Asia-Pacific Economic Cooperation

Smart Families

APEC SMART FAMILIES

Menu of Policy Options for Demographic Resilience

A Rights-Based Policy Approach to Comprehensively & Proactively Support Family Planning and Fertility Planning

APEC Health Working Group
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Asia-Pacific
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APEC Smart Families: Menu of Policy Options for Demographic Resilience

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Produced by

Dr. Bunyarit Sukrat
Bureau of Reproductive Health
Department of Health, Ministry of Public Health
Nonthaburi, Thailand 11000

For
Asia-Pacific Economic Cooperation Secretariat
35 Heng Mui Keng Terrace
Singapore 119616
Tel: (65) 68919 600
Fax: (65) 68919 690
Email: info@apec.org
Website: www.apec.org

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TABLE OF CONTENTS

OVERVIEW: A MENU OF POLICY OPTIONS FOR COMPREHENSIVE FAMILY PLANNING & FERTILITY PLANNING

The APEC Context

The relationship between reproductive health and economic impact is well-documented. When individuals are able to make informed decisions about their reproductive health – particularly around if, when, and at what intervals to have children – there are tangible individual and societal economic benefits. Historically, efforts to mitigate negative economic consequences related to demographic trends have centered on reducing unintended pregnancy (UIP) and rapid population growth.[i]

As demographic trends shift, economies around the globe are pivoting their attention to addressing falling birth rates and associated concerns around labor market shortages and ageing populations.[ii] It is important to note that while birth rates have been falling in many APEC economies for some time, periods of demographic transition are slow to materialize. As such, the concrete economic effects of changing fertility patterns are just starting to be realized for most APEC economies. Similarly, policy responses – while critical to creating an enabling environment for reproductive choice and economic decision-making – can take time before palpable benefits are measurable.

While many economies have begun to implement policies to address concerns associated with falling birth rates, evidence around effectiveness remains limited.[iii]

Family planning and fertility planning in this document is guided by the "APEC Smart Families: Comprehensive, Holistic Policy Options" project scope, and focuses on comprehensive and holistic family planning options (inclusive of both fertility planning for those individuals and families who want to have children and avoidance of unintended pregnancies). The foundation for this framing is from World Health Organization's terms for family planning as the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is accomplished through use of contraceptive methods and the treatment of involuntary infertility.[iv]

Implicitly, Family Planning also includes "preconception care,"[1] which is a set of interventions that aim to improve the health and well-being of women and couples before pregnancy, as well as to increase the chances of conception when pregnancy is desired.[v] Importantly, preconception care and fertility planning are not often received in tandem with contraception and sexual health education, which would provide the opportunity to prevent some of the upstream contributors to infertility.[2] Fertility Planning is therefore distinguished in this instance but still encompasses the preservation of fertility, preconception care, and the treatment of infertility, which are aspects of holistic family planning.

This ***Menu of Policy Options*** provides policy-based recommendations anchored in research, evidence, best practices, and rights-based approaches that proactively and holistically create an enabling environment for both family planning and fertility planning. APEC economies are encouraged to adapt these options to implement and scale combinations of policies as relevant to their individual settings.

[1] Preconception care involves fertility care-for infertility and subfertility issues, screening and management of chronic diseases, prevention and treatment of infections, nutrition counseling, genetic counseling, mental health support, and promotion of healthy behaviors. (Source: WHO, Preconception care: Maximizing the gains for maternal and child health - Policy brief. https://www.who.int/publications-detail-redirect/WHO-FWC-MCA-13.02)

[2] For more information on the upstream causes of infertility please see: WHO, Infertility Key Facts Sheet. https://www.who.int/news-room/fact-sheets/detail/infertility

Intended Audience

The overarching goal of APEC Smart Families is to build the capacity of **health and economic policymakers** to address demographic trends through the development of comprehensive, holistic policy options inclusive of both family planning and fertility planning. The intended target audience includes decision-makers or those with the ability to contribute to high-level decisions within the APEC economies, and may include government representation from health, gender, finance, education, economics, demography, and labor ministries; international organizations or civil society organizations; academia; businesses and the private sector.

Organization of the Menu of Policy Options

The ***Menu of Policy Options*** is organized into three sections:

- Reproductive Health & Health Literacy
- Labor & Economics
- Funding & Financing Mechanisms

Within each section, the policy options are organized into an identified barrier to a healthy enabling environment, a proposed policy intervention (or in many cases, interventions), and relevant implementing entities. Where possible, the policy recommendations are also grounded in existing examples of policies from within the APEC region or other parts of the globe.

Considerations for implementation

Utilization of the ***Menu of Policy Options*** is voluntary and the adoption of different policy recommendations may largely depend on the individual context of different APEC economies. While many of the policy recommendations listed in the ***Menu of Policy Options*** could be implemented in isolation, the overarching intention of these policies is to create an enabling environment for reproductive decision-making, which requires a multipronged approach that addresses barriers from multiple angles. In the addendum section, there are a few different case studies that provide examples of how different combinations of policies could be implemented together for a more holistic approach.

Overwhelmingly, the evidence base indicates that the best practice for building an enabling environment for reproductive choice is rooted in a holistic, multi-sectoral approach. For example, if an economy adopts a policy to subsidize childcare, but does not adopt policies for paid parental leave or medical care for child dependents, they may fail to realize the benefits from the policy. Similarly, if the private sector does not adopt policies that create an enabling environment for parental leave, success from that policy recommendation may be limited. As such, economies are encouraged to consider a comprehensive approach to implementing and scaling related policy recommendations. One example of a policy that addresses multiple barriers to the enabling environment for families who want to have children is the American Jobs Plan in the United States. This policy would increase the volume and quality of childcare facilities in the United States, particularly in communities with limited access, while also providing 12 weeks of federally funded paid family and medical leave, childcare subsidies on a sliding scale anchored to family income, and expanding early childcare and education options.[vi]

Policy implementation from the ***Menu of Policy Options*** should also be supplemented with more robust data collection, analysis, and modelling. To forecast and respond to anticipated demographic trends, APEC economies will need access to timely and relevant – as well as accurate and complete – data that help them analyze projected trends in birth rates and ageing. Data have a critical role in identifying the reason or causation behind falling birth rates or persistent rates of unintended pregnancy, but also help measure the extent to which policies are effective. **As such, systems for routinely collecting both comparative and longitudinal data will be essential.** These data should also incorporate opportunities to leverage new research or models to better forecast potential impacts.

APEC economies will also need to build mechanisms for accountability: good policies can only go so far without strong implementation, monitoring and evaluation, and opportunities to fail forward and learn from mistakes. While designing policies to more proactively address family planning and fertility planning needs is an important first step, a willingness to support the implementation and enforcement of simultaneous policies will be imperative for success. APEC economies will be most successful if they are willing to share progress, document failures, and collaboratively iterate on pathways forward.

There is also tremendous opportunity for APEC economies to learn from one another as they navigate these demographic trends and associated economic implications. It would be beneficial for APEC economies to continue to share lessons learned from policy implementation, including successes, failures, and opportunities to improve the policy environment for reproductive decision-making and demographic resilience.

It is also prudent to highlight that there are significant sociocultural and political differences both across and within many of the APEC economies. In many contexts, decision-making around if, when, and how many children to have is closely tied to social, cultural, or political factors. While the policies contained within the subsequent ***Menu of Policy Options*** may be accepted in some APEC economies, they may not in others. The success of many of these policy recommendations may be closely tied to sociocultural considerations and could be supplemented with increased public awareness or social and behavioral change campaigns.

Finally, to fully understand the extent to which the implementation of these policies is effective, robust indicators to measure success and long-term implications on both demographic trends and economic resilience will be critical. The Expert Working Group have shaped an initial set of recommendations, but indicators will need to be adapted and applied within the unique context of individual economies.

BACKGROUND & RATIONALE: THE CASE FOR DEMOGRAPHIC RESILIENCE

Demographics and economics are inextricably linked. Demographic trends like falling birth rates, ageing populations, or high levels of unintended pregnancy can affect both macro-level and micro-level economic outcomes due to their impact on the labor market, economic systems, and financial systems as well as on individual or family economic well-being.[vii] Economics can also influence demographic trends: during times of economic strain or stress, many families choose to delay having children, have fewer children, or choose not to have children altogether, which – when sustained over time – can result in falling birth rates or declining populations.

Across the Asia-Pacific, the APEC economies are simultaneously grappling with falling birth rates and persistent rates of unintended pregnancy and associated economic consequences. As birth rates across the region fall below replacement level, APEC economies are eager to identify policies that will reverse falling birth rates, yet many policies enacted to date have fallen short.[viii] At the same time, progress in reducing the rate of unintended pregnancy has stagnated in many APEC economies, particularly among vulnerable populations, often resulting in significant financial cost to both families and governments. ***Typically, women and girls bear the brunt of the physical, economic, and financial burden associated with limited access to reproductive health education and services.***

One of the underlying reasons that policies have continued to fall short in addressing demographic trends is because we may not be asking the right questions.[ix] Rather than focusing policy efforts on *responding to demographic trends*, we should seek to better *understand what is driving these demographic trends*, and, where possible, how to build economic structures that are more resilient to demographic change. For example, instead of questioning how to *reverse* falling birth rates, it would be helpful to question why birth rates are falling in the first place. Then, where possible, economies would be better positioned to address barriers that individuals and families may face when choosing to have children while also more effectively and efficiently considering how economies could be adapted to withstand sustained trends of falling birth rates.

Falling birth rates, for example, can likely be attributed to a multitude of both individual and population-level factors: economic concerns associated with the cost of raising children, higher rates of education, greater proportions of women in the workforce, shifting gender norms, greater availability of contraceptives, and/or challenges with infertility.[x] Therefore, while expanding access to infertility treatment or fertility preservation – like in vitro fertilization (IVF) or egg freezing – may enable some couples to have children who couldn't previously, this approach alone won't address the economic barriers that other couples face in realizing their fertility goals.

Similarly, reductions in rates of unintended pregnancy have stagnated, which can be attributed to multiple barriers, again both individual and population-level: a lack of access to modern contraceptive methods (either due to cost to the user, lack of awareness, or limited contraceptive method choice), gender norms or stigma around using contraceptives, misinformation or concerns around contraceptive side effects.[xi] Therefore, while covering the cost of contraceptives is a good step in ensuring that all individuals who wish to use contraceptives have access, this policy alone won't address a lack of awareness or education around contraceptive options.

In the 2023 State of the World's Population (SWP) Report, the United Nations Population Fund (UNFPA) highlights the need for a rights-based approach in viewing population change and demographic trends. "Interventions aimed at influencing fertility rates, whether high or low, are never the answer because these rates are neither inherently good or bad," writes UNFPA. "With the right approach, resilient societies can thrive, whatever their fertility rate may be."[xii] ***The Menu of Policy Options*** is one such approach. By adopting a human rights-based lens to demographic change, the proposed policy options support economies in navigating fluctuations to fertility rates by focusing on ensuring that all individuals have access to the necessary tools, resources, and services to realize their own fertility goals – whether those goals include having children or

"Interventions aimed at influencing fertility rates, whether high or low, are never the answer because these rates are neither inherently good or bad," writes UNFPA. "With the right approach, resilient societies can thrive, whatever their fertility rate may be."[xii]

not having children. The policy options included address both barriers to access to reproductive health services as well as upstream influences around costs that may drive reproductive decision-making.

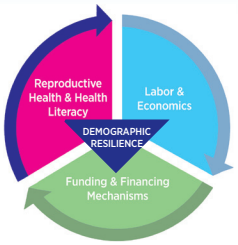
UNFPA also proposes a re-framing of some of the key questions guiding policy-making and decision-making around demographic trends. For example, UNFPA proposes re-framing questions around incentivizing women to have more children to "How can we support women in their reproductive choices?" and questions around avoiding ageing populations towards "How can we ensure that older people are supported throughout their lives."[xiii] These questions will not only help to create a better understanding of population trends, but also ensures society is positioned to respond to changing needs, human-rights, and reproductive choice.

Policies aimed at mitigating the negative consequences of demographic trends can also run the risk of placing economic considerations at odds with reproductive choice, running the risk of coercive policies. For example, when policies are constructed to encourage higher (or lower) fertility rates, they may create an incentive that is counter to the fertility goals of an individual or family. These policies not only run the risk of coercing reproductive decision-making, but they also typically fail to create the intended change: in this case, economic growth.[xiv] **Policies that instead prioritize creating an enabling environment for reproductive decision-making are the most powerful: they can help remove barriers to having children for families who want to have children while also addressing barriers in preventing pregnancy for families who are seeking to avoid or delay pregnancy.** When individuals and families have the tools to make the reproductive decisions that are best for them, there are also tangible economic impacts, at both the micro- and macro-levels.

The most effective approach, therefore, is one that can simultaneously create an enabling environment for reproductive health – holistically bringing together both family planning and fertility planning – while also maximizing economic opportunities. To do this, we propose a framework of **demographic resilience.** Demographic resilience refers to the concept that economies can forecast demographic trends and proactively enact policy responses that prioritize and center reproductive choice. This approach creates an opportunity to move beyond viewing demographic trends as a problem that needs to be responded to and towards an approach that mitigates economic consequence while upholding reproductive choice.

Embracing a framework of demographic resilience will require addressing downstream consequences that stem from demographic trends – in addition to ensuring that individuals and their families have the tools that they need to make informed reproductive choices. This will require a shift to a more rights-based approach that centers reproductive choice, as well as subsequent shifts to health financing, health systems, infrastructure, and economic structures.

Decisions underpinning reproductive choice and fertility goals are complex. Creating an enabling environment for decision-making that upholds reproductive choice requires a multi-faceted approach. It requires creating access to quality reproductive health education and services so that all individuals have access to the information, tools, and resources to make reproductive health decisions that best support their reproductive choices. It requires addressing economic barriers that restrict choice – whether those are cost barriers that affect access to contraceptives or fertility services, or impact on careers of starting a family and/or costs associated with raising a child. And finally, it requires understanding the barriers that stand in the way of enabling reproductive choice – and then proactively addressing them.



REPRODUCTIVE HEALTH & HEALTH LITERACY POLICIES

This section of the ***Menu of Policy Options*** focuses on policies to create an enabling environment for reproductive choice and decision-making. These policies are aimed at addressing barriers that limit access to reproductive health services and information, including opportunities to enhance reproductive health literacy. This includes recommendations around the provision of quality family planning and fertility planning services, opportunities to raise public awareness around family planning and fertility planning services, and opportunities to overcome barriers to access. This also includes policies that create an enabling environment for reproductive choice and human rights, including policies that discourage early and forced marriages or interpersonal violence.

Common implementers involved in this section include: Government (economy, district and local levels), Departments of Health or Public Health, Ministries of Health, Departments of Education, Medical Oversight Boards, District Health Offices, Public and Private Sector Providers

Implementation of recommended policies in this section will depend on how healthcare service delivery and public health is regulated within individual APEC economies. Generally, these policy recommendations can be translated into regulations and rules or implemented as guidelines. As such, a critical component of their success will be ensuring that subsequent regulations and guidelines are well-crafted vis a vis other local policies or contextual factors.

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
Many individuals have low fertility awareness and do not learn about options for fertility planning or family planning until after having trouble realizing their reproductive goals.	Develop guidance and train healthcare providers to provide comprehensive reproductive health care and education when counselling patients on family planning. The counseling information should be inclusive of preconception care including information on fertility preservation options, such as egg-freezing or other assisted reproductive technologies. The guidance should also raise awareness about the importance of integrated family planning approach.	***Real world example:*** The People's Republic of China implemented a robust preconception care policy in 2010, with the goal of better supporting couples who were seeking to get pregnant in the short-term. This economy-wide policy is integrated into China's universal healthcare scheme as both a primary healthcare/preventative care technique and focuses both on counselling and behavioral and environmental factors to promote healthy pregnancy.[xv]
	Develop and implement curriculum to teach comprehensive, age-appropriate sexual and reproductive health education in public and private schools. This curriculum could include information around contraceptives and the prevention of unintended pregnancy, fertility awareness and the preventable causes of infertility. *Implementers: Ministry of Health, Ministry of Education, Public and Private Schools, Public and Private Providers*	***Real world example:*** In the Philippines, the Adolescent Health and Development Program (AHDP), implemented by the Department of Education focuses on comprehensive access to sexual and reproductive health education (as well as other health issues) for adolescents in a youth-friendly environment (aged 10-19). This policy aims to create access to age-appropriate, comprehensive sexual health information and topics relevant to the stages of the pubescent period. [xvi]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
Individuals are not always able to access fertility screening or treatment (e.g., IVF or egg harvesting/ freezing) without spousal consent or being legally married. This limits the ability for many individuals to seek fertility treatments proactively.	Develop and implement guidance and economy-wide laws to remove barriers for individuals seeking fertility treatments. Work with District Health Offices to train providers on fertility treatment counselling for individuals seeking fertility treatments. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** In 2008, the Australian state Victoria enacted the Assisted Reproductive Treatment Act, which expanded access to fertility treatments by removing legal barriers to access for unmarried couples and individuals.[xvii] ***Real world example:*** In 2022, Singapore announced plans to enable single women to access egg-freezing services, which were previously inaccessible to unmarried individuals. Starting in 2023, this policy would enable single women from 21-37 to freeze their eggs.[xviii]
Fertility services are often inaccessible beyond seeking care from a fertility specialist, limiting access and affordability of these services.	Develop guidance to integrate basic fertility investigation into primary healthcare in order to expand access to basic fertility services (e.g., for fertility screening). *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** In the Republic of Korea, fertility screening is integrated into the primary healthcare services provided through the National Health Insurance Service (NHIS). This includes infertility testing, semen analysis, hormone testing, and biopsy. Additional fertility treatments for stimulating ovulation, egg retrieval, intrauterine insemination (IUI) and in vitro fertilization (IVF) are also covered through subsidies from the NHIS.[xix]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
A wide range of contraceptive methods is not always available, which limits contraceptive choice.	Develop guidance and enact economy-wide laws to establish access to a wide range of contraceptive methods that includes *all* long-acting reversible contraceptive (LARC) methods. *Implementers: Ministry of Health, District Health Offices*	***Real world example:*** Through its FP2020 Commitments, Indonesia mobilized USD1.6 billion between 2015-2019 for family planning programs, highlighting the integration of family planning and contraceptives into its universal health coverage program and expanding the method mix within Indonesia. Particular attention was paid to expanding method mix access via new service delivery points and emphasis on long-acting reversible contraceptive (LARC) methods.[xx]
	Develop guidance and train District Health Officers or other relevant parties to forecast demand of contraceptive methods and implement procurement planning, where relevant. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** In Indonesia, the National Planning Agency, in partnership with the National Population and Family Planning Agency (BKKBN) and Ministry of Health, alongside external stakeholders, collaborated to strengthen the Logistics Management Information System (LMIS) for use in quantifying, forecasting, and procuring contraceptive commodities in order to avoid stockouts. Under this collaboration, the National Planning Agency undertook an evaluation of the LMIS, identified opportunities to strengthen predictability of stockouts, and built capacity at economy, provincial, and district levels to support planning.[xxi]
	Strengthen family planning supply chains by integrating guidance on equipment and consumable supplies planning for methods that are more material intensive (e.g., LARC methods) into service delivery guidelines for family planning. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Guidance example:*** While not a specific APEC example, EngenderHealth has developed a checklist of basic furniture, equipment, instruments, and expendable supplies needed in LARC service provision. This checklist can be integrated into family planning supply planning – and where relevant, tied to costed implementation plans (CIPs) to ensure that the right equipment and consumable supplies are planned for, procured, and made available.[xxii]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
(Continued from previous page) A wide range of contraceptive methods is not always available, which limits contraceptive choice.	Strengthen family planning supply chains by integrating guidance on equipment and consumable supplies planning for methods that are more material intensive (e.g., LARC methods) into service delivery guidelines for family planning. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** As an example of this integration, the Indonesia Costed Implementation Plan (2017-2019) for family planning specifically includes consumable supplies in costing exercises for anticipated expenditure on family planning programming, and calculates the programmatic cost and cost per user to incorporate consumable supplies. The CIP for Indonesia also makes regular reference to other supplies needed to deliver family planning services.[xxiii]
	Develop and implement laws on provider training and/or retraining on the full range of contraceptive methods available within the specific economy. Coordinate with District Health Offices to roll-out training. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** The Republic of the Philippines passed the Responsible Parenthood and Reproductive Health Act of 2012, which expanded access to all modern contraceptive methods through the Philippines' economy-wide health insurance mechanism. In this policy, all accredited public health facilities were mandated to provide the full range of contraceptive methods available in the Philippines and providers must be trained on counselling and providing access to the full range of contraceptive methods. [xxiv]
Contraceptive counselling does not always present women with the wide range of contraceptive methods available and is not always situated within the context of broader reproductive or fertility goals. Contraceptive counselling does not always result in proper use.	Develop and implement guidance on quality contraceptive counselling. Guidance could include the full range of contraceptive methods available within the economy and could emphasize informed choice. Guidance could also include discussions around broader reproductive and fertility goals. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** Family Planning NSW, Family Planning Victoria, and True Relationships and Reproductive Health jointly published an evidence-backed, medical experts co-authored handbook that provides accurate information on all available contraceptive methods and related clinical practice for health-care practitioners. The handbook, *Contraception: An Australian Clinical Practice Handbook*, 4th edition, is a comprehensive resource for providers on contraceptive methods and counselling, including guidance on definitions, mechanisms of action, advantages & disadvantages of different methods, contraindications, and advice surrounding quick start methods. [xxv]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
(Continued from previous page) Contraceptive counselling does not always present women with the wide range of contraceptive methods available and is not always situated within the context of broader reproductive or fertility goals. Contraceptive counselling does not always result in proper use.	Coordinate with the Department/Ministry of Finance and economy-side insurance mechanisms to ensure that a wide range of contraceptive methods is included in economy-wide insurance schemes/universal health financing. *Implementers: Ministry of Health, District Health Offices, Department/Ministry of Finance*	***Real world example:*** Thailand covers all contraceptive methods under its universal health coverage program, which provides comprehensive access to a wide range of sexual and reproductive health services.[xxvi] Through this program, there is also a family planning clinic placed within all government hospitals and all midwives, nurses, and doctors are trained in family planning service provision.[xxvii]
	Develop and implement guidance and easy-to-use resources on proper contraceptive use of a wide range of contraceptive methods (e.g., instruction on daily use for oral contraceptives). Coordinate with District Health Offices to create access to educational materials through a variety of dissemination channels. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers, International NGOs*	***Real world example:*** The New Zealand Family Planning Association created a webpage to provide comprehensive information around family planning options, how to use them, and potential side effects. The site provides women with information on how to access contraceptives within New Zealand. The site also includes additional information around sexual and reproductive health.[xxviii]
Adolescents and young people are not always able to access contraceptives or have limited choice around contraceptive methods. Often, adolescents and young people are required to seek parental or spousal approval before accessing contraceptives.	Develop and implement guidance to remove age-related restrictions in accessing contraceptive methods in both the public and private sector. Coordinate with District Health Offices to train providers to ensure an understanding of the policy change. *Note that age-related restrictions can include both legal restrictions (e.g., requiring parental consent for contraceptives) as well as cost constraints to the potential user, education, or access. Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** In the United States, a study demonstrated that when cost, education, and access barriers to accessing long-acting reversible contraceptives (LARCs) were removed, there was an 80% reduction in teen births compared to economy-wide statistics.[xxix] Study data from the United States also show that when barriers to access were removed, 70% of teens (aged 14-19) chose LARC methods.[xxx] The American Association of Pediatrics (AAP) developed guidance and recommendations on counselling adolescents on the use of LARC and other contraceptive methods, and additional resources and guidance have also been made available by the American College of Obstetricians and Gynecologists (ACOG).[xxxi]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
(Continued from previous page) Adolescents and young people are not always able to access contraceptives or have limited choice around contraceptive methods. Often, adolescents and young people are required to seek parental or spousal approval before accessing contraceptives.	Develop and implement guidance to prioritize adolescent and youth-responsive care. Work with District Health Offices to train providers on adolescent and youth-responsive approaches to quality contraceptive counselling and fertility planning. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** In the Philippines, the Adolescent Health and Development Program (AHDP) provides family planning services to young people (aged 10-24), with a particular emphasis on youth-friendly services that are responsive to the unique needs of young people. The program also includes age-appropriate education around sexual and reproductive health services.[xxxii] ***Real world example:*** In Viet Nam, the Ministry of Health has developed an economy-wide action plan for sexual and reproductive health care that focuses on adolescents and young people. In its implementation, Viet Nam will focus on access to information surrounding sexual and reproductive health, raising awareness around services available, developing youth-friendly services, and enhancing existing policies and laws to support implementation.[xxxiii]
Vulnerable populations are often not reached.	Develop guidance to prioritize the needs of vulnerable and marginalized populations (including, but not limited to: adolescents and youth, individuals living in fragile or humanitarian settings, rural populations, persons living with disabilities or pre-existing medical conditions, and low-income populations). *Implementers: Ministry of Health, District Health Offices, Public and Private Providers*	***Real world example:*** As part of Thailand's National Family Planning Program, there is a targeted approach to better meet the needs of vulnerable populations, including: remote rural villages, Muslim religious communities, ethnic minorities (including the hill tribe groups), and unmarried adolescents.[xxxiv] ***Real world example:*** The Responsible Parenthood and Reproductive Health Act in the Republic of the Philippines includes a specific section on meeting the sexual and reproductive health needs of disabled populations. This section includes guidance on removing barriers to services for persons with disabilities, ranging from transportation barriers to service delivery and accessibility barriers that limit access.[xxxv]
	Develop and implement guidance to ensure that immigrants living without documentation or legal immigration status are able to access healthcare services, including contraceptives and fertility treatments. *Implementers: Ministry of Health, District Health Offices, Public and Private Providers, Department of State, Ministry of Family Welfare*	***Real world example:*** Through the Deferred Action for Childhood Arrivals (DACA) Program in the United States, youth without legal immigration documented are granted temporary forbearance from removal status. The program's status was found to contribute to the reduction of unintended pregnancy (UIP) among this population, closing the gap by approximately 50% compared to Hispanic populations in the United States who did legal documentation. [xxxvi]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
Many cases of unintended pregnancy (UIP) are the direct consequence of forced marriage, child marriage, or interpersonal violence.	Implement policies to prohibit forced marriage, including child marriage and/or change age of consent and marriage laws to prevent cases of child marriage. *Implementers: Department of State, Department of Family, Department of Children's Welfare, Department of Justice*	***Real world example:*** Malaysia recently raised the minimum age of marriage of girls from age 16 to age 18 as an effort to reduce the prevalence of child marriage and forced marriage. This policy is also supplemented with the National Strategic Plan in Handling the Causes of Child Marriage 2020-2025, which includes a multi-stakeholder strategy to reduce child marriage by addressing different causes (e.g., household poverty, lack to sexual and reproductive health information and services, low education, cultural norms, and gaps within the legal frameworks).[xxxvii] ***Real world example:*** In 2015, Papua New Guinea revised the Lukautim Pikinini Act to enforce a legal marriage age of 18 years old. This policy revision was supplemented with the development of a child protection policy to guide implementation.[xxxviii] ***Real world example:*** Indonesia amended its 1974 Marriage Act to increase the marriage age for girls with parental permission from 16 to 19 years old, matching the legal marriage age for boys. (The age without parental permission for both girls and boys is 21.) This policy not only raises the marriage age with an intention of reducing child marriage, but also, promotes gender equality by equalizing the marriage age for both boys and girls.[xl]
	Implement or strengthen policies to prevent interpersonal violence (including sexual violence). *Implementers: Department of State, Department of Family, Department of Justice*	***Real world example:*** Chile has recently passed legislation to reduce the prevalence of sexual harassment and violence,[xxxx] in addition to enacting policies that require all higher education institutions to adopt comprehensive policies against sexual harassment, sexual violence, and gender-based discrimination and violence.[xli]

LABOR AND ECONOMIC POLICIES

This section of the ***Menu of Policy Options*** focuses on policies aimed at addressing barriers to – and strengthening the enabling environment for – supportive labor policies and working environments across the family planning and/or fertility planning journey. This includes recommendations around benefits offered by employers, guidance for employers around creating supportive environments, and labor laws.

Common implementers involved in this section include: Government (both district and economy levels), Department of Labor, Public and Private Sector Employers

Implementation of recommended policies in this section will depend on how labor is regulated within an individual APEC economy and the extent to which this regulation is centralized through economy-wide laws. Broadly speaking, recommendations contained in this section can (and could) be implemented at the economy level and further reinforced by public and private employers.

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
Many employers – both public and private – do not create an environment that supports individuals in realizing their fertility goals. Many workplace environments penalize extended time off (including for parental leave) in promotion or hiring decisions.	Develop guidance to encourage employers (both public and private) to adopt supportive policies across the family planning and family building journey. *Implementers: Department of Labor, Public and Private Employers*	***Real world example***: In Thailand, several government policies have enabled supportive, family-friendly policies within the private sector. Among them are the 12th National Economic and Social Development Plan (2017-2021) and the Labour Protection Act (No. 7). Both policies establish the foundation for a coherent set of recommendations and practices to promote family well-being across the economy, including through private sector employers.[xlii]
	Implement economy-wide labor laws to provide paid parental leave (for both parents) and/or implement workplace policies (both public and private) to provide paid parental leave. *Implementers: Department of Labor, Public and Private Employers*	***Real world example***: In the Republic of Korea, mothers are entitled to three months of maternity leave (45 days must be taken immediately following birth). Pay varies based on the company size and insurance offerings at the company. Korea also provides parental leave for parents who need to care for a child under six-years old, receiving 40% of monthly income from employment insurance during that time.[xliii] ***Real world example***: In Indonesia, women are guaranteed 13 weeks of maternity leave with full wages throughout the duration of that time. This leave is fully funded by employers.[xliv]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
(Continued from previous page) Many employers – both public and private – do not create an environment that supports individuals in realizing their fertility goals. Many workplace environments penalize extended time off (including for parental leave) in promotion or hiring decision.	Implement economy-wide labor laws to provide paid parental leave (for both parents) and/or implement workplace policies (both public and private) to provide paid parental leave. *Implementers: Department of Labor, Public and Private Employers*	***Real world example***: In April 2022, Japan expanded the provision of childcare leave, including the establishment of a new system that would entitle employees to four weeks of childcare leave (at full pay) within eight weeks from the birth of a child, making it easier to take leave immediately following the birth of a child. This policy builds upon Japan's existing Child Care and Family Care Leave Law, which provides parental leave and childcare leave benefits for up to one year (whereby workers are eligible for 67% of their salary for the first six months and 50% of their salary for the second six months). Historically, childcare leave has been underutilized by men, so this new policy also includes a specific focus on encouraging men to take leave to support their partners and children.[xlv, xlvi] ***Real world example***: Peru provides 98 days of paid maternity leave to female employees, including 49 days before the birth of the child and 49 days after the birth of the child. This leave can be extended for up to 30 days if there are complications during childbirth. Maternity leave in Peru is compensated by the National Health System (EsSalud) or the Private Health System (Entidades Promotoras de Salud, EPS). Men are entitled to ten days of paid paternity leave following the birth of a child, which can be extended to 20 days if there are childbirth complications.[xlvii]
	Develop guidance for workplace norms and sensitivity in supporting reproductive choice of all employees, including guidance around paid leave, parental leave, and flexible working hours. *Implementers: Department of Labor, Public and Private Employers*	***Real world example***: A private sector example includes Organon, a global women's healthcare company, which recognizes the diversity of its workforce and different needs, wants and circumstances of its employees. In many geographies around the world, Organon introduced employment benefits, such as leave benefits that support the reproductive health needs of its employees, including pay continuation and time off to attend consultations, appointments, and treatments related to fertility, adoption, foster care, surrogacy via its Global Care Leave Policy. Flexible Leave was implemented with the understanding that employees' needs, with respect to their reproductive health journeys, are likely to be unique and can be taken as employees see fit.[xlviii]

IDENTIFIED BARRIER	MENU OF POLICY OPTIONS	REAL WORLD EXAMPLES
(Continued from previous page) Many employers – both public and private – do not create an environment that supports individuals in realizing their fertility goals. Many workplace environments penalize extended time off (including for parental leave) in promotion or hiring decision.	Develop labor laws and guidance to prevent employer-discrimination for expecting parents (e.g., limiting promotion potential, hiring bias). *Implementers: Department of Labor, Public and Private Employers*	***Real world example:*** The Labor Code of the Republic of the Philippines prevents discrimination against female employees who are pregnant (or might become pregnant or recently gave birth). Additional laws within the Philippines also provide additional benefits and protections to pregnant women, including paid medical leave and flexible work schedules.[xlix]
	Develop guidance to support employers (both public and private) in measuring the utilization of offered benefits to assess use and effectiveness. *Implementers: Department of Labor, Public and Private Employers*	***Real world example:*** While not a specific APEC example, Employee Assistance Programs (EAP) are one model where employees are offered employer-provided benefits and services. The Society for Human Resource Management (SRHM) offers guidance around establishing effective EAPs, including guidance around measuring use and following-up with employees as well as templates and tools for developing EAP policies.[l]
Fertility treatments (e.g., IVF or egg-freezing) can often be time-intensive, requiring individuals to miss work. Many employers do not provide sick time or paid leave for individuals seeking fertility treatment.	Establish sick leave laws for employees. Where sick leave laws exist, strengthen laws and/or employer policies to include coverage for fertility treatments. Develop guidance to encourage confidentiality on the justification for sick leave. *Implementers: Government, Public and Private Employers, Department of Labor*	***Real world example:*** A private sector example includes Westpac, a bank in Australia, that recently adopted a paid sick leave policy that would grant one week of paid leave to employees seeking to undergo fertility treatments.[li]
Many individuals face difficulty in identifying affordable childcare during the workday.	Where possible, integrate childcare into employer-provided benefits packages. *Implementers: Public and Private Employers*	***Real world example:*** In the Republic of Korea, employers with over 500 employees, or more than 300 female employees, are required to provide on-site childcare.[lii]
	Implement flexible working hours for employees who need to work alternate hours or work remotely to balance childcare needs. *Implementers: Public and Private Employers*	***Real world example:*** Singapore implemented a Work-Life Grant program where companies could apply for grants to support the implementation of flexible work arrangements for employees, with an overarching goal of creating better work-life balance. These arrangements could include job sharing arrangements, compressed work weeks, or flexible locations of work.[liii]

FUNDING & FINANCING MECHANISMS

This section of the ***Menu of Policy Options*** focuses on policies aimed at addressing barriers to – and strengthening the funding or financing environment for – family planning, fertility planning, and other reproductive health services. This includes recommendations around overcoming cost barriers associated with both family planning and fertility planning services, as well as recommended funding and financing mechanisms for supporting families with costs associated with having children. This is also inclusive of recommendations around macro-level financing of the proposed policies, including exploring opportunities for innovative financing.

Common implementers involved in this section include: Government, Departments of Finance or Economics, Department of Social Security or Economy-wide Health Insurance Schemes, Public and Private Insurance Companies, Public and Private Companies, Novel players (e.g., impact investors).

Implementation of recommended policies in this section will depend on how financing for healthcare is regulated and to what extent the individual APEC economy has a centralized, universal health coverage program vs. more decentralized public or private insurance mechanisms. Many of the recommendations included in this section will require economy-wide policy changes, but will also include policy options for insurance providers. Note that many of the policies included within this section – particularly around subsidies or tax credits – could be pursued on a sliding scale or for specific economic demographics.

IDENTIFIED BARRIER	MENU OF PROPOSED POLICY OPTIONS	REAL WORLD EXAMPLES
Fertility treatments can be cost-prohibitive to the potential user and often fall outside of established financing mechanisms, like public or employer-provided insurance.	*Provide government-funded subsidies or tax credits to cover the cost of fertility treatments (e.g., IVF or egg freezing).* Subsidies/credits should be substantial enough to overcome cost barriers. *Implementers: Ministry of Finance, Ministry of Health*	***Real world example:*** In Hong Kong, China the Hospital Authority heavily subsidizes the cost of fertility treatments.[liv] ***Real world example:*** In Australia, in addition to subsidies in the form of a rebate under the Medicare Benefits Schedule (MBS), funding to support patients with their out-of-pocket costs for fertility treatments is available through the Medicare Safety Net program. This program provides additional benefits to patients after they reach a certain threshold and covers both fertility treatments and assisted reproductive treatments listed on the MBS and delivered in an out-of-hospital setting.[lv]
	Integrate fertility treatments into economy-wide insurance schemes or employer-provided insurance schemes (both public and private). *Implementers: Government, Public and Private Insurance Mechanisms, Employers*	***Real world example:*** In Japan, the economy-wide health insurance scheme now reimburses the cost of infertility treatments, reducing the total cost of IVF by about 70%.[lvi] This policy includes several different fertility treatment methods as well as multiple attempts, and establishes a fee management structure for more advanced treatments, as needed.[lvii]

IDENTIFIED BARRIER	MENU OF PROPOSED POLICY OPTIONS	REAL WORLD EXAMPLES
Medical costs associated with having a child are often cost-prohibitive, particularly costs associated with pregnancy and childbirth.	Provide government-funded subsidies or tax credits to cover the cost of pregnancy and childbirth. Subsidies/ credits should be substantial enough to overcome cost barriers. *Implementers: Ministry of Finance, Ministries of Family or Child Development, Ministry of Health*	***Real world example:*** Chinese Taipei recently adopted a comprehensive policy aimed at expanding access to services across the reproductive life-cycle, including access to fertility treatments, childbirth, and raising a family. These policies include fertility treatment subsidies (and expanded eligibility criteria for accessing the subsidies), free prenatal exams for eligible pregnant women, and enhancing access to paid leave (including for prenatal exams – for pregnant women and spouses), access to stipends during leave without pay, and access to flexible working hours.[lviii]
	Integrate medical care for pregnancy, childbirth, and both antenatal and postnatal care into public insurance schemes or employer-provided insurance schemes (both public and private). *Implementers: Government, Public and Private Insurance Mechanisms, Employers*	***Real world example:*** Indonesia has expanded access to financing for maternal newborn health through several different policies, beginning with the Safe Motherhood Initiative in the 1980s. Through its Jampersal I policy, Indonesia focused on antenatal, delivery, and postnatal care for uninsured women and newborns. This care also included referrals for complications as well as childcare for newborns. Now, JKN -- the economy-wide health insurance mechanism in Indonesia – provides antenatal care, delivery care, postnatal care, and neonatal health services to all JKN-insured women. It also covers a variety of additional costs, including transportation to/from referral facilities and referral services for complications. This policy is supplemented by Jampersal II, which focuses on uninsured women and newborns.[lvix]
	Implement policies that include children in insurance mechanisms (universal health coverage or employer-funded/ private insurance). *Implementers: Government, Public and Private Insurance Mechanisms, Employers*	***Real world example:*** Malaysia has an economy-wide universal health coverage program, inclusive of children and infants. Since its implementation, Malaysia has boasted impressive reductions in newborn mortality and child vaccination rates.[lx]

IDENTIFIED BARRIER	MENU OF PROPOSED POLICY OPTIONS	REAL WORLD EXAMPLES
Childcare costs are often cost-prohibitive. This can be a barrier to choosing to have children and/or choosing to continue working after having children.	Provide government-funded subsidies or tax credits to cover the cost of childcare. Subsidies/credits should be substantial enough to overcome cost barriers. *Implementers: Government*	***Real world example:*** Canada passed federal funding to reduce fees in licensed childcare facilities by 2026 to an average daily rate of CAD10 and plans to build 40,000 new childcare facilities across the economy.[lxi] Canada also recently announced a CAD30 billion investment over five years to reduce the cost of childcare and early learning, with a vision of establishing an economy-wide childcare program and reducing the cost of childcare by up to 50% on average.[lxii] ***Real world example:*** Korea recently implemented a law that will pay parenting allowances of USD520 per month to households with children under age 1 and USD260 per month to households with a child under 2.[lxiii] ***Real world example:*** Starting 10 July 2023 Australia is set to change its Child Care Subsidy (CCS) program to make child care more affordable for more families expanding to include some families who previously were not eligible. Some of the changes include increasing the subsidy rate from 85 % to 90%, shifting the family income eligibility limit upward to AUD530,000 per annum, a 90 % subsidy rate for families earning less than AUD80,000 and other additional benefits for indigenous population.[lxiv] ***Real world example:*** The Russian Federation has a maternity capital program, where payments are made to families to cover costs associated with having children. (The payments range from approximately USD7,350 for the first child to approximately USD2,370 for the second child.) The maternity capital is intended to cover specific costs, including paying a mortgage, building housing, paying for childcare or children's education. Families can opt for monthly payments instead, but the amount received is lower. Finally, families are eligible for mortgage repayment of up to USD7,000 if they have a third child.[lxv]
	Establish policies for childcare subsidies or employer-funded childcare through public and private employers. Subsidies/credits should be substantial enough to overcome cost barriers. *Implementers: Public and Private Employers*	***Real world example:*** Singapore is implementing a policy to provide parents up to SGD600 per month for full-day infant care and up to SGD300 per month for full-day childcare. Lower-income families are eligible for higher subsidies through the program. The program also includes fee assistance for kindergarten, also anchored to gross family income as well as number of children.[lxvi]

IDENTIFIED BARRIER	MENU OF PROPOSED POLICY OPTIONS	REAL WORLD EXAMPLES
The cost of contraceptives, particularly long-acting reversible contraceptives (LARCs) or permanent methods (e.g., sterilization) can be cost-prohibitive to potential users. While LARC methods and permanent methods are cost-effective over time, the upfront costs can be cost-prohibitive for potential users when not fully covered by insurance schemes.	Provide government-funded subsidies or tax credits to cover the cost of a wide range of contraceptive methods. Subsidies/credits should be substantial enough to overcome cost barriers. *Implementers: Government*	***Real world example:*** Indonesia covers financing for contraceptives both through JKN (the economy-wide health insurance scheme) as well as through BKKBN (the National Population and Family Planning Board). BKKBN provides an operational assistance fund that enables districts to roll-out family planning programs, including mobile FP services to reach remote communities through additional points of services.[lxvii]
	Integrate a wide range of contraceptive methods into public insurance schemes or employer-provided insurance schemes (both public and private). *Implementers: Government, Public and Private Insurance Mechanisms, Employers*	***Real world example:*** In the Philippines, the economy-wide PhilHealth Insurance Program covers a wide variety of long-acting methods, including intrauterine device (IUD) insertion, contraceptive implant insertion, vasectomy, and tubal ligation. PhilHealth will also cover short-acting methods (e.g., oral contraceptive pills) under the new UHC Law.[lxviii] ***Real world example***: In 2014, Mexico shifted the purchasing of contraceptives from the state to federal level of the Ministry of Health. The goal of this policy change was to procure large volumes of contraceptives, thereby driving down the cost and increasing overall supply. As a result of pooling this purchasing, Mexico's investment in contraceptives nearly doubled from the previous year. As part of the same reform, Mexico also aligned maternal health policies with family planning policies, lowering financial barriers and improving access to both services. As a result, family planning coverage increased.[lxix] While this policy provides a strong example of how different economies could procure large volumes of contraceptives at a lower cost, effectiveness of outcomes across different methods will likely depend on corresponding policies around awareness and access to method preference.
	Develop guidance for employers and private insurance mechanism schemes that prioritizes client choice in electing contraceptives, ensuring coverage of a wide range of choices within each contraceptive method categories. *Implementers: Government, Public and Private Insurance Mechanisms, Employers*	***Real world example:*** In the United States, the Department of Health and Human Services, Department of Labor, and the Treasury issued joint guidance on the coverage of family planning services under the Affordable Care Act. This guidance includes coverage of a wide range of contraceptive methods. This guidance was issued to both health insurers as well as employer-provided health plans.[lxx]

IDENTIFIED BARRIER	MENU OF PROPOSED POLICY OPTIONS	REAL WORLD EXAMPLES
The cost of many contraceptive methods, fertility treatments, and other reproductive health products can be cost-prohibitive for economies to purchase.	Explore opportunities to implement volume guarantees.[3] Note that volume guarantees will have broader effectiveness if economies explore opportunities for economy specific pricing and access based upon need, volume, and local capabilities. *Implementers: Ministry of Health, Ministry of Finance, International NGOs, International Donor Organizations/Foundations, Manufacturers*	***Real world example:*** Under the Implants Access Program (IAP) two negotiated volume guarantees for procuring contraceptive implants, coupled with capacity-building, supply chain strengthening, and global coordination resulted in a 10x increase in contraceptive implant procurement and prevalence in 6 years.[lxxi] While this is one effective way to generate economy relevant pricing, this can also assist in expanding access and procurement requirements.
	Where appropriate, investigate opportunities to utilize innovative or sustainable financing through the use of social impact bonds or other financing mechanisms. While evidence to date on utilizing results-based financing or sustainable financing for family planning is limited, it presents a promising option for further exploration as it relates to family planning. *Implementers: Ministry of Health, Ministry of Finance, International NGOs, International Donor Organizations/Foundations, Manufacturers*	***Real world example:*** While not an APEC-specific example, a USAID-funded case study in India indicated positive results in expanding access to family planning services through a pay for performance model. This case study included 70 payment milestones over a 3-year timeframe, with an overarching goal of expanding access to family planning through enhanced private sector capacity. A second case study, also from India, utilized a maternal newborn health impact bond to extend access to quality maternal and newborn care.[lxxii]

[3] Market volume guarantees for contraceptive products are agreements between buyers and suppliers of contraceptive products that aim to increase access and affordability of these products in low- and middle-income economies. These agreements reduce the risk and uncertainty for suppliers by ensuring a minimum demand and price for their products, while also lowering the price for buyers by creating economies of scale and competition.

IDENTIFIED BARRIER	MENU OF PROPOSED POLICY OPTIONS	REAL WORLD EXAMPLES
(Continued from previous page) The cost of many contraceptive methods, fertility treatments, and other reproductive health products can be cost-prohibitive for economies to purchase.	Where appropriate, investigate opportunities to create lower cost products or products at lower (or negotiated) prices for low- or middle-income economies. For example, to make reproductive health products more accessible for low- or middle-income economies, some options are to use pricing models that are tailored on the economy's economic level and/or to use/produce generic drugs. New and creative ways for NGOs to get affordable contraceptive products should also be considered. *Implementers: Ministry of Health, Ministry of Finance, International NGOs, International Donor Organizations/Foundations, Manufacturers*	***Real world example:*** One example is the Pan American Health Organization (PAHO)'s Revolving Fund. The Revolving Fund focuses on creating access to vaccines among member states by creating affordable prices. This is achieved by increasing the strategic purchasing power through demand forecasting and negotiations with suppliers, in turn reducing vaccine prices. This approach creates a predictability for individual economies and for suppliers, while also accelerating health impacts.[lxxiii]
For couples or individuals who want children but cannot have them biologically, adoption is often cost-prohibitive.	Explore opportunities to reduce the cost of adoption, including the implementation of government-funded subsidies or tax credits. *Implementers: Ministry of Health, Ministry of Finance, Ministry of Child Health*	***Real world example:*** Korea, through the Ministry of Health and Welfare developed a strategy to promote domestic adoptions. This approach included both institutional and financial support for adoptive families, access to maternity leave for adoptive parents, and supporting both single and unmarried individuals in pursuing adoption. It also included additional financial support to families, including adoption charge support, medical bill support, financial support for counseling, and childcare expense support.[lxxiv]
Individual economies or programs often lack access to funding or financing mechanisms to support the implementation of new policies or programs related to family planning or fertility planning.	Where appropriate, explore sustainable financing mechanisms (e.g., results-based financing or pay for performance) to identify external (often private) funding or investment to implement reproductive health programming. In this model, payment incentives are established and disbursed based on successful outcomes. *Implementers: Private subject matter experts, program operators, monitoring and evaluation entities, Ministries of Finance and Health, and other relevant parties*	***Real world example:*** While not specific to APEC, one example of a sustainable financing mechanism for the delivery of sexual and reproductive health services was in Kenya. 'In Their Hands,' a pilot program of a 2-year development impact bond (beginning 2022) investigated opportunities to pair a development impact bond with results-based financing. This initiative created access to contraceptive methods for 193,000 girls aged 15-19 across 16 counties in Kenya. Findings indicate promising opportunities to explore social impact bonds and highlight the need to identify appropriate indicators for effective results.[lxxv]

CONCLUDING REMARKS

The ***Menu of Policy Options*** is designed to provide a variety of different approaches to create a holistic enabling environment for reproductive decision-making. In considering ways to implement the policies contained within the ***Menu of Policy Options***, APEC economies will have the opportunity to consider which policies might be best-positioned for their unique needs and individual contexts. **While determining which policies might be most impactful, APEC economies are also encouraged to consider a multi-sectoral, whole of government approach where multiple policy options are combined or implemented simultaneously.** This will enable enacting policies that address both upstream barriers (such as cost, or economic concerns) while also responding to direct barriers to reproductive health services (such as expanded method mix or access to fertility treatments). In the Addendum Section, there are several different case studies from APEC economies that adopt a multi-sectoral, multipronged approach to address barriers from multiple angles.

Adopting policy recommendations from the ***Menu of Policy Options*** is a critical first step in creating an enabling environment for reproductive health decision-making; however, policy implementation is only the first step. For these policies to be most effective, APEC economies will need to define what success looks like, outline metrics of success, and monitor implementation to determine whether or not the policies are effective. Successful policy implementation will also require broad political will to overcome barriers to effective implementation. Such barriers might include stigmas associated with sexual and reproductive health education, awareness, misinformation, marginalization of vulnerable populations, access to services and a lack of funding to support policy implementation.

APEC economies are encouraged to come together to share lessons learned, best practices, and challenges in implementing policies from the ***Menu of Policy Options***. Prioritizing a rights-based approach while navigating changing demographic trends will require a willingness to share ideas, innovate, and apply lessons learned as new policies and approaches are implemented.

*Utilization of the **Menu of Policy Options** is voluntary and the adoption of different policy recommendations may largely depend on the individual context of different APEC economies.*

The Development of the Menu of Policy Options

The ***Menu of Policy Options*** was developed via APEC Smart Families, a public-private partnership led by the Thailand Ministry of Public Health, with the support of a consortium of partners providing technical and policy expertise. These partners include Organon, a pharmaceutical company aimed at delivering better medicines and solutions for women, and Jhpiego, a global health nonprofit affiliated with Johns Hopkins University that creates and delivers transformative health care solutions that save lives.

To inform the development of a comprehensive ***Menu of Policy Options***, an Expert Working Group[4], comprised of participants from government (primarily health, gender, finance, education, economic, demography, and labor policymakers), international organizations, academia, business, and other interested members of civil society, was established. The Initiative was launched on 22 August 2022 at the APEC Smart Families Policy Dialogue meeting, which was then followed on by the formation of an Expert Working Group that met three times to draft, review, and validate the included policy options. The policy recommendations were supplemented by a literature review and technical analysis.

[4]*See Appendix A for the full list of Expert Working Group Members and participating Resource Speakers.*

ADDENDUM: CASE STUDY EXAMPLES OF HOLISTIC POLICY APPROACHES

CASE STUDIES OVERVIEW & APPLICATION

The ***Menu of Policy Options*** is designed so that APEC economies can select and implement the policies that are most relevant to their unique needs or contexts. While any of the policies included could be implemented as standalone policies, they will be most impactful when implemented holistically. By combining multiple policy recommendations from the ***Menu of Policy Options***, APEC economies will be better positioned to take a more holistic approach, addressing both upstream challenges that influence reproductive health decision-making (e.g. cost or economic) while also prioritizing access to quality reproductive health information, tools, and services.

In addition to identifying the *components* of a comprehensive policy approach to improving reproductive health outcomes, it is important to measure whether those policies are working – and where they aren't, to identify opportunities to strengthen the approach. To accomplish this, it is important to develop indicators, measure performance, and course correct, when necessary. The following case studies are intended to serve as examples for how APEC economies can combine different policy recommendations to build a more comprehensive, holistic program around expanding access to family planning and fertility planning services.

These examples are explored by policy, but are color-coded to match the three policy buckets from the **Menu of Policy Options: Reproductive Health & Health Literacy policies in pink, Labor & Economic policies in blue, and Funding & Financing policies in green.**

CASE STUDY #1: AUSTRALIA

Government Policies to Establish an Enabling Environment to Support Families in Reproductive Health Decision-Making

Australia presents another interesting case study in exploring policy approaches to creating access to comprehensive sexual and reproductive health, inclusive of both family planning and fertility planning. This case study explores how the Australian government has enacted multiple policies aimed at overcoming barriers that prevent individuals – or families – to recognize their sexual and reproductive health goals. These policies represent multiple components of the ***Menu of Policy Options,*** and when implemented simultaneously, create comprehensive reproductive health programming. Private companies, including health insurance, private sector employers, etc. often supplement the government-funded or provided coverage.

POLICY COMPONENTS

AUSTRALIA MEDICARE PROGRAM

Medicare is Australia's universal healthcare insurance scheme. It provides both free and subsidized health care services via Medicare benefits (rebates) for privately rendered services listed on the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) subsides medicines and free hospital services for public patients in public hospitals, via agreements with the states and territories.[i] Medicare provides all Australians (and some overseas visitors) access to a wide range of community-based health and hospital services at low or no cost. Medicare provides comprehensive access to reproductive health services across different family planning and fertility planning goals: pregnancy prevention, conception and fertility treatment, pregnancy and

childbirth, and post-partum care.[ii] These services are available to families, children, Indigenous Australians, and people living in remote or rural communities.[iii] Financial support and cost reimbursement varies based on different factors and services. Through Medicare, the following services and approaches are utilized:

- Financial support of pregnancy-related costs, including visits to doctors and midwives, pathology, diagnostic imaging, blood testing, and immunizations during pregnancy, which is further supported by the National Immunization Program;
- Financial support of three pregnancy counselling visits to support mental health during pregnancy;
- Financial support for in vitro fertilization (IVF), including additional financial coverage through the Medicare Safety Net;
- Financial support for costs related to childbirth, including midwife or obstetrician-provided services. Patients who deliver in public hospitals will not have to pay for childbirth costs;
- Financial support for post-pregnancy care is also available, including specialist care for the infant if needed, as well as care provided by midwives and obstetricians, infant immunizations, and general follow-up visits to a primary care provider;
- Financial support for the baby once the baby is enrolled in Medicare;
- Financial support for children's healthcare through Medicare, including dental and immunization coverage;[iv]
- Financial support to new parents through a lump sum payment and tax benefit when they have a child, or a child comes into their care through adoption. This benefit has specific rules and access criteria based on a variety of factors, including utilization of other provided benefits.[v]
- Specific support for children with disabilities, including screening and assessment, diagnosis, and treatment; financial support for parents who care for children with disabilities;[vi]
- Specific support for healthcare access, including reproductive healthcare, for Indigenous Australians;[vii] Specific support for healthcare access, including reproductive healthcare, for Australians living in rural and remote communities, particularly through telehealth visits, mobile clinics, and tailored rural health services.[viii]

AUSTRALIAN GOVERNMENT PARENTAL LEAVE PAY SCHEME

In Australia, new parents are entitled to government funded parental leave, paid parental leave by their employers, and additional unpaid parental leave. Access to these benefits, and payment amounts, vary based on different eligibility criteria.[ix] Paid parental leave benefits include:

- Eligible employees are entitled to 18 weeks of paid parental leave at the economy minimum wage. This 18-week period is divided into a 12-week first period, which is used at once and a second period where the employee can use an additional 30 days of paid leave until the child turns two years old;

- Employees also have access to flexible working hours, where they can explore reducing their hours or days of work each week, changing their pattern of working hours, and/or choosing to take additional unpaid leave;
- Paid parental leave is paid by the government, typically directly to the employer;
- Dad and Partner Pay is available for two weeks of leave, paid at the economy minimum wage; the Australian government pays these benefits directly to the employee;
- Employees who have access to employer-funded paid parental leave are eligible to take that leave i*n addition to* the government funded leave;

Starting 1 July 2023, there will be several changes to the parental leave pay scheme. Notably, the current 18 weeks of paid parental leave will be combined with the two weeks of Dad and Partner Pay. This will create 20 paid weeks of parental leave for new parents, who can determine how to divide the time. Single parents can claim the full 20 weeks. Additional changes include family income limits in accessing this benefit, expanded eligibility requirements for partner leave, creating the ability for families to flex the paid leave time through when the child turns two, and removing a requirement to return to work following the leave.[x]

CHILD CARE SUBSIDY

The Australian Government also provides a childcare subsidy to caretakers of children under the age of 13 who is not attending secondary school.[xi] Eligibility depends on different conditions and circumstances, but in general the policy includes:

- Financial coverage or support for childcare for parents (or caretakers) with children under 13 who are not enrolled in secondary school. For coverage, the child has to attend an approved childcare service, and the recipient of the subsidy must be responsible for making payments;
- Additional support is also available through the Additional Child Care Subsidy, which is available by application to grandparents, parents or caretakers who are transitioning jobs or workplaces, or those experiencing financial hardship;[xii]

OUTCOMES, SUCCESSES, AND OPPORTUNITIES FOR IMPROVEMENT

The Centre for Population recently commissioned an assessment on fertility-related policies in Australia and corresponding outcomes with regards to fertility decision-making. ***The study indicated that financial incentives, paid parental leave, and childcare subsidies have had a positive impact on fertility rates within Australia.***[xiii] These findings indicate that addressing macro-level, upstream barriers – like costs associated with having children – can lead to a successful pathway in supporting families who want to have children, but have not been able to do so due to economic concerns.

The study also found that Australia has established strong support for assisted reproductive technologies (ART) resulting in Australia having one of the highest proportions of children born as a result of ART globally (5% of births). The impact of ART alone has been relatively modest with regards to increases in the total fertility rate within Australia, at this time. This indicates that while people are using ART, and access to ART

has helped individuals achieve their own fertility goals, there are additional factors that may influence fertility and population-level changes in fertility.[xiv] Fertility goals are influenced by a variety of different factors – both biological and economic – and the most effective policies will take a multipronged approach in addressing these barriers simultaneously. The report also indicates that "different factors were of greater importance to different groups of people," recognizing that there is no 'one sizes fits all' approach.[xv] Finally, the report outlines several economic conditions that have also influenced fertility decision-making within Australia. Among the most important factors are costs associated with raising children, job security, relationships, the ability to buy a home, and age.[xvi]

Australia's policies, particularly those offered via Services Australia and the Department of Health and Aged Care, have helped to create an enabling environment for families who want to have children to act on their fertility goals. To further support families who want to have children, Australia could consider different upstream policies aimed at addressing economic barriers that prevent families from acting on their reproductive goals. These policies could also be applied further among vulnerable populations.

CASE STUDY #2: THE PHILIPPINES

The Responsible Parenthood and Reproductive Health Act of 2012[xvii]

In 2012, the Philippines passed The Responsible Parenthood and Reproductive Health Act (RPRH) to take a multi-pronged, multi-sectoral approach to reproductive health. This policy takes a rights-based approach, emphasizing reproductive health and choice as a human right, and highlighting the linkage between reproductive decision-making and women's equality and economic empowerment. To do this, the legislation utilizes multiple approaches, which are reflected in several of the policy recommendations from the ***Menu of Policy Options***.

RESPONSIBLE PARENTHOOD AND REPRODUCTIVE HEALTH ACT OF 2012: POLICY COMPONENTS

REPRODUCTIVE HEALTH & HEALTH LITERACY

- Reproductive healthcare, as included in the policy, is defined to comprehensively include family planning (including both information and services); maternal, infant, and child health & nutrition; management of post-pregnancy complications; adolescent and youth reproductive healthcare; prevention, screening & treatment of STIs; prevention of violence against women and children; education on reproductive health & sexuality; treatment of breast and reproductive tract cancers & gynecological disorders; the role of male partners in reproductive health; prevention, treatment, and management of infertility; reproductive health education, including for adolescents; and mental health aspects of reproductive healthcare.
- Reproductive health programs will promote and provide information on all methods of family planning and individuals will have the right to choose their preferred method;
- Specific programs to create access to reproductive healthcare information and services will be implemented for poor and vulnerable populations, including prioritizing understanding the unique needs and experiences of marginalized communities;

- All families have the right to determine their ideal family size and programming will prioritize access to information and services to ensure that families are equipped with what they need to achieve fertility goals;
- A comprehensive reproductive health program will prioritize addressing the health needs of people across their full lifecycle;
- The policy prohibits any discriminatory practices that limit an individual's ability to exercise their reproductive rights;
- The RPRH emphasizes the importance of post-pregnancy care, including any maternal health complications or challenges that arise during childbirth;
- The RPRH includes a specific focus on procurement and supply chain management of family planning supplies across the economy;
- The RPRH includes a specific focus on adolescent and youth populations, including comprehensive age-appropriate SRH education;
- The RPRH includes a specific focus on persons living with disabilities and removing barriers to reproductive health services for these populations;
- The RPRH includes training for health workers across different cadres, including mobile health clinics to reach hard to reach populations.

LABOR & ECONOMICS

- The RPRH recognizes the rights of all individuals and families to a living wage and income.

FUNDING & FINANCING MECHANISMS

- The RPRH provides universal access to reproductive healthcare services, methods, devices, and supplies;
- The RPRH prioritizes the allocation of funding for family planning to poor and marginalized communities.

In addition to the multi-pronged approach to reproductive health – stretching across reproductive health & health literacy, labor & economics, and funding & financing mechanisms – the RPRH is guided by several principles and overarching approaches that center and prioritize concepts of demographic resilience. For example, the RPRH notes:

> "There shall be no demographic or population level targets and the mitigation, promotion, and/or stabilization of the population growth rate is incidental to the advancement of reproductive health."

The emphasis on advancing reproductive health access over specific population-level targets shows a commitment to a rights-based approach, rather than an attempt to influence overall fertility rates within the Philippines. Policies aimed at influencing birth rates or fertility rates risk becoming coercive and can be at odds with individual fertility goals. The act also specifically highlights the criticality of free and informed "decision-making" for reproductive health, the importance of data and defined indicators in assessing and shaping programming, and accountability mechanisms.

RESPONSIBLE PARENTHOOD AND REPRODUCTIVE HEALTH ACT OF 2012: OUTCOMES, SUCCESSES, AND OPPORTUNITIES FOR IMPROVEMENT

Since it was passed in 2012, the RPRH has expanded access to reproductive healthcare across the Philippines, including significant improvements in key reproductive health outcomes. For example, unmet need for family planning methods dropped to 17% in 2017 (five years after implementation of the RPRH) – down from 30% in 1993.[xviii] Reductions in the adolescent fertility rate were also seen following the implementation of the RPRH. In 2013, the teenage pregnancy rate in the Philippines was 10%. It has since been halved to 5.4% in 2022.[xix]

While the RPRH was successful in expanding access to reproductive health services throughout the Philippines, there are also opportunities to improve the policy. For example, specific interventions or programs for the most vulnerable populations would likely reduce inequities in reproductive health outcomes. An exemplar of this is among the Philippines' most impoverished populations, where women are more likely to have more children than they desire, and have – on average – 2.5 more children than other economic groups.[xx] The RPRH could also incorporate greater focus on sexual and reproductive health education, inclusive of both family planning and fertility planning opportunities. Modern contraceptive use remains relatively low among married women in the Philippines (54% contraceptive prevalence rate) and there were only minor improvements in the gap between total fertility rate and wanted fertility rates.[xxi]

Moving forward, there are many different opportunities to strengthen the RPRH Act or similar policies within the Philippines. Following a 2021 assessment on the RPRH Act's performance to date, there were several recommendations to further integrate the activities of the RPRH into local government units (LGUs) and allow for adaptability to specific community needs. This shift would not only align with political developments within the Philippines, but would also allow local stakeholders to better reflect individual needs of their local contexts. These recommendations, which were further explored in the 2021 Annual Report for RPRH, also included opportunities to further enhance political will and prioritization of the RPRH activities, implement public-private partnerships to accelerate impact, and streamline and strengthen monitoring and evaluation to avoid duplication and promote accountability.[xxii, xxiii] Both the RPRH 2021 Annual Report and RPRH Assessment include more in-depth recommendations around measurement and policy adjustments by result area.

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APPENDIX A. Expert Working Group Members

Name	Title	Organization	Economy
Stephen Page		Fertility Society of Australia and New Zealand	Australia
Narelle Dickinson		Fertility Society of Australia and New Zealand	Australia
Danielle Mazza	Professor of General Practice & Director	SPHERE NHMRC Centre of Research Excellence in Women's Sexual and Reproductive Health in Primary Care, Monash University	Australia
Bernie Towler	Principal Medical Adviser	Population Health Division, Department of Health and Aged Care	Australia
Carolynn Dubé	Executive Director	Fertility Matters Canada	Canada
Claudia Zajer	President	Chilean Society of Gynecology and Adolescence, SOGIA	Chile
Maria Mercedes Vivas	Executive Director	Oriéntame	Colombia
Dr. Lam Wai-cheung	Executive Director	The Family Planning Association of Hong Kong	Hong Kong, China
Dr. Candy Chu	Senior Medical Officer	Family Health Service, Department of Health	Hong Kong, China
Anjali Sen	Representative	UNFPA Indonesia	Indonesia
Dr. Majdah binti Mohamed	Public Health Physician, Maternal Health Sector	Family Health Development Division, MOH	Malaysia
Dr. Izwana binti Hamzah	Public Health Physician	Perlis State Health Department, MOH	Malaysia
Dr. Khansa' binti Abd Halim	Medical Officer	Human Reproduction Division, National Population and Family Development Board (NPFDB)	Malaysia
Dr. Narimah Awin	Consultant	UNFPA Malaysia	Malaysia
Karla Hernández	Secretary General	CONAPO	Mexico
Mary Sitaing	Acting President	PNG's Midwifery Society	Papua New Guinea
Rolando Ancevalle	Director	APROPO	Peru
Milka Dinev	Executive Director	FOROLAC	Peru
Lolito Tacardon	OIC-ED	Commission on Population and Development (POPCOM)	The Philippines

Name	Title	Organization	Economy
Arnold L. Vega, MAN, RN	Clinical Services Program Manager	Likhaan Center for Women's Health, Inc.	The Philippines
Dr. Junice D. Melgar	Executive Director	Likhaan Center for Women's Health, Inc.	The Philippines
Dr. Bernabe Marinduque	President and Board Member	Philippine Society for Responsible Parenthood (PSRP)	The Philippines
Patricia Gomez	Executive Director	Integrated Midwives Association of The Philippines (Imap)	The Philippines
Elizabeth Angsioco		Democratic Socialist Women of The Philippines (Dswp)	The Philippines
Ms. Nataliya Dolgushina	Chief Specialist on Reproductive Health of Women	MOH	Russia
Tan Poh Lin	Assistant Professor	Lee Kuan Yew School of Public Policy, NUS	Singapore
Dr. Bunyarit Sukrat	Director, Bureau of Reproductive Health; APEC Smart Families Project Overseer	Ministry of Public Health, Thailand	Thailand
Duangkamol Ponchanmi	Head of Office	UNFPA Thailand Country Office	Thailand
Unnop Jaisamrarn	Head of Family Planning and Reproductive Health Unit	Secretary General, WHO CCR Department of Obstetrics and Gynecology	Thailand
Jessica Marcella	Deputy Assistant Secretary; Director	Office of Population Affairs; Office of Adolescent Health, HHS	United States
Dr. Michelle McConnell	Director, Asia and Pacific	Office of Global Affairs; Office of the Secretary, HHS	United States

APPENDIX B. Resource Speakers & External Participation on the Expert Working Group

Name	Title	Organization
Daniela Ramirez	Managing Partner	Silverback Earth
Moises Uribe	Chief Executive Officer	Silverback Earth
Stuart Gietel-Basten	Professor	Hong Kong University of Science and Technology and Khalifa University of Science and Technology
Alison Gemmill	Assistant Professor	Johns Hopkins University, Bloomberg School of Public Health
Gathari Ndirangu Gichuhi	Global Director of Family Planning	Jhpiego
Ricky Lu	Senior Technical Advisor, Family Planning	Jhpiego
Sarah Webb	Technical Advisor, Market Solutions & Reproductive Health	Jhpiego
Brittney Ehlers	Senior Program Coordinator	Jhpiego
Aelaf Tesfasilasie	Senior Program Coordinator	Jhpiego
Christopher Costigan	Executive Director, Policy, Asia-Pacific, Japan, and China	Organon
Noha Salem	Executive Director, Global Public Policy	Organon
Christina Marzocca	Associate Director, Women's Health Policy	Organon
Liamsuwan Sittipong (Oat)	Director, Access Policy and Communication	Organon
Maymay Mitisubin	Policy and Government Affairs Lead	Organon
Patricia Wu	Vice President and Managing Director	Crowell & Moring International
Trey Flowers	Senior Consultant	Crowell & Moring International
Anne Blatchford	Associate Consultant	Crowell & Moring International
Adrienne Mendenhall	Director	Crowell & Moring International

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APEC Project: HWG 06 2022S
Project Overseer: Thailand

For Asia-Pacific Economic Cooperation Secretariat
35 Heng Mui Keng Terrace Singapore 119616
Tel: (65) 68919 600 Fax: (65) 68919 690
Email: info@apec.org
Website: www.apec.org