develop Youth Friendly Services Guidelines
- 3.3.4 Build the capacity of staff and volunteers to enable them provide youth friendly ASRH services
- 3.3.5 Develop Monitoring and Evaluation plan for regular review of health services and data for informed decisions and evidence-based programming
- 3.3.6 Establish Platform for youth and adolescents to share their concerns

**STRATEGIC AREA 3.4:** Increased awareness and acceptance of youth friendly services through systematic, coordinated community engagement activities (including peer-led initiatives)

- 3.4.1 Improve access to information through multimedia campaigns for reproductive health among young people (including Tobacco, Alcohol, and Substance Abuse etc.)
- 3.4.2 Support initiatives aimed at creating reproductive health awareness among youth in difficult circumstances (youth in street, pastoral communities, youth with disabilities etc.)

**STRATEGIC AREA 3.5:** Promotion and support for youth participation and representation in SRH decision making

- 3.5.1 Establish mechanisms for youth to be incorporated in health decision-making, particularly in the area of SRH
- 3.5.2 Declare and observe Teenagers Awareness Day

**4.3.4 Key Policy Area 4: The control of STIs/HIV and integration with other SRH programs**

**POLICY STATEMENT:** Comprehensive information, services and support shall be provided to all individuals for prevention and management of STIs and HIV including linkage and integration into other SRH services for improved access.

Sexually Transmitted Infections (STIs) have a great impact on sexual and reproductive health. It can lead to serious consequences beyond the immediate impact of the infection itself. Prompt

treatment can help prevent the complications of some STIs as well as prevent further transmission. Several factors that contribute to the rise of infection include sexual attitude and life style, social economic factors, rape and violence. STIs including HIV are still strongly stigmatized. Thus, management of STI should be more comprehensive and should be looked at beyond the disease.

Based on case reporting, the rate of HIV in RMI is low, however, the rate of STI/RTI is high particularly Chlamydia. Hence the need for control of STI has become urgent since STIs are now recognized as independent risk factor for HIV transmission as well as associated with significant STI morbidity for both males and females.

Delivering services for both STI-HIV and SRH target the same population. Clients seeking SRH services and those seeking STI-HIV services share many common needs and concerns. Therefore, by linking and integrating STI-HIV and SRH services, clients have access to both services and providers are able to efficiently and comprehensively provide them.

Regarding sexual and reproductive health, "**integration**" refers to various types of administrative and service integration. Undertaking sexual and reproductive health service delivery requires improved understanding of the conceptual and practical linkages between administration and service delivery to best utilize a limited pool of resources yet maximize its impact on those accessing it.

**Linkages.** In sexual and reproductive health, "**linkages**" refers to ensuring continuity and sustainability of various types of sexual and reproductive health services where "integration" is not feasible, available or existing.

#### **STRATEGIC AREAS AND ACTIVITIES:**

**STRATEGIC AREA 4.1:** Strengthen integration of STI/HIV and SRH services in all health service delivery systems to provide efficient and effective services

- 4.1.1 Build capacity at all levels of service delivery for effective integration of STI/HIV into RH services (and vice versa)
- 4.1.2 Develop clear referral system within the health sector and with other relevant sectors
- 4.1.3 Review current referral protocols and guidelines to identify areas for improvement and strengthening of linkages
- 4.1.4 Strengthen communication and transport between all levels of care
- 4.1.5 Extend integrated SRH/HIV/STI services to cover more geographical areas in the outer islands
- 4.1.6 Increase availability of commodities and supplies for prevention and management of STIs, HIV and AIDS at all levels of service provision
- 4.1.7 Integrate STIs/HIV and RH education materials in all preservice curriculums in RMI

**STRATEGIC AREA 4.2:** Strengthen linkages where reproductive health and STI/HIV services integration is not feasible.

- 4.2.1 Support supervision to monitor the provision of appropriate prevention, counseling, and management services for reproductive tract infections, including STIs and HIV.
- 4.2.2 Improve monitoring and evaluation systems for RH, STIs, HIV and AIDS interventions at all levels.
- 4.2.3 Make available resources to ensure health facilities are supported by strong linkage mechanisms.

**STRATEGIC AREA 4.3:** Empower populations to create demand for and increase utilization of SRH services

- 4.3.1 Create awareness on STI/HIV and SRH integration
- 4.3.2 Engage communities and facilitate dialogues on STIs/HIV and SRH integration

**STRATEGIC AREA 4.4:** Strengthen behavior change to reduce risk and vulnerability, by inspiring hope, strengthening education, and ensuring social and moral support for behavior changes

- 4.4.1 Increased availability of HIV and STIs and sexual health education
- 4.4.2 Strengthening social and moral support
- 4.4.3 Maintain zero vertical transmission of HIV
- 4.4.4 Providing a safe blood supply.

**STRATEGIC AREA 4.5:** Strengthen antiretroviral treatment services for all people living with HIV who are eligible for treatment, and foster a supportive environment for all individuals, partners, families and the community (regardless of HIV or STI status)

4.5.1 Improve comprehensive diagnosis and treatment of STIs

4.5.2 Support health and wellbeing of people living with HIV

#### **4.3.5 Key Policy Area 5: Other gynecological morbidities: abortions, infertility, and menopause**

**POLICY STATEMENT:** All women and partners including girls have access to information and comprehensive, quality, affordable and sustainable gynaecological services both in urban and rural areas of RMI.

Infertility can cause enormous stress and pressure to individual women, spouse, partner as well as to families. Any individual or couple with infertility has a right to information and services. The management of infertility should include counselling, prevention and early diagnosis and treatment of conditions that lead to infertility.

Medical and physical abortions are illegal in RMI, except in cases where the mother's life is in danger. It should however be ensured that post-abortion care is available to reduce morbidity and mortality from miscarriage related complications.

With improvement in the socio-economic status of individuals, life expectancy improves with a corresponding rise in the reproductive health needs of the elderly. Menopausal problems are increasingly being reported and are sometimes the source of emotional and psychological problems, sexual dysfunction and marital disharmony.

Menopause which occurs at about 51 years of age marks the end of reproductive capacity in women. Women can suffer from severe menopausal symptoms and post- menopausal problems.

There is no equivalent of menopause in men however andropause is used to define a physiological process leading to a decline in the production of male hormones resulting in reduced sexual drive.

**STRATEGIC AREAS AND ACTIVITIES:**

<b>STRATEGIC AREA 5.1:</b> Strengthen provision of quality care to women with gynecological conditions	
5.1.1	Review and update evidence based guidelines for Obstetrics and Gynecology Clinical Practice
5.1.2	Conduct training to health care providers to equip them with skills and competencies on prevention and management of prevalent gynecological conditions based on the National Guideline
5.1.3	Develop referral system to ensure women receive appropriate care in a timely manner
5.1.4	Regular support and monitoring of staff performance
<b>STRATEGIC AREA 5.2:</b> Strengthen community awareness on prevention of prevalent gynecological conditions and where to access treatment	
5.2.1	Conduct community awareness (including in school) on prevention and treatment of miscarriage and infertility, available services for postmenopausal problems and sexual dysfunction
5.2.2	Dialogue with cultural and religious bodies to ensure that cultural and religious practices are in harmony with the RMI Government’s commitment to achievement of SRH goals
<b>STRATEGIC AREA 5.3:</b> Ensure provision of post-miscarriage counselling and family planning services at all levels to women who have had a miscarriage	
5.3.1	Strengthen timely access to services for women who have suffered a miscarriage
5.3.2	Provide technical guidance to health service providers on the prevention, management of miscarriage and post abortion care
5.3.3	Conduct training of service providers and equip facilities to deliver quality comprehensive post-abortion care services, including family planning

**STRATEGIC AREA 5.4:** Ensure that women and men continue to enjoy good physical and psychological health as senior citizens

- 5.4.1 Initiate awareness programs about problems related to the physiological changes associated with post reproductive age in both men and women
- 5.4.2 Introduce services for appropriate management of problems of reproductive organs of persons in post reproductive age
- 5.4.3 Review and adopt policies and or legislation that protect the elderly persons against violence, abuse and discrimination

#### **4.3.6 Key Policy Area 6: Cervical and Breast Cancer**

**POLICY STATEMENT: All men and women have access to prevention and cancer care both in urban and rural areas of RMI.**

Cancers of the reproductive organs in both men and women tend to be diagnosed late. Cervical, breast, and ovarian cancer are the most common cause of premature death in women with cervical cancer being the second most common cancer in women worldwide. (WHO, 2013)

Early diagnosis and timely management can save the lives of those affected. It is important therefore to ensure that functioning services are available for prevention and management of cancers of the reproductive system among men and women.

#### **STRATEGIC AREAS AND ACTIVITIES:**

**STRATEGIC AREA 6.1:** Strengthen national leadership and coordination of cervical cancer prevention activities by creating a national cervical cancer prevention and control programme

- 6.1.1 Establish a national cervical cancer management team with clear responsibilities and accountability for the program
- 6.1.2 Establish stakeholder advisory group consisting of UN agencies, civil society, women's group, local leaders etc.
- 6.1.3 Establish M and E framework for the C4P program

- 6.1.4 Develop budget for planning, implementation and monitoring and evaluation of C4P program
- 6.1.5 Allocate a portion of the National Health Budget to fund the national cervical cancer prevention and control program (so the program will not solely be dependent on donors or grants)
- 6.1.6 Task force formed from MOH, specialists, international organizations
- 6.1.7 Utilize NCD Coalition to advocate to the politicians and advisory group for support on the screening, prevention, management and treatment of cancer
- 6.1.8 Collaborate with Faith Based Organizations to advocate to the politicians and advisory group for support on the screening, prevention, management and treatment of cancer
- 6.1.9 Resource mobilization to raise funds to support the cancer screenings and vaccination services.
- 6.1.10 Provide resources for cancer prevention, management and control

**STRATEGIC AREA 6.2: Strengthening awareness on cancer prevention and treatment services and Community engagement and empowerment to enable women and men to access screening and detection services**

- 6.2.1 Develop IEC to inform the community about cervical cancer, its causes and natural history
- 6.2.2 Undertake community visits for cancer and prevention awareness and provide counselling on self- examination in the case of breast and testicular cancers.
- 6.2.3 Involve mass media to disseminate information/awareness about cervical cancer and C4P program
- 6.2.4 Involve mass media to disseminate information/awareness about cervical cancer and C4P program
- 6.2.5 Reduce ignorance, fear, embarrassment and stigma related to cervical cancer
- 6.2.6 Inform the public of available services and where to get them
- 6.2.7 Empower communities with information to enhance decision making and promote positive health seeking behavior

**STRATEGIC AREA 6.3: Strengthening of primary and secondary prevention based on the RMI National Cancer Screening Guidelines**

- 6.3.1 Integrate HPV vaccination with National EPI program
- 6.3.2 Provide education to schools (Middle School, High School and College) on cancer, risk factors, early screening, and availability of services (particularly on primary prevention)
- 6.3.3 Provide cervical cancer screening services at all levels of the health care system.
- 6.3.4 Improve Cytopathology and histopathology units with regards to PAP smear and biopsy/ECC results

**STRATEGIC AREA 6.4: Strengthen capacity of health care facilities to diagnose and provide quality of care to women and men diagnosed with targeted cancers**

- 6.4.1 Provide technical guidance to health care providers in treatment and control of cancers of the reproductive system
- 6.4.2 Capacity trainings on management of cervical, breast, and colorectal cancer
- 6.4.3 Develop efficient referral system for cases suspicious for cervical cancer for definitive diagnosis and treatment
- 6.4.4 Enhance capacity of HCP at all levels to provide palliative care services.
- 6.4.5 Strengthen availability at all levels of commodities and supplies needed for the screenings and management of overt cancer including palliative care is readily available in sufficient amounts
- 6.4.6 Establish registry for cancers of the reproductive organs to monitor trends of the disease and evaluate the effectiveness of services.

**4.3.7 Key Policy Area 7: Gender and Reproductive Health**

**POLICY STATEMENT:** SRH information and services shall be provided in a non-discriminatory and gender sensitive environment with equal access to all.

Gender has emerged as a cross-cutting issue that now has been recognized as a key factor to strengthening a country’s ability to grow, to reduce poverty and to improve standard of living.

Gender-based violence in Pacific countries including in RMI is showing incidence and prevalence figures in excess of those found in other parts of the world. The response to GBV is everyone’s

business. Most countries adopt a multipronged strategy when addressing GBV, combining legislative change, community advocacy and education and special training for health professionals.

Gender issues are central to SRH with GBV being often sexual in nature and leads to the violation of sexual and reproductive health and rights of girls, women and boys in the communities.

**STRATEGIC AREAS AND ACTIVITIES:**

<b>STRATEGIC AREA 7.1:</b> Capacity building and in-service training for all staff involved in the care of victims of GBV, including training on provision of gender sensitive counselling and management of victims of GBV
7.1.1 Develop technical guidelines on management of survivors of gender based violence for all the levels of care
7.1.2 Build capacity of HCP at all levels of service delivery for management of survivors of GBV
7.1.3 Monitor the provision of appropriate counseling and management services survivors of GBV
7.1.4 Strengthen collaboration with all key stakeholders for strengthened response by all stakeholders
<b>STRATEGIC AREA 7.2:</b> Ensure the availability and accessibility of comprehensive services for survivors of GBV/SGBV, including collection of medico-legal evidence, PEP, and emergency contraception
7.2.1 Review of current Gender Based Violence (GBV) response services and programmes in health facilities
7.2.2 Reorient services to facilitate provision of comprehensive care for survivors of GBV
7.2.3 Establish referral links to other services such as legal, police and support areas
<b>STRATEGIC AREA 7.3:</b> Conduct community and school based awareness on GBV and its detrimental social, cultural, personal and health effects
<b>7.3.1</b> Develop a research on the causes and possible preventions of SGBV for decision making

- 7.3.2 Advocate for strengthened response to GBV and support for GVB survivors including gender equality in the health and development of RMI
- 7.3.3 Create awareness on protections provided by existing laws and protocol- especially in the outer islands
- 7.3.4 Advocate for schools to incorporate information on SGBV and domestic violence prevention into health education curricula
- 7.3.5 Mobilize men to take part in promoting gender equity and identify their role in prevention of GBV

#### 4.3.8 Key Policy Area 8: Men involvement in Reproductive Health

**POLICY STATEMENT:** All men in RMI have access to men-friendly facilities and participate fully in reproductive health activities involving their partners and children

Women cannot achieve gender equality and sexual and reproductive health without the cooperation and participation of men. In many situations, men usually decide on the number, timing and frequency of sexual activity and the use of contraceptives. However, men also have their specific needs of RH services.

In fact, neglecting to provide information and services for men can detract women's overall health. For example, men who are educated about reproductive health issues are more likely to support their partners in decisions on contraceptive use and family planning, support that is essential if women are to practice safe sex or avoid unplanned pregnancy. (Grady et al, 1996)

#### STRATEGIC AREAS AND ACTIVITIES

**STRATEGIC AREA 8.1:** Advocate for, promote and ensure more participation of men in their own RH choices and activities

- 8.1.1 Raise awareness among men and boys on gender and SRH issues and
- 8.1.2 Mobilize men to take part in promoting, advocating and participation in prevention of STI/HIV and SRH

8.1.3 Advocate and provide support for husbands and partners to accompany their wives/partners attending Antenatal Clinic, Post Natal and FP clinics.

**STRATEGIC AREA 8.2:** Develop programs on FP, RH, STI/HIV specifically focusing on men's health

8.2.1 Establish men-friendly facilities as an integral part of implementing RH programs

8.2.2 Build capacity of health care facilities on prevention and management of SRH concerns of men

8.2.3 Monitor the provision of appropriate prevention, counseling, and management services for men SRH concerns

#### 4.3.9 Key Policy Area 9: Reproductive Health Commodity Security

**POLICY STATEMENT:** All women, men and children in RMI have access to quality reproductive health commodities at the right time, right place, right condition, in the right amounts.

Reproductive Health Commodity Security (RHCS) is defined as ensuring a secure supply and choice of quality contraceptives and other reproductive health commodities to meet every person's needs at the right time and in the right place.

RHCS has four essential features, namely:

- Estimation of requirements (forecasting);
- Allocation of budget (financing);
- Purchase and delivery of commodities (procurement);
- Warehousing and distribution of commodities.

#### STRATEGIC AREAS AND ACTIVITIES

**STRATEGIC AREA 9.1:** Ensure that all facilities are continuously equipped and have adequate drugs, commodities and other essential supplies to cater for the needs of the population

- 9.1.1 Consensus on a minimum package of essential SRH interventions, the level at which these services will be provided and list essential RH commodities that will be provided at each level.
- 9.1.2 Review and update the essential medicines, equipment and health supply list to incorporate obstetric drugs (particularly lifesaving commodities) and equipment
- 9.1.3 Develop a commodity Inventory/Logistics management information system both for Ebeye and Majuro
- 9.1.4 Improve the logging system in place
- 9.1.5 Conduct annual quantification, forecasting and procurement workshops for RH commodities and consumables.
- 9.1.6 Develop a costed Procurement Plan for essential drugs, medical supplies and equipment for SRH services.
- 9.1.7 Investigate if new technologies (e.g. SMS) would improve real-time stock monitoring and re-supply planning, especially to Atolls
- 9.1.8 Improve the commodity monthly inventory and monitoring in all clinics including the outer island dispensaries to ensure that all service delivery points have uninterrupted supply of drugs and other essential RH commodities
- 9.1.9 Shorten the time frame of commodity forecasting, distribution, and ordering from annually to biannually.

**STRATEGIC AREA 9.2: Capacity building on forecasting and logistics management**

- 9.2.1 Conduct onsite training on forecasting and logistics management through appropriate use of stock cards for national and all service deliveries
- 9.2.2 Provide training to health care providers on storage, inventory, and forecasting
- 9.2.3 Conduct warehouse capacity building trainings
- 9.2.4 Develop inventory guidelines for RH's commodities
- 9.2.5 Monitoring and supply for RH's commodities to all service delivery points

**STRATEGIC AREA 9.3: Create supportive regulatory framework**

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| <p>9.3.1 Advocate for an enabling environment for secure access to reproductive health commodities</p> <p>9.3.2 Strengthen warehousing management business practices through appropriate accreditation of warehousing standard operating procedures and policies with established KPI</p> <p>9.3.3 National emergency preparedness plans articulate maintenance of RHCS in event of emergency</p> |
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## **5. CROSS CUTTING STRATEGIES**

Achievement of the objectives of the National Reproductive Health Policy requires that the scope of coverage of sexual and reproductive health services is expanded. This in turn will require sustainable financing mechanisms, human resources, quality in service provision and use of services. There is therefore need to understand and address the factors which limit the scope of coverage, and impede the demand for and utilization of reproductive health services in RMI.

Cross cutting strategies will focus on creation an enabling environment to ensure availability and accessibility of quality SRH information and services to all persons regardless of sex, gender, age, status, sexual orientation and religion according to their needs. Crosscutting strategies essential for ensuring that the Government of the Republic of the Marshal Islands deliver on the commitments made in this policy include:

1. Availability of and access to sexual reproductive health care services - The current level of access to SRH services is limited and needs to be augmented.
2. Utilization of sexual and reproductive health services
3. Quality of the sexual and reproductive health services - High-quality services are essential for delivering effective SRH interventions
4. Resource mobilization.

The MOHMS is committed to reduce the high levels of SRH morbidity and mortality by motivating, mobilizing, setting standards, monitoring progress, coordinating and collaborating with partners in delivery of SRH information and services.

It is envisaged that the National Reproductive Health Policy will ensure coordinated and integrated delivery of comprehensive quality SRH information and services in order to improve the health and well-being of the people of the Republic of Marshal Islands.

### **Cross Cutting Strategic Areas and Activities**

**Strategic area 1 : Improve the availability, accessibility and acceptability of high quality SRH information and services for all the youth, women and men who need them**

- 1.1 Identify, eliminate and address regulatory barriers and socio-cultural beliefs, myths or practices that impede access to skilled care
- 1.2 Strengthen existing health infrastructure and provide additional structures for under-served areas, the disadvantaged people and people with disabilities
- 1.3 Strengthen capacity to provide quality SRH information and services
- 1.4 Expand outreach health care services to other OI
- 1.5 Strengthen transport and communication systems between outer islands and capital
- 1.6 Establish/strengthen collaboration with community structures chiefs, local councilors and other community leaders to facilitate provision of emergency transport for SRH emergencies particularly pregnant mothers
- 1.7 Strengthen the skills of Community Health Workers to carry out their defined roles in the delivery of SRH health service at community level
- 1.8 Strengthen an integrated approach for provision of sexual and reproductive health care services and other related services such as sexually transmitted infections, HIV and AIDS
- 1.9 Ensure coordination with Emergency Preparedness and Response Office/Unit on the development of provincial emergency preparedness plan to ensure that RH issues and needs are well addressed / Provision of Minimum Initial Services Package (MISP) will be ensured during the onset of emergencies

**STRATEGIC AREA 2:** Create demand for sexual and reproductive health care services by providing continuous evidence based SRH information and education to community with emphasis on different needs of the population groups

2.1 Develop Social and Behavior Change Communication strategies for SRH issues

2.2 Establish and maintain dialogue with cultural and religious sectors to ensure that their beliefs and practices are in harmony with stated sexual and reproductive health goals.

2.3 Promote increased male participation in antenatal, intra-partum and postnatal care

2.4 Raise the awareness and involvement of men in SRH matters, including family planning.

2.5 Create support networks on key SRH issues

2.6 Undertake campaigns on key SRH issues

**STRATEGIC AREA 3:** Quality comprehensive SRH services shall be provided by competent and skilled health care providers in adequately equipped health facilities providing SRH at all levels of care

3.1 Periodic review of Curricula for pre and in-service education of health workers in the management of sexual and reproductive health

3.2 Develop and implement human resource strategy to orient and train, deploy and retain health system workers

3.3 Institutionalize the infection prevention and control program at all levels of care

3.4 Ensure availability of safe blood and safe blood products in emergency cases

3.5 Strengthen quality assurance monitoring of SRH services and giving feedback to the facilities to help them improve the quality of their services

3.6 Ensure availability of appropriate technical guidance tools (standards and protocols) to service providers for effective SRH service delivery

3.7 Ensure that the performance of service providers meets national standards through regular monitoring, on-the-job supportive supervision and performance appraisal

**STRATEGIC AREA 4:** Resource mobilization for sexual and reproductive health services

4.1 Advocate for increase the budget allocation to the health sector to ensure scale up and sustainability of programs and commodities

4.2 Mobilise additional funding for sexual and reproductive health services from development partners and private sector

4.3 Establish and strengthen public, private, partnerships for strengthened delivery of SRH information and services at all levels of care

## **6. MONITORING AND EVALUATION**

The implementation of reproductive health policy will be monitored and evaluated on a regular basis in order to assess progress towards and achievement of the Policy objectives. Monitoring and Evaluation is expected to promote evidence-based decision making as well as meet information needs of various stakeholders at all levels and should fit within the national monitoring and evaluation system. Monitoring mechanisms for timely availability of data for planning, programming and decision-making, will be strengthened, integrated, and streamlined. It is therefore important for monitoring and evaluation to be continuous to measure outcomes, impacts and overall success and ultimately ensure strengthening of the reproductive health program through field visits and reporting. This section describes in general terms the core components of the national monitoring and evaluation of the strategy.

- Development of a simple system for collection, reporting and management of essential RH data.
- Ensuring that data generated by the M&E system serve the needs of many constituents;
- Efficient use of data and resources and avoid duplication of efforts;
- Strengthened communication between different groups involved in the national as well as subnational response.
- Development of a research agenda or SRH research strategy for evidence based decision making

Annex 2 provides a set of indicators for measuring coverage, utilization, quality, and resources, as well as monitoring output and impact. A detailed monitoring and evaluation plan will be developed alongside the costed implementation plan. Where data is available baselines will be provided including proposals for targets to reach in 2018. Effort should be made to establish baseline data where data is not available. Effort will be made to put measure in place for collection of indicators that are not currently collected.

All stakeholders are expected to establish and support routine monitoring mechanisms that will utilize the indicators and targets in the Monitoring and Evaluation plan. Joint monitoring exercises will be carried out to ensure that lessons learnt are shared amongst stakeholders.

There should be a midterm evaluation using of existing tools where appropriate. Evaluation should therefore be built into SRH program activities from the planning stage. Midterm and the 2018 evaluations of the implementation of the Policy will be undertaken to inform revision or development of new strategies. The evaluations will also provide baseline data for the next strategy and will facilitate reporting on the SDG targets.

## **7. OPERATIONAL FRAMEWORK OF THE RH POLICY**

### **7.1 Leadership and Stewardship**

The Government of the Republic of the Marshall Islands will provide leadership and stewardship in the implementation of the Policy. Whilst the implementation of the policy should involve various stakeholders, the strategic thrust of the proposed interventions places most of the responsibility on the Ministry of Health.

The Ministry of Health will be responsible for the technical and management oversight in the implementation of the RH Policy and Strategy for improved delivery of RH care services in RMI. The Ministry of Health therefore, shall monitor and evaluate the implementation of the policy, including the coordination of all agencies, institutions and organizations involved in the provision

of SRH services in the country. The Ministry of Health shall also develop a human resource plan for training, employment, and retention of qualified health workers.

The national Reproductive Health Working group and Perinatal Committee led by the Secretary for Health shall provide technical advice, guidance, and facilitate the network of technical expertise in the implementation of this policy. The working group/committee shall lead the development of the operational plan and national guidelines, standards, and protocols to guide implementation. It shall also assist the Ministry in revision of the policy by providing the required technical inputs.

### **7.2 Reproductive health Unit**

Reproductive Health Unit in the Ministry of Health shall carry out the functions of co-ordination monitoring and evaluation on behalf of the Ministry.

### **7.3 Non-Government organization**

The non-governmental organization and religious organizations shall continue to participate in Reproductive health activities. Due recognition and support shall be given based on their work, expertise, experience and resource capabilities.

### **7.4 Co-operation partners**

Donor agencies, international non-governmental organizations and the private sector will continue to play a vital role in providing support to the implementation of this policy.

### **7.5 Community Level**

Existing community structures will be strengthened and new ones established and oriented on SRH issues to facilitate promotion of SRH at community level and ensure meaningful community participation in SRH.

## 8. GLOSSARY

**Total Fertility Rate:** The average number of children that would be born alive to a woman during her lifetime if she were to pass through her child bearing years conforming to the age –specific fertility rates of a given year.

**Life Expectancy at Birth:** The average number of years a newly born infant is expected to live if current mortality trends were to continue.

**Maternal Mortality Rate:** The number of women who die due to pregnancy and child birth complications per 100,000 live births in a given year.

**Infant Mortality Rate:** The number of deaths of children under one year of age in a given year per 1,000 live births in that year.

**Parity:** The number of children born live to a woman.

**Adolescent:** Person aged between 10 - 19 years.

**Abortion:** Is termination of pregnancy expulsion or extraction of embryo/fetus before 22 weeks of gestation or below 500gm weight of fetus.

**Infertility:** Absolute inability of a couple to achieve pregnancy after 12 months of active sexual inter-course.

**Sub-fertility:** relative inability / difficulty at conceiving.

**Fertility:** The actual output of births, as opposed to the potential output.

**Cervical cancer:** Cancer (Malignancy) arising from the neck of the womb (cervix).

**Breast cancer:** Malignant tumour arising from the breast.

**Ante Natal Care:** Ante Natal Care is the care provided to pregnant women from conception through to onset of labour.

**Postnatal Care:** This is the care provided to the woman and her baby at the follow up postnatal visit from the time of discharge from hospital to the end of the puerperium.

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## Annex 1: List of Participants to Policy Workshops and Contributors to the Policy Document

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**Annex 2: M&E Plan: Reproductive Health Policy and Implementation Strategy  
2016-2018**

<b>Key Policy Area 1: Maternal and Neonatal health</b>
Maternal mortality ration: # maternal deaths/100,000 live births
Perinatal mortality rate: # perinatal deaths. This is defined as the number of death of fetus from 28 weeks of gestation to the first seven days of life per 1,000 live births in a given year
Neonatal mortality rate: # neonatal deaths/1,000 live births. Number of deaths occurring among infants aged 0 to 28 days / Denominator: Total number of live births in a given year
% of deliveries attended by a skilled birth attendant
ANC Coverage (%); i) 1-3 visits; ii) $\geq 4$ visits
% pregnant women presenting for first ANC visit at $\leq 12$ weeks
# ANC mothers accompanied by male partner for $\geq 1$ visit during pregnancy
Prevalence of anemia in pregnancy
Prevalence of Syphilis in pregnancy
# of traditional birth attendants/ village health workers trained on early referral of pregnant women for delivery at health facility
Met need for EmONC: Proportion of women with major obstetric complication treated at EOC facilities disaggregated by region
% Functional basic and comprehensive EmONC facilities
% Mothers receiving postnatal care within 2 days of delivery
% babies delivered in health facilities initiating breastfeeding within 1 hr
% of births registered/ Proportion of children under 5 years of age whose births have been registered with a civil authority, by age
% Maternal and perinatal deaths notified and reviewed
% support supervision visits undertaken
% of communities (and young women respondents) aware of birth preparedness and complication readiness
<b>Key Policy Area 2: Provision of Family Planning</b>
% of women aged 15-49 using any method of contraception - Contraceptive Prevalence Rate (CPR) disaggregated by age
Unmet need for Family Planning disaggregated by age
Met need for Family Planning/ Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
# VHWs trained on community based distribution of family planning
% health facilities reporting no stock-outs in the previous 3 months

% of service delivery points offering integrated SRH/STI/HIV services
<b>Key Policy Area 3: Adolescent Sexual and Reproductive Health</b>
Adolescent birth rate/ Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
% of women aged 20 – 24 who were married or in a union before age 18 (Child marriage)
HIV prevalence/incidence among population 18 – 24 years
# of schools that offer FLE
# facilities quality offering YFS / # health care facilities with designated space and systems for YFS
# of Youth Clinics established in Schools (Middle School, High School, College)
% target respondents correctly answer questions about sexual and reproductive health
# of young people aged 15 - 24 who correctly answer questions about HIV/AIDS and STIs
<b>Key Policy Area 4: The control of STIs/HIV and integration with other SRH programs</b>
Number and percentage of infants born to HIV-infected mothers who are HIV-infected.
Prevalence (%) of STIs (disaggregated by type of infection) amongst ANC mothers
# males reported with urethritis / STI prevalence reduced in men (aged 15-49)
% females/males aged 25-49 who correctly answer questions about HIV, AIDS and STIs
% of young men and women aged 10-24 who both correctly identify ways of preventing the sexual transmission of HIV.
<b>Key Policy Area 5: Other gynecological morbidities: abortions, infertility, and menopause</b>
Case fatality from complications of abortion
Prevalence of infertility
Prevalence of unsafe abortion
# of facilities offering post reproductive age (menopausal, sexual dysfunction) care services
# of health care providers with skills and competencies on counselling, prevention and management of prevalent gynaecological (infertility, menopause) conditions according to clinical guidelines
Clinical guidelines and protocols for prevention and management of prevalent gynecological conditions available in all facilities
# of cases treated for infertility
# of women treated for menopausal symptoms
# of men treated for sexual dysfunction

# of facilities offering post abortion care
<b>Key Policy Area 6: Cervical, Breast and Colorectal cancer</b>
Incidence of common cancers (disaggregated by type of cancer – breast, cervical colorectal cancer)
Prevalence of cervical pre-cancer (HSIL)
Mortality rate from breast, cervical and colon cancers
Availability of cancer screening, prevention, counselling and treatment services
% women aged 30-49 reached through cervical screening (disaggregated by type of screening – PAP and VIA)
% women aged >30 reached through breast cancer screening
% population reached with colon cancer screening
# girls aged – who have completed vaccination schedule for HPV
# of facilities with capacity to provide surgical treatment for prevalent cancers
# of health facilities offering palliative care/# of palliative care facilities establishes
<b>Key Policy Area 7: Gender and Reproductive Health</b>
Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from an intimate partner/year GBV from a current or former intimate partner
Percentage of women aged 14 – 49 who think a husband/partner is justified in hitting or beating his wife/partner under certain circumstances
Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
Percentage of women aged 14 – 49 who think a husband/partner is justified in hitting or beating his wife/partner under certain circumstances
# of health care facilities with services for victims of SGBV, including collection of medico-legal evidence, PEP, and emergency contraception and adherence to referral and management protocols
# of health care providers with skills and competencies to manage victims of SGBV, including collection of medico-legal evidence, PEP, and emergency contraception and adherence to referral and management protocols
# of coordination meetings between all stakeholders working in area of GBV
# committees upon which the health sector is representing responses to sexual violence
<b>Key Policy Area 8: Men involvement in Reproductive Health</b>
Proportion of men and boys reached

Proportion of men who accompany their wives/partners to ANC/FP (and other SRH services)
# men accessing no-scalpel vasectomies
Incidence of male sexual dysfunction
# of health care facilities that have integrated male sexual dysfunction services
# of health facilities offering male friendly services (Well man clinic)
<b>Key Policy Area 9: Reproductive Health Commodity Security</b>
# of health facilities with life-saving maternal / reproductive health medicines
# of facilities which comply with the list essential RH commodities specific for that level of care
Minimum package of essential SRH interventions and list essential RH commodities defined for each level of care
Proportion of health care facilities which report no stock-outs of SRH commodities in the previous 12 months
# of health care providers trained on forecasting and logistics management
Functional logistic management information system for forecasting and monitoring reproductive health commodities in place
% Health Sector and Government Emergency Preparedness Plans articulating RHCS measures
<b>Cross Cutting Strategies</b>
Guidelines outlining referral criteria, routes and key contact persons developed (for different SRH services)
Proportion of health facilities that provide essential SRH services
# of health care facilities with easy access by people with disabilities
Proportion of health facilities that provide postpartum, postabortion and/or HIV services that also provide clients who use those services with contraceptive information and care
# of mothers waiting homes close to health facilities for women who live far from the health care facilities
# of reviews for adherence to set standards
Case fatality for different aspects of SRH conditions
Budget allocation for SRH programs
# of PPPs formed with the Ministry of Health / # of MOUs signed by the Ministry of Health and private partners
# of health care providers trained on monitoring, timely reporting and use of data

**Annex 3: RMI Prevention of Adolescent Pregnancy**