World Health Organization
Western Pacific Region

Pacific Community
Communauté du Pacifique

Monitoring progress towards the vision of Healthy Islands in the Pacific

Second progress report 2019

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FOREWORD

Significant time and work have been devoted to establishing an agreement on a monitoring methodology for the Healthy Islands vision. This began with the creation of a multidisciplinary, cross-cluster group within the World Health Organization (WHO) that developed its first monitoring proposal in 2015. The first report using the *Healthy Islands Monitoring Framework* was endorsed by the Pacific health ministers in August 2017. The ministers and heads of health in the Pacific recognized that the development of a strong and high-quality indicator framework is a technical process, and one that will need to evolve over time. Consequently, they have proposed further efforts to strengthen it.

This joint report by the Pacific Community and WHO on progress towards the Healthy Islands vision is the second in the series, and is the result of contributions from many Pacific island countries and areas (PICs), and stakeholders. Eighteen PICs and numerous agencies took part in the review process, contributing to data collection and validation.

The reported information is a combination of existing data and data reported by PICs. Many data sets are works in progress that require improvement, including capacity-building and overall strengthening of health information systems. The monitoring efforts in this report aim to promote accountability by encouraging PICs to commit to reporting progress. It is anticipated that by developing the Framework and reporting internationally comparable indicators, this report will encourage PICs to tailor indicators to their local circumstances.

This report presents some challenges, not only in the vision and undertaking, but also in terms of measuring progress towards that vision. There is a broad understanding of what needs to be done in relation to monitoring the indicators. The primary challenge now is to ensure that the required monitoring systems are strengthened or introduced to ensure data are collected regularly and with a high degree of accuracy. Underpinning these efforts is the recognition that investment from national budgets and development partners is required to strengthen national health information systems.

On behalf of the Technical Secretariat of the Heads of Health and Pacific Health Ministers, it is our privilege to present the second progress report monitoring progress towards the vision of Healthy Islands in the Pacific.

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ABBREVIATIONS

CVD	cardiovascular disease
CRVS	civil registration and vital statistics
DHIS2	District Health Information System
DTP	diphtheria, tetanus, pertussis
GHO	Global Health Observatory
HIMF	Healthy Islands Monitoring Framework
HPV	human papillomavirus
IHR	International Health Regulations
NCD	noncommunicable disease
Pacific MANA	Pacific Monitoring Alliance for NCD Action
PHMM	Pacific Health Ministers Meeting
PICs	Pacific island countries and areas
SDG	Sustainable Development Goal
SPAR	State Party Annual self-assessment Reporting tool
SPC	Pacific Community
SSB	sugar-sweetened beverage
STEPS	WHO STEPwise approach to Surveillance
TB	tuberculosis
UHC	universal health coverage
WASH	water, sanitation and hygiene
WHO	World Health Organization

1 INTRODUCTION

1.1 Background

Healthy Islands is a vision introduced in 1995 at the first meeting of the Pacific ministers of health on Yanuca Island, Fiji. The health leaders of the Pacific envisioned Healthy Islands where:

- children are nurtured in body and mind;
- environments invite learning and leisure;
- people work and age with dignity;
- ecological balance is a source of pride; and
- the ocean which sustains us is protected.

The vision laid the foundation for health and well-being in the island communities. It also laid the foundation for meetings of the ministers of health that have occurred every two years. The Healthy Islands vision remains important and relevant for development in the Pacific. This report covers the progress and follow-up made towards the fulfilment of that vision in a coordinated way.

Technical experts and partners worked collaboratively for more than two years to develop the *Healthy Islands Monitoring Framework* (HIMF), culminating with the endorsement of the progress report and Framework in August 2017. The first progress report presented initial data along with discussions of the requirements needed to support more robust monitoring of progress towards the Healthy Islands vision.

Starting in 2017, the data for the HIMF are updated by April every two years in preparation for the annual meeting of the heads of health of the Pacific. They will also be followed with a full progress report at the Pacific Health Ministers Meeting held biennially.

Most of the data in this report have been subject to an official consultation with Pacific island countries and areas (PICs) carried out in 2018. Countries are the main actors in monitoring and evaluation. National ownership is key for the successful implementation of the HIMF. This Framework also supports monitoring of the national Sustainable Development Goals (SDGs) and health, with PICs adopting additional indicators as relevant.

1.2 The current Framework and reporting mechanism

The final HIMF includes 48 mandatory indicators. They are divided into four sections that correspond to the 2015 Yanuca Island Declaration on health in Pacific island countries and territories. The mandatory indicators have been separated into core and complementary indicators: 33 core indicators (to be updated every one to two years) and 15 complementary indicators (to be updated as survey data are updated, typically every five to 10 years). In addition to the mandatory indicators, 31 optional indicators are proposed that can be selectively reported, subject to national priorities and reporting systems.

The HIMF presents the results of a broad technical process of development. The indicator framework has been reviewed with the World Health Organization (WHO) and other partners, and the monitoring methodology was revised repeatedly to meet the requirements of different partners. From the more than 60 indicators, 16 key indicators were selected as a minimal subset to provide a snapshot of progress towards the Healthy Islands vision (see Annex 1 Summary of key milestones of developing the HIMF).

Although PICs were successful in reporting baselines against 40 of the 48 indicators in the Framework in 2017, the first data collection round and the first progress report revealed key monitoring challenges. These included data gaps on eight indicators with no data. The Healthy Islands vision is also associated with global and regional priorities, such as the commitment to universal health coverage (UHC). Overlaps are also becoming evident, including the acknowledgement of the relationship between health and climate change, and the links between health and regional security. The latter resulted in the adoption of the *Pacific Health Security Coordination Plan*. All of these intersecting priorities make it essential that the Framework be continuously amended to ensure alignment with new regional action plans and monitoring frameworks.

The Pacific health ministers and heads of health recognized that the development of a strong and high-quality indicator framework is a technical process that will need to continue and advance over time. The leaders have asked the Technical Secretariat of the Heads of Health and Pacific Health Ministers to report back in 2019 on progress made in reviewing the HIMF.

1.3 Target audience

This report is primarily intended for use by the Pacific health ministers to inform the implementation status of the Healthy Islands vision. Furthermore, this report is also useful for stakeholders and partners active in the area of health information or interested in investing.

1.4 Lessons learnt and recommendations

First and foremost, readers must note that this publication is the result of a compilation exercise that provides a snapshot of data available on HIMF indicators in the Pacific by the end of 2018 – mostly from data producers across governments.

Therefore, the data points presented in this report should be considered documentation of what kinds of data currently exist, while noting that this is a work in progress that will require further quality improvements, further capacity-building and the overall strengthening of the health information systems in the region. The Pacific health ministers and heads of health have recognized that the development of a robust and high-quality indicator framework is an iterative process that will need to continue over time.

One of the challenges is that the global definition of the SDG indicators at the global level remains a work in progress; therefore, the HIMF indicators also may need to be continuously revised to be aligned with the global reporting standards. In 2018, a review of the reporting system and the indicators was executed by the Secretariat with support of the Australian Institute of Health and Welfare,[1] using explicit guidelines for indicator quality enhancement in order to update and refine the Framework. The Secretariat's recommendations on the indicator definition changes are based on the technical review and the aspiration that HIMF indicators are aligned with the SDG indicators (see suggested changes in Annex 1).

The review process also addressed structural challenges in the reporting framework that could be improved in the future. For instance, the HIMF structure could have a better balance of process and outcome and core and complementary indicators. Too many indicators are measured at the outcome level instead of monitoring service provision. Fewer core indicators would also reduce the reporting burden for countries. Moreover, indicators should better reflect the burden of disease or challenges experienced in the Pacific. For example, too few indicators monitor noncommunicable diseases (NCDs), while some communicable diseases with low burden are overrepresented (for example, HIV). The Secretariat acknowledges limited appetite for wholescale change given that the indicator framework was endorsed in 2017. Therefore, the recommendation is to keep the current structure and continue implementing the Framework and collecting lessons learnt before suggesting additional changes.

As noted, the regional framework should be based to the extent possible on national official data sources, but this presents other challenges. For example, if biennial reporting (meaning every second year) is conducted, the same data will likely be reported twice as national periodic surveys may not occur every two years. One solution is to consider alternative data sources, such as increased use of health facility records for reporting. Given their continuous collection, such records would facilitate identification of significant changes, be able to detect genuine trends within the reporting period, and help identify health inequities and advance UHC. Strengthening routine health information systems, including administrative and health facility data-based monitoring mechanisms, will help when compiling indicators.

[1] The Australian Institute of Health and Welfare was requested to undertake a desk study to: review the HIMF and provide general expert feedback on the allocation of the indicators between core and complementary, with a particular focus to improve the eight "no data" indicators. Proposed new indicators should be carefully defined with standards, calculation methods and proposed reporting frequency.

At the 13th Pacific Health Ministers Meeting, heads of health may consider:

- endorsing the second progress report (Annex 1) to be submitted at the 13th Pacific Health Ministers Meeting;
- endorsing the proposed changes to the *Healthy Islands Monitoring Framework* (Annex 2); and
- following up on the implementation of the Framework and report progress at the next Pacific Health Ministers Meeting in 2021, with any amendment if necessary.

Governments may consider:

- actively participating in validating and reporting indicators every two years (before meetings) and introducing quality reviews as part of data reporting; and
- continually improving national health information systems as well as civil registration and vital statistics (CRVS), as well as reinforcing equity-oriented health information analysis.

Development partners may consider:

- continually supporting PICs to strengthen national health information systems and, in turn, enabling them to sustainably produce country data;
- strengthening institutional capacity at the country level to collect and utilize data at all levels of the health system; and
- supporting regional organizations such as the Pacific Health Information Network and Brisbane Accord Group to strengthen regional cooperation among PICs to improve eHealth and health information systems, as well as CRVS across the Pacific.

2 BROAD SPECTRUM OF HEALTH CHALLENGES: SELECTED ISSUES IN THE PACIFIC

2.1 The coverage of essential health services in the HIMF

Universal health coverage (UHC) means that all people have access to good quality health services without financial hardship. UHC is one of the many important targets (target 3.8 specifically) to be reached by 2030 as part of the SDGs. The key concept and attributes of UHC are very relevant in the Pacific and strongly embedded within the vision of Healthy Islands. In the vision, the essential health services have been described as the main source to ensure "children and adults can grow, learn, play and age with dignity".

Concrete links between the Healthy Islands vision and UHC were addressed[2] during the Pacific Health Ministers Meeting (PHMM) in 2017. Commitments included: (i) to increase resources allocated to primary health care; (ii) to determine the right services and the right service model; and (iii) to plan and budget resources for UHC.[3] As outlined in the PHMM outcome paper from 2017, achieving UHC and Healthy Islands requires improving health service delivery as a key to ensure better quality of care and expand the coverage to reach all marginalized populations in society.

The United Nations Statistical Commission in March 2017 adopted two indicators to monitor progress towards UHC: indicator 3.8.1 on the coverage of essential health services, and indicator 3.8.2 on the proportion of households with large expenditures on health as a share of total household consumption or income.

We will concentrate on SDG indicator 3.8.1 and how it relates to the HIMF. The definition of indicator 3.8.1 is: Coverage of essential health services, defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, NCDs, and service capacity and access, among the general and the most disadvantaged population.[4]

The HIMF was developed before the SDG and UHC frameworks were finalized. One could say that this means the Pacific was way ahead. But the reality is that it has caused some difficulties because not all of the HIMF indicators that relate to essential health services are aligned with the 16 tracer indicators as proposed in the SDGs.

Table 1 gives an overview of the alignment of SDG 3.8.1 tracer indicators with those in the HIMF. Overall, six SDG tracer indicators are not included in the HIMF list, and 10 tracer indicators are reflected in the list of HIMF indicators with similar themes and definitions. Of those 10 indicators that overlap in principle, six have the same definition and statistical methodology as the SDG tracer indicators. The remaining four vary in definition.

[2] Universal health coverage on the journey towards Healthy Islands in the Pacific. Manila: WHO Regional Office for the Western Pacific; 2018 (iris.wpro.who.int/handle/10665.1/14233, accessed 8 February 2019).

[3] Outcome of the Twelfth Pacific Health Ministers Meeting, Rarotonga, Cook Islands, 28–30 August 2017. Manila: WHO Regional Office for the Western Pacific; 2018.

[4] A total of 16 tracer indicators were selected for the building of the index to measure the coverage of essential health services, which included four from within each of the categories of: 1) reproductive, maternal, newborn, and child health; 2) infectious disease; 3) NCDs; and 4) service capacity and access.

Table 1. Comparison of SDG indicator 3.8.1 and HIMF indicators

Category	UHC service coverage index (SDG indicator 3.8.1)	Healthy Islands Monitoring Framework	Note
Reproductive, maternal, newborn, child and adolescent health	Family planning: Percentage of women of reproductive age (15–49 years) who are married or in-union who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1)	2.12 Contraceptive prevalence: Percentage of women aged 15–49 years who are sexually active, who are currently using, or whose sexual partner is using, at least one method of contraception.	Different definition on contraceptive methods
	Pregnancy and delivery care: Percentage of women aged 15–49 years with a live birth in a given time period who received antenatal care four or more times	3.7 Antenatal care coverage: Women aged 15–49 years with a live birth in a given time period who received antenatal care, four times or more.	Same definition
	Full child immunization: Percentage of infants receiving three doses of diphtheria-tetanus-pertussis containing vaccine	3.9 Immunization coverage for DTP3: percentage of children 1 year of age who have received three doses of vaccine against diphtheria, tetanus, pertussis (DTP3) in a given year	Same definition
	Child treatment: Percentage of children under 5 years of age with suspected pneumonia	N/A	N/A
Infectious diseases	Tuberculosis (TB) detection and treatment: Percentage of incident TB cases that are detected and successfully treated	2.14 Tuberculosis (TB) incidence: Estimated number of new and relapse TB cases arising in a given year per 100 000 population	Different definition of indicators
	HIV treatment: Percentage of people living with HIV currently receiving antiretroviral therapy	N/A	N/A
	Insecticide-treated bed nets (ITN) coverage for malaria prevention: Percentage of population in malaria-endemic areas who slept under an insecticide-treated net the previous night [only for countries with high malaria burden]	N/A	N/A
	Improved water and adequate sanitation source: Percentage of households using improved sanitation facilities	4.4 Population using improved sanitation facilities: Population using an improved sanitation facility in a specified time period (usually one year)	Same definition

Table 1. Comparison of SDG indicator 3.8.1 and HIMF indicators (cont.)

Category	UHC service coverage index (SDG indicator 3.8.1)	Healthy Islands Monitoring Framework	Note
NCD	Prevention of cardiovascular disease: Age-standardized prevalence of non-raised blood pressure (systolic blood pressure <140 mm Hg or diastolic blood pressure <90 mm Hg) among adults aged 18 years and older	N/A	N/A
	Management of diabetes: Age-standardized mean fasting plasma glucose (mmol/L) for adults aged 25 years and older	N/A	N/A
	Cervical cancer screening: Percentage of women aged 30–49 years who report ever having been screened for cervical cancer	2.9 Cervical cancer screening: Coverage of the national cervical cancer screening among women aged 30–49 years	Same definition
	Tobacco control: Age-standardized prevalence of adults >=15 years not smoking tobacco in last 30 days (SDG indicator 3.a.1)	2.1 Smoking prevalence: (opposite) Age-standardized prevalence of tobacco smoking among persons 15 years and older	Same definition
Service capacity and access	Hospital access: Hospital beds per capita, relative to a maximum threshold of 18 per 10 000 population	N/A	N/A
	Access to essential medicines: Percentage of health facilities with essential medicines	2.8 Access to essential NCD drugs: essential NCD drugs available and accessible in public health sector primary care facilities	Different methodology
	Health workforce: Health professionals (physicians, psychiatrists and surgeons) per capita	1.1 Health worker density: Skilled health worker density per 10 000 population	Different definition of indicators
	Health security: International Health Regulations (IHR) core capacity index, which is the average percentage of attributes of 13 core capacities that have been attained (SDG indicator 3.d.1)	1.4 IHR core capacity score: Average of 13 core regulations core capacity that have been attained at a specific point in time	Same definition

N/A: not available in the HIMF

The following six SDG 3.8.1 tracer indicators are not part of the HIMF:

- Reproductive, maternal, newborn, child and adolescent health
  - Child treatment: Percentage of children under 5 years of age with suspected pneumonia

- Infectious diseases
  - HIV treatment: Percentage of people living with HIV currently receiving antiretroviral therapy
  - Insecticide-treated bed net coverage for malaria: Percentage of population in malaria-endemic areas that slept under an insecticide-treated net the previous night (only for countries with high malaria burden)

- NCDs
  - Prevention of cardiovascular disease: Age-standardized prevalence of non-raised blood pressure: systolic blood pressure <140 mm Hg or diastolic blood pressure <90 mm Hg) among adults aged 18 years and older
  - Management of diabetes: Age-standardized prevalence of non-raised blood pressure: Age-standardized mean fasting plasma glucose (mmol/L) for adults aged 25 years and older

- Service capacity and access
  - Hospital access: Hospital beds per capita, relative to a maximum threshold of 18 per 10 000 population

The way forward

SDG indicator 3.8.1 was proposed as a composite to monitor progress towards expanded essential health services. A comparison of SDG 3.8.1 and HIMF indicators demonstrates that the HIMF has a capacity to monitor the coverage of essential health services, such as: reproductive, maternal, newborn, child and adolescent health; infectious diseases; NCDs; and service capacity and access. Given that the aim of the HIMF is to harmonize and align monitoring and evaluation actions to the extent possible with regional/global frameworks and database while not increasing the burden of data collection on countries, this section recommends considering the following actions for better monitoring of essential health services with the Framework:

- Strengthen efforts to collect the six SDG 3.81 tracer indicators that are included in HIMF indicators (1.4, 2.1, 2.9, 3.7, 3.9, 4.4).
- Realignment of HIMF indicators (2.12, 2.14, 2.8, 1.1) in line with four SDG 3.8.1 tracer indicators.

2.2 NCD prevalence, prevention and control

NCDs are a growing global threat to human health and economic development. Many Pacific islands have among of the highest rates of adult and child obesity and diabetes globally. The Pacific islands have also been at the forefront of political commitment and action to tackle NCDs. Investment on NCD prevention and control is particularly important in low- and lower-middle-income countries, where the NCD burden continues to rise and health systems are less resilient (Box 1).

NCDs include cardiovascular disease (including stroke), diabetes, cancer and chronic respiratory diseases. They share four key risk factors: poor diet, insufficient physical activity, use of tobacco and misuse of alcohol. Other important risk factors include genetics, family history, ageing, stress and environmental pollution. Intermediate risk factors include overweight, raised blood sugar (glucose) and raised blood pressure. While countries in the Pacific islands are at different stages of disease transition, all countries have worryingly high rates of the four main risk factors and of the intermediate risk factors.

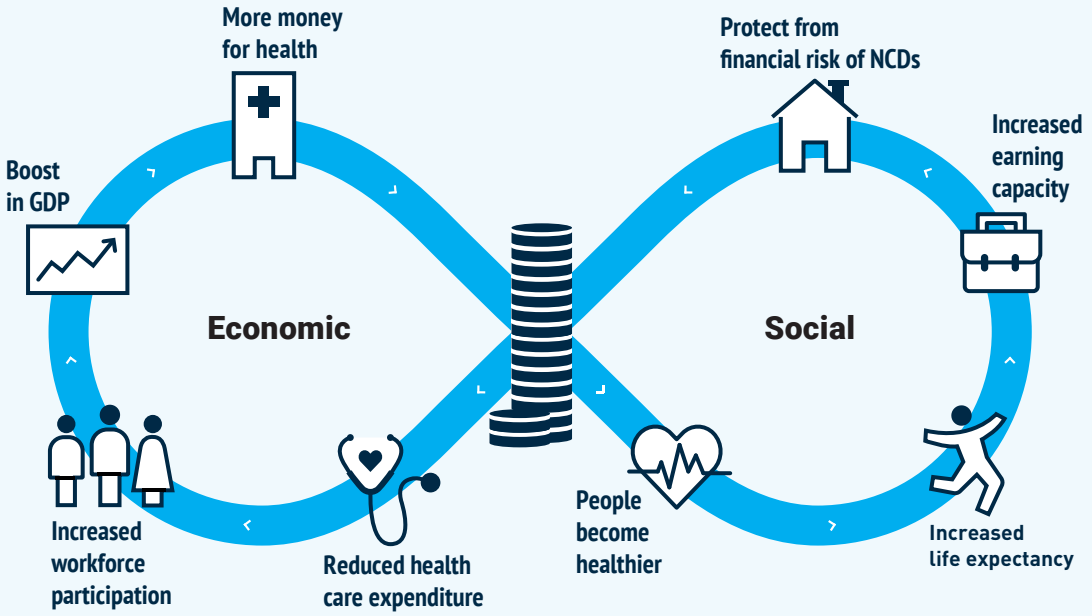
The causality of the high burden of NCDs is complex and linked with changing lifestyles and environments. By necessity, tackling NCDs will require multifaceted approaches. The development of NCDs occurs over time, with unhealthy behaviours in young people, for example, translating into increased NCD burden in later life. For this reason, efforts

and interventions to combat NCDs must be sustained to have the desired impact, which will happen over the course of decades not years.

In the Pacific islands, there has been high-level recognition of the critical importance of effectively tackling NCDs. This recognition has included commitments and declarations by leaders from the national to the community level. Ministers of finance and economy and ministers of health agreed in 2014 to a Pacific NCD road map to chart the way forward for prioritized actions. More recently, ministers of health have demanded more action and support to tackle the issue of childhood obesity in many PICs.

Box 1. The value of preventing and controlling NCDs

Investing in NCD prevention and control not only improves health and saves lives, but can also improve a country's economic productivity. It can improve workforce participation and productivity, and limit the financial burden of unexpected health costs from NCDs on individuals and families.



Source: Saving lives, spending less: a strategic response to noncommunicable diseases. Geneva: WHO; 2018 (WHO/NMH/NVI/18.8)

Unlike the Millennium Development Goals, the SDGs include targets related to NCDs. As such, all countries report on progress towards the target of reducing by one third premature mortality from NCDs. However, given the disproportionate impact of NCDs on health in the region, Pacific ministers of health also requested other indicators for NCD progress be monitored in countries through the HIMF.

Within the HIMF, NCD indicators capture the stages of NCD development – risk factors, intermediate risk factors, the burden of disease and the impacts of the NCDs. Given the extended development of NCDs, it is also important to consider environmental and policy factors that affect the environment and development of risk factors. To develop these indicators, the Pacific Monitoring Alliance for NCD Action (Pacific MANA) dashboard was drawn up.

The Alliance was formed to bring together countries, partners and other key representatives to work together to improve monitoring of the NCD burden and the use of that information for action. With guidance from WHO and other partners, the Alliance developed the Pacific MANA dashboard to support countries to monitor and assess the status of actions to combat NCDs. It captures, for example, the progress of a country in taxing

tobacco (so that excise tax is at least 70% of the retail price, in line with the recommendation of the *WHO Framework Convention on Tobacco Control*), controlling the availability of alcohol and controlling the marketing of foods to children. This allows countries to identify their gaps and where future efforts might be prioritized. It also facilitates sharing of progress and success stories among Pacific islands. Selected indicators for the Pacific MANA dashboard have been included in the HIMF, including excise tax on alcohol, sugar-sweetened beverages (SSBs) and access to essential NCD drugs.

The NCD-related data in this HIMF, therefore, provide a snapshot of the current status of actions, environment changes, high-risk behaviours, diseases and outcomes in the Pacific islands. These are all linked with regional and global commitments and agreed actions. It is critical that this information be used to inform action. The data show that a significant disparity exists between PICs in all the indicators and that significantly more progress is needed if NCDs (including childhood obesity) are to be effectively addressed.

Achievements

While some PICs have been finding reduced rates of tobacco use in the past 10 years, progress has been too slow. Tobacco use rates remain alarmingly high in some PICs, particularly among men. There are proven strategies to tackle tobacco use, and further work is needed to ensure that all countries are effectively implementing these measures. For example, only one country currently has reached the global minimum recommended for tobacco taxation rates of at least 70% of retail price being excise tax. Likewise, alcohol misuse is more common in men than women in most countries, and proven approaches of controlling supply, access and increasing price would decrease use if they were more widely implemented.

Physical inactivity is a growing problem that has been heavily influenced by changes in the environment with more transport options, more mechanization and more sedentary leisure pursuit options, such as television viewing and Internet surfing. Understanding the barriers to physical activity can be an essential part of improving the levels of activity in communities. Along with poor diet, physical inactivity is a significant contributor to increased obesity and NCD risks. Improving physical activity levels can contribute to the control of child overweight and obesity. Some PICs have shown significant improvements in physical activity levels over the past decade. The HIMF includes an indicator on taxing sugar-sweetened beverages, in line with recommendations from WHO and the Pacific Community (SPC). Progress on this has been good in the Pacific, but some taxes are still quite low and may not sufficiently impact consumption.

The HIMF also includes indicators for service provision on NCDs and what the coverage is for those receiving screening for NCDs. While the focus of efforts is prevention, there is a significant burden of people already experiencing an NCD or one of the intermediate risk factors. Finding those individuals early and adequately treating them can have a significant impact on their outcomes, reducing their mortality and morbidity risk. While this is a challenging indicator to report — this report shows many countries without data — it is a vitally important indicator because it allows countries to monitor how well they are doing in managing their NCD burden through primary health care. Reaching high coverage requires a robust primary health care service that effectively finds and treats those at risk, early and when necessary refers to a higher facility, such as a specialized clinic.

Early detection and effective control of diabetes substantially reduce the risk of complications such as renal failure, foot/limb sepsis and amputation, and diabetic retinopathy. Lower-limb amputation due to diabetes is, therefore, also included in the HIMF. There have been remarkable successes in some PICs on reducing rates of diabetes-related amputations through primary health care. Other countries can benefit from similar approaches.

The way forward

Overall, Pacific islands are in the undertow of an NCD tsunami that threatens lives, families and development. While some PICs have made progress, much more needs to be done. The indicators in the HIMF related to NCDs allow us to monitor the progress towards the Healthy Islands vision. It is critically important that PICs collect and collate the data needed for monitoring NCDs to inform actions and determine the priority issues.

2.3 Health security and the International Health Regulations

Health security efforts reduce population vulnerability to acute threats to health through collective action. All Pacific island countries and areas are vulnerable to emerging infectious diseases, including pandemics, food and water insecurity, and natural hazards. This includes extreme weather events, which are expected to increase in severity or frequency as a result of climate change. These hazards threaten national and regional health security and cause lasting social, political and economic vulnerability. They also increase the burden of existing health problems.

The Pacific region frequently experiences outbreaks of endemic outbreak-prone diseases. These include arboviral diseases, such as dengue, chikungunya and Zika virus disease. They also include leptospirosis, typhoid fever, influenza and diarrhoeal diseases, which continue to be serious, sometimes even life-threatening. The Pacific has also experienced the emergence of new infectious diseases in recent years, such as the Zika virus outbreaks that occurred in most PICs.

The *World Risk Report 2018* assessed a matrix of factors, including exposure to hazards, vulnerability, and capacity to adapt and respond. The report found that six PICs were among the world's 15 most at-risk countries from natural disasters. In 2017 and 2018, the Pacific experienced 49 infectious disease events and 15 public health disasters, which collectively caused widespread economic and social disruption, along with significant loss of life and damages.

Progress towards implementation of IHR (2005)

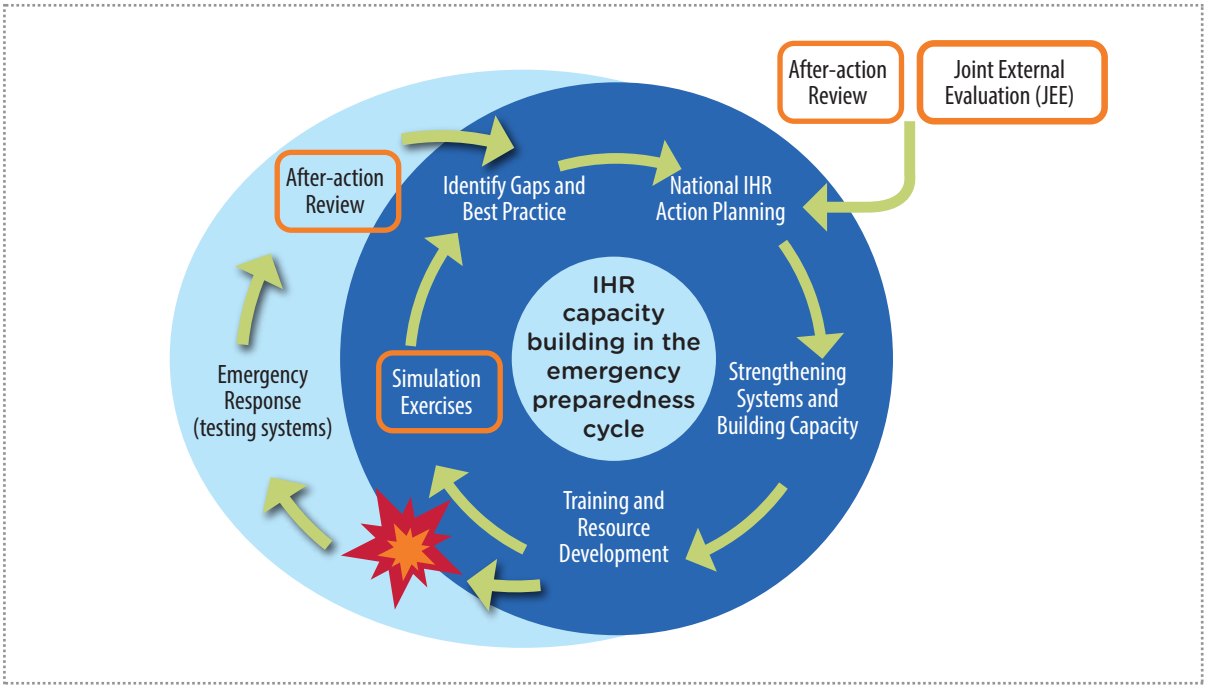
The International Health Regulations, known as IHR (2005), are a legally binding global agreement between 196 states parties, including 13 Pacific island countries. Under IHR (2005), countries are obliged to develop and maintain minimum core capacities to prevent, detect, assess and respond to potential public health events of national and international concern. IHR (2005) came into force in June 2007, setting a June 2012 deadline for countries to develop these capacities, which was extended to June 2016.

In 2008, the World Health Assembly adopted a resolution in accordance with Article 54 of IHR (2005) whereby all states parties and WHO report to the World Health Assembly on progress in implementing IHR (2005). In 2010, the *IHR Monitoring Questionnaire* was introduced as the annual self-assessment tool. The questionnaire was used to assess the 13 IHR (2005) capacities from 2010 to 2017. The change was intended to foster learning and improvement, as well as a more objective assessment of IHR (2005) implementation status. In 2018, the questionnaire was replaced by the State Party Annual self-assessment Reporting tool (SPAR). SPAR has 13 capacities assessed by a total of 24 indicators. The SPAR's assessment structure is similar to the five-point Likert scale used in the Joint External Evaluation tool, from 1 (limited capacity) to 5 (sustainable capacity).

In 2015, the IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation (WHA 68/22 Add.1) recommended: "to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts".

In 2015, the WHO *IHR Monitoring and Evaluation Framework* (Fig. 1) was developed to address this recommendation. The Framework consists of four components: the mandatory annual self-assessment report and three voluntary components – simulation exercises, after-action reviews and the Joint External Evaluation.

Fig. 1. Application of the IHR Monitoring and Evaluation Framework in the emergency preparedness and response cycle



In the Pacific, IHR (2005) implementation is guided by the Healthy Islands vision and the *Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies* (APSED III), the regional road map for IHR (2005) implementation. There is considerable overlap between efforts to implement IHR (2005) capacities (such as surveillance, laboratories, protection through safe health-care delivery, infection prevention and control, antimicrobial resistance management, and human resources) and health systems strengthening.

While the region has seen significant progress in recent years in implementing IHR (2005) core capacities, PICs continue to face fundamental challenges in building strong, resilient health systems. Strong health systems are the foundation of national and regional health security. In the Pacific, limited human and financial resources, geographical remoteness, and limited economies of scale highlight the importance of access to IHR (2005) capacities through sharing scarce, highly specialized resources, partnership and networks.

To better coordinate national and partner initiatives in the region, the Pacific health ministers in 2017 endorsed the *Pacific Health Security Coordination Plan 2017–2022* to spur collective action towards regional health security by fast-tracking IHR (2005) implementation and supporting the objective assessment of IHR (2005) core capacities, using the *IHR Monitoring and Evaluation Framework*.

The Plan has four interrelated areas of action:

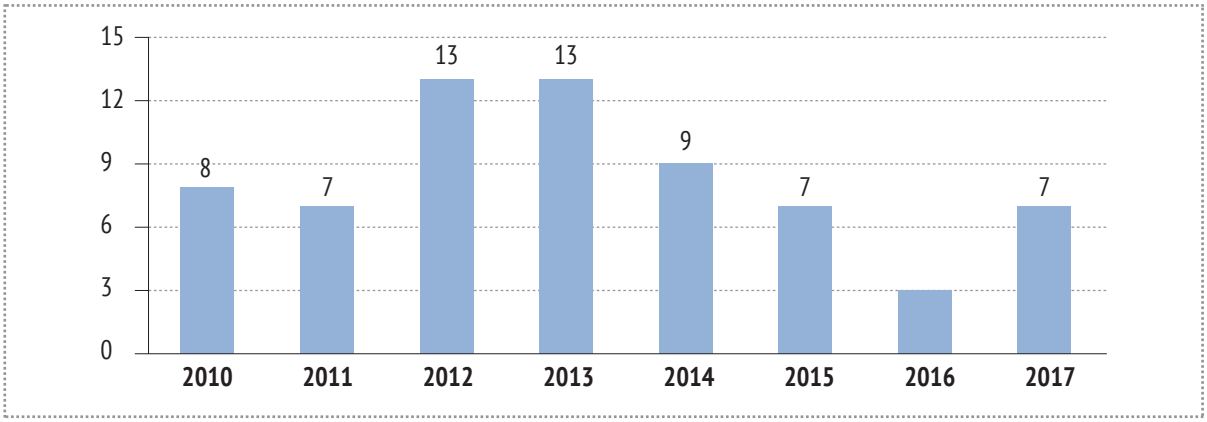
1. Improve preparedness for, and prevention of, health security threats at national level.
2. Strengthen national response to outbreaks and sudden-onset health emergencies.
3. Conduct objective assessment of IHR (2005) implementation using the *IHR Monitoring and Evaluation Framework*.
4. Strengthen regional-level preparedness, alert and response functions.

Achievements

Data from 2015 show that Pacific states parties are making good progress on a number of core capacities, notably in the areas of surveillance, zoonotic diseases, response, coordination, laboratory, legislation policy and risk communication, and this data can be found in the Global Health Observatory (GHO). The number of Pacific states parties to IHR (2005) submitting the *IHR Monitoring Questionnaire* on time so that

their data appear on the GHO, and more recently the Strategic Partnership for International Health Regulations (2005) and Health Security website since 2010, has varied considerably over time, ranging from three countries in 2016 to 13 in 2012 and 2013 (Fig. 2).

Fig. 2. Number of Pacific states parties to IHR (2005) submitting their IHR Monitoring Questionnaire on time, 2010–2017



During this period, there have been a total 67 timely submissions to the IHR Secretariat from Pacific states parties.

Fig. 3. Regional IHR core capacity summary scores for 13 Pacific states parties

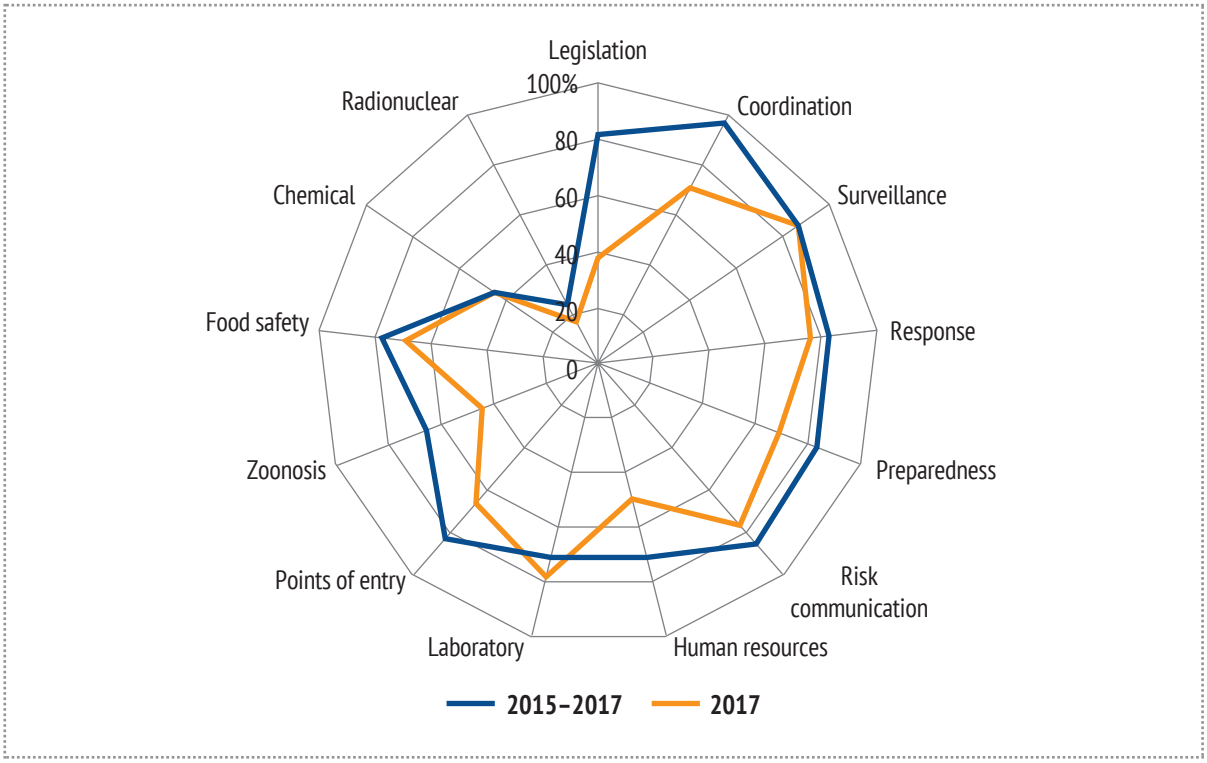


Fig. 3 provides the summary score for countries in their most recent year of reporting. The average scores for the Pacific from 2015 to 2017 inclusive are: 68% for national legislation, policy and financing (capacity 1); 88% for coordination and National IHR Focal Point communications (capacity 2); 86% for surveillance (capacity 3); 80% for response (capacity 4); 78% for preparedness (capacity 5); 82% for risk communication (capacity 6); 64% for human resource capacity

(capacity 7); 75% laboratory (capacity 8); 77% for points of entry (capacity 9); 58% for zoonotic events (capacity 10); 75% for food safety (capacity 11); 46% chemical hazards (capacity 12); and 22% for radiation emergencies (capacity 13). Moving forward, efforts are needed to sustain gains in the core capacities of surveillance, assessment and response, while further efforts are needed for the areas with lower scores, proportional to the risk.

The effectiveness of accessing certain core capacities, especially those with high infrastructure and service delivery costs, and/or those needed for lower risk hazards in the Pacific, through collective regional resources is more accurately accounted in the new 2018 SPAR.

The way forward

To adapt and respond to changing environments and new health threats, continuous efforts are needed to strengthen national and regional IHR (2005) capacities in the Pacific. Guided by the Healthy Islands vision and the *Pacific Health Security Coordination Plan 2017–2022* areas of action, PICs will be supported to undertake *IHR Monitoring and Evaluation Framework* activities to help identify areas of need and inform the development of national action plans to strengthen IHR (2005) implementation.

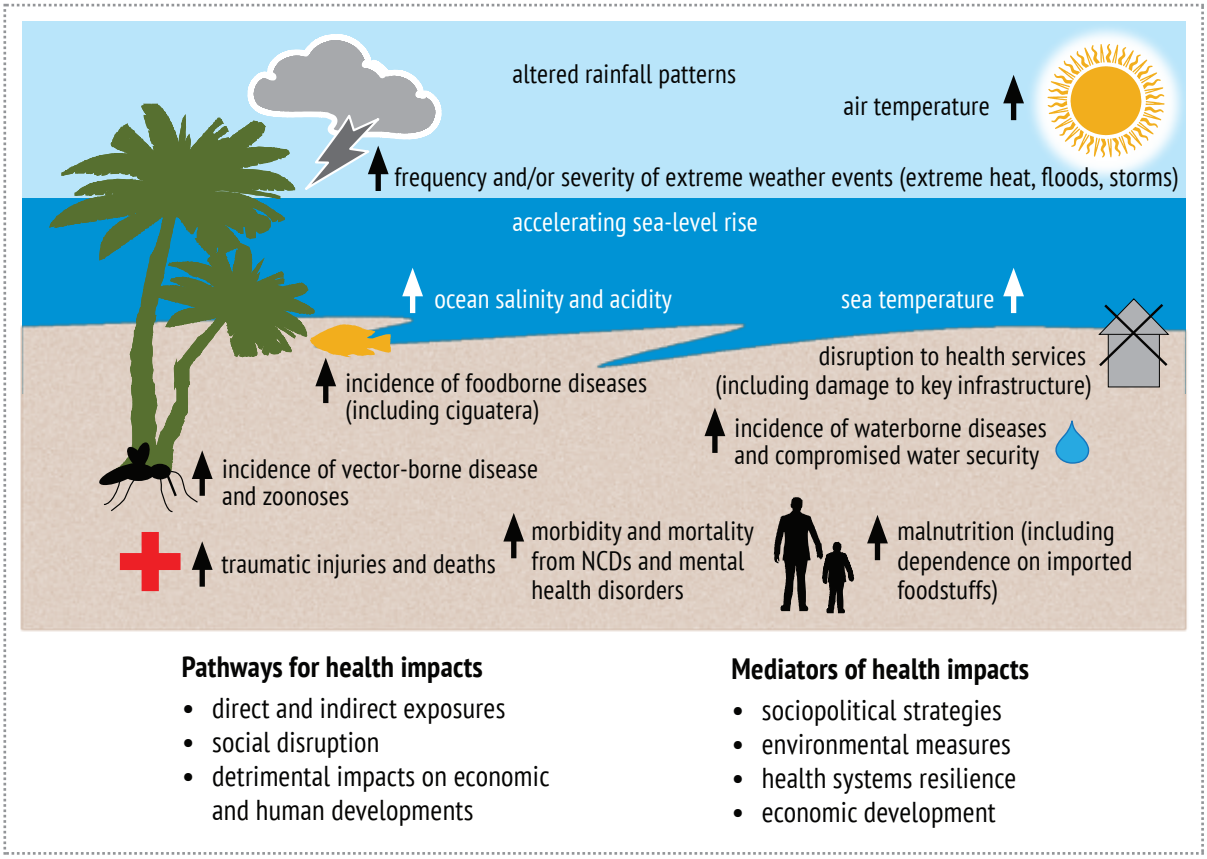
Achieving health security through IHR (2005) implementation necessitates multisector coordination and collaboration. PICs, with support from regional partners, need to work in partnership with other sectors to establish a common understanding of health security threats, such as those required for zoonosis and points of entry, and work in collaboration to strengthen these shared capacities.

In 2018, every effort will be made to complete the new SPAR with all 13 Pacific states parties to IHR (2005), with multisectoral stakeholder engagement to better reflect capacities involving sectors outside the health sector.

2.4 Climate change and health

Pacific islands are ecologically fragile and among the most vulnerable to climate change due to geographic, demographic and socioeconomic factors. Many small islands in the region present high burdens of climate-sensitive health risks, such as vector-borne, foodborne and waterborne diseases. Climate change results in increased average temperatures, increased incidence and intensity of more severe extreme weather events (such as floods, cyclones, storm surges and drought), sea-level rise, and decreased food and water security. All these hazards translate into increased mortality and morbidity from extreme weather events and climate-sensitive diseases such as malaria, dengue, cholera, filariasis, leptospirosis and ciguatera fish poisoning. The current and potential impacts of climate variability on health and health systems represent an immediate challenge in the Pacific (Fig. 4).

Fig. 4. Pathways by which climate change may affect human health in the Pacific islands



Source: Human health and climate change in Pacific island countries. Manila: WHO Regional Office for the Western Pacific; 2015 (http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303_eng.pdf).

At the 12th Pacific Health Ministers Meeting in 2017, ministers acknowledged that PICs are among the most vulnerable to climate change and its health impacts. They called for a massive scale-up of efforts and increased investments to mitigate the adverse impacts of climate change on human health. WHO has responded with a Special Initiative on Climate Change and Health in Small Island Developing States, which was launched at the 23rd Conference of the Parties to the United Nations Framework Convention on Climate Change in 2017.

The Initiative calls for small island developing states to develop climate change and health action plans to build health systems that are resilient to climate change. It also emphasizes actions by countries to reduce carbon emissions, both to protect the most vulnerable from climate risks and to gain the health co-benefits of mitigation policies. The *Pacific Islands Action Plan on Climate Change and Health* (Box 2) was launched by the Pacific health leaders at a side event during the World Health Assembly in May 2018.

Box 2. Pacific Islands Action Plan on Climate Change and Health

The Pacific Islands Action Plan has four strategic lines of action:

1. Empowerment – supporting health leadership in the Pacific to integrate health into national climate change planning and engage in international climate change negotiations
2. Evidence – producing country profiles of climate change and health, describing vulnerabilities and adaptation options (e.g. morbidity and mortality attributed to unsafe water, unsafe sanitation and lack of hygiene, malnutrition, disasters)
3. Implementation – building climate-resilient health systems, including the strengthening of governance and policy, integration of climate early warning systems with health information systems, preventive and curative service delivery, and disaster-proof and smart health-care facilities
4. Resources – facilitating access to climate and health financing mechanisms such as the Green Climate Fund and the Global Environment Facility and other sources of funds to support climate-resilient health systems in the Pacific.

Climate-sensitive health indicators in the HIMF

Steps must be taken to strengthen health systems to address climate-sensitive health outcomes, including increased access to vaccination, safe water and improved sanitation. The health sector has long managed the risks of climate-sensitive health outcomes. As such, there are established indicators for monitoring these burdens.

The HIMF includes climate-sensitive health indicators, such as the number of undernourished children and the proportion of people with access to improved drinking-water and sanitation. There is also an indicator measuring the mosquito-borne disease burden in the region.

Climate financing is a prominent topic in international discussions on climate change, but there is no agreement on the metrics to track the amount of capital flowing into climate change-related investments in the health sector. By any measure, however, the amount of climate finance allocated to health is small in relation to the total mobilized globally. According to WHO estimates, only 1.5% of all funding for climate change adaptation goes towards shoring up the health response globally, and only a fraction of that money goes to small island developing states, despite their acute vulnerability.

To monitor the final commitment on climate change and health in the Pacific under the HIMF, WHO developed indicator 4.2. It measures "a total dollar value linked with new projects implemented in the past year that have established integrated low-carbon, climate-resilient, disaster risk reduction development strategies". Unfortunately key stakeholders have not been able to calculate accurately the total amount of finance flowing into health investments that aim to adapt and mitigate climate change impacts. As a result, PICs have not reported the indicator, and the technical working group reviewing the HIMF has recommended replacing or simplifying it.

Achievements

Because the proportion of climate change funds allocated to the health sector was unknown in the Pacific, WHO conducted a study to assess the current baseline of climate change-related funds allocated to the health sector. It was estimated that in 2018, US$ 21 301 153 was allocated to the health sector on climate change work, which was around 2% of the total amount of funds allocated for climate change projects in the Pacific in 2016 (since the total amount of climate change funds in the Pacific for 2018 was not available).

The most significant funding supporting the health sector in climate change adaptation programming is the Building Resilience of Health Systems in Pacific Island LDCs to Climate Change project funded by the Global Environment Facility. This project involves four countries in the Pacific (Kiribati, Solomon Islands, Tuvalu and Vanuatu), using the Least Developed Countries

Fund with a total budget of US$ 17.85 million. The project will run for five years from around the middle of 2019 with the overall objective to strengthen climate-resilient health systems and health service delivery.

The way forward

As funding allocation in the Pacific to the health sector is relatively small compared with other sectors, it is critical to mobilize more resources on building health resilience to climate change. The *Pacific Islands Action Plan on Climate Change and Health* aimed by 2023 to triple the current level of investment of climate finance for health in Pacific small island developing states (that is, from US $21 million in 2018 to approximately US$ 60 million in 2023). WHO is developing a draft road map for implementation of the Plan, which will undergo consultations with Member States. One of the short-term measures is resource mobilization. That is, Member States and WHO need to work jointly to ensure international finance is available to implement the Pacific Islands Action Plan, including developing plans to identify new and innovative forms of funding and resource mobilization mechanisms.

3 UNDERSTANDING DATA IN THE HIMF

3.1 Data sources and availability

In the first progress report (2017), the baseline country data for 48 indicators of the HIMF were collected from 22 PICs. For this second progress report (2019), data collection for the 48 indicators was continued and refreshed. These data are presented in Chapter 4. Both reports contain two types of data: global and country (Box 3). The two types are included in order to compensate for gaps in availability and quality of the underlying primary data in PICs. However, national data are preferable to global data for the vast majority of the indicators. It's noted that countries also report data to WHO and partner agencies on indicators concerning water, sanitation and hygiene (WASH), immunizations, TB incidence, HIV and IHR (2005) and so on.

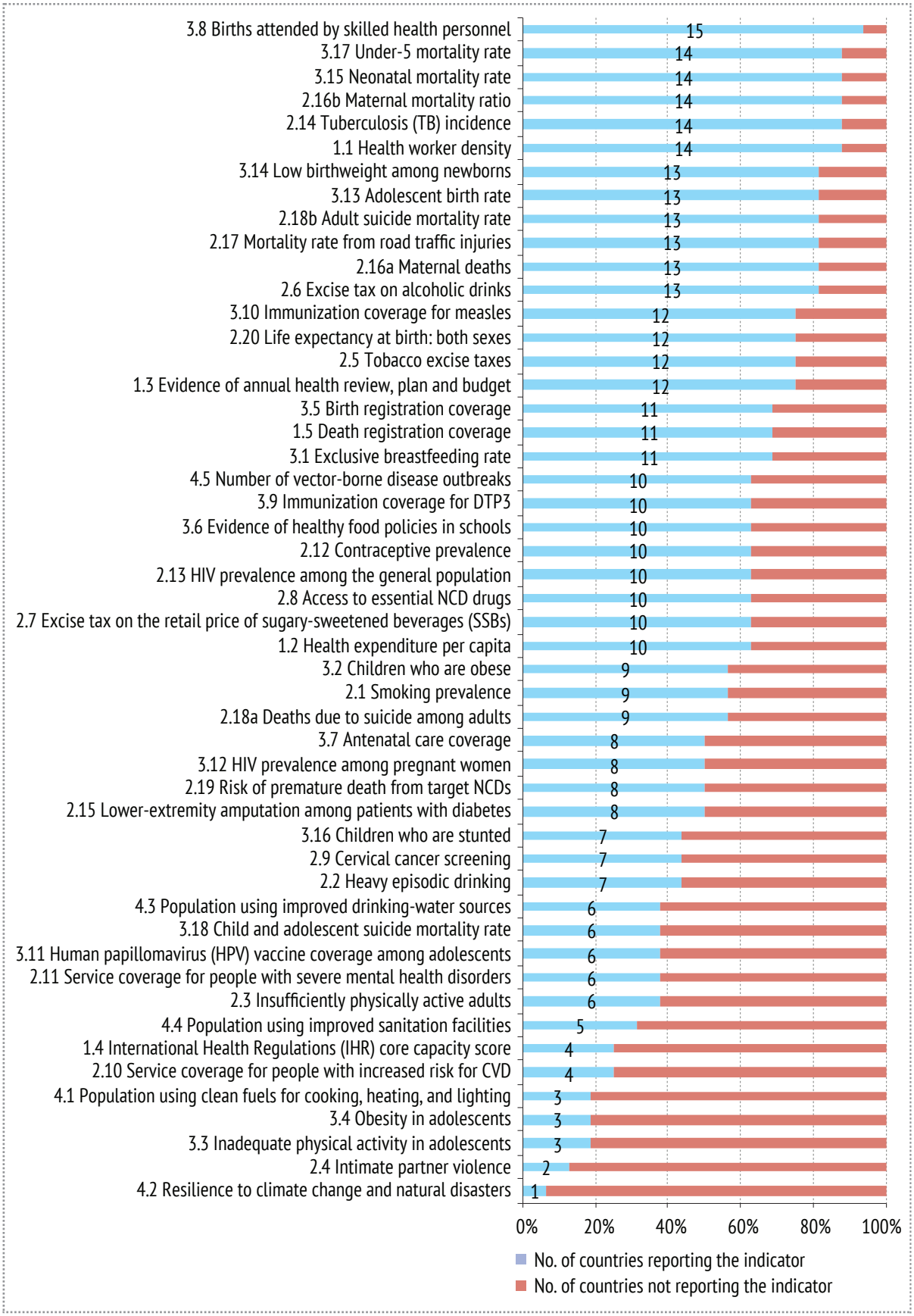
Box 3. Global and country data

Global data are collected from global or regional databases regularly maintained by international agencies. These data have been generated using primary data and a mathematical or statistical model to calculate estimates over time. Hence, global data may differ from official national statistics of individual PICs.

Country data were collected from PICs directly from October 2018 to January 2019. These data are usually derived from census or health information systems, including surveillance system data, health facility or administrative records, surveys and vital statistics.

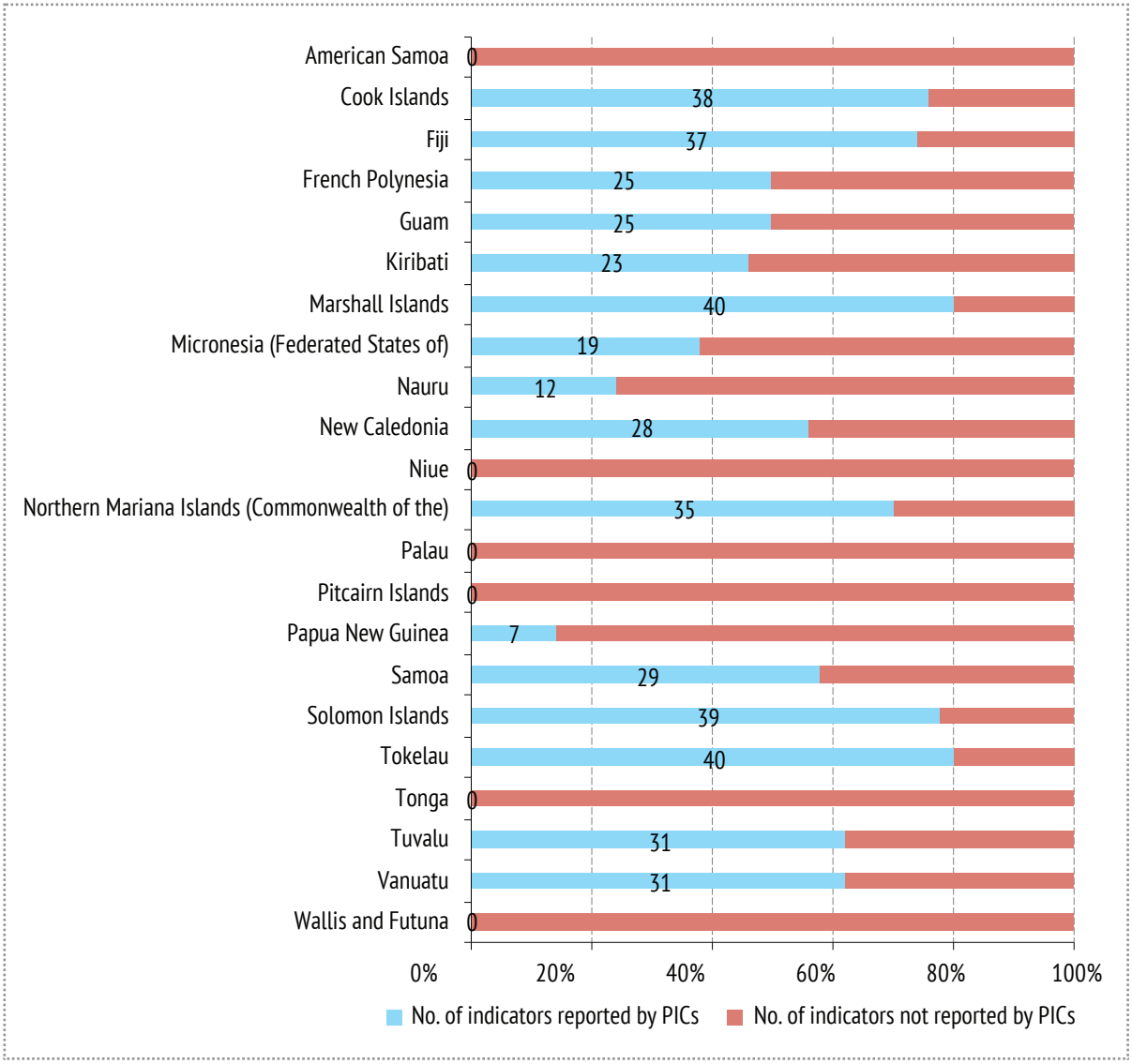
Data availability on indicators varied from country to country but was fairly similar across regions and generally high, with 72% countries (16/22) having their own data estimates for the indicators. PICs reported 28 out of 48 Healthy Islands indicators with national data (Fig. 5). On average, nine countries reported per indicator, from a total of 16 countries (Fig. 6). There has been great variance in response rates for specific indicators, with the highest response rates for SDG-related indicators.

Fig. 5. Reported numbers of PICs by indicator in the 2019 HIMF progress report



Note: The data shown are country data reported during the current round of data collection (2018/2019). Although some extreme data are excluded in Chapter 4, the number shown here includes all the original reported data series. The indicators are sorted in descending order of the numbers of reported PICs.

Fig. 6. Reported numbers of indicators by PIC in the 2019 HIMF progress report

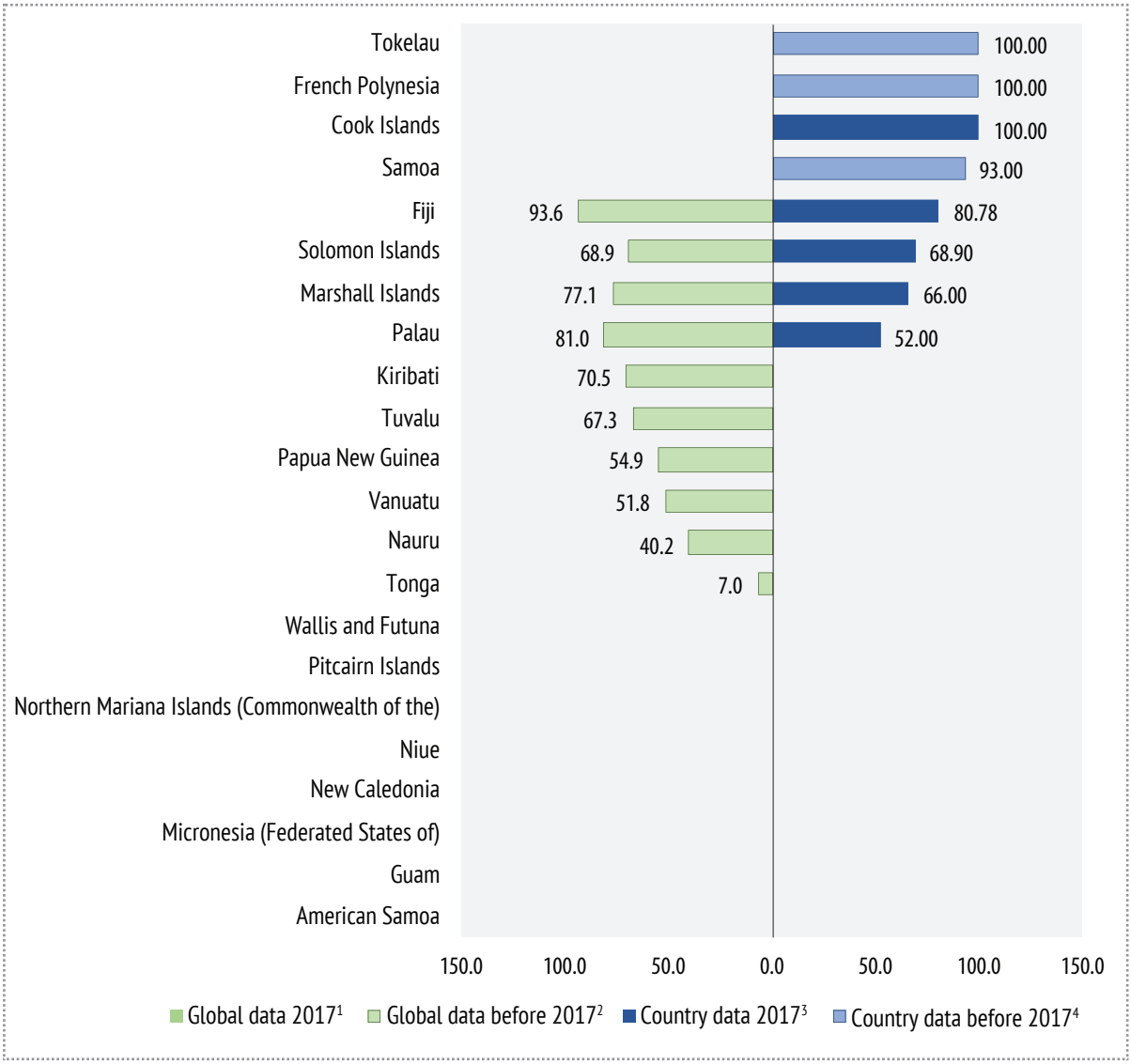


Note: The data shown are country data reported during current round of data collection (2018/2019). Although some extreme data are excluded in Chapter 4, the number shown here includes all the original reported data series. PICs are in alphabetical order.

3.2 Data demonstration

For most of the indicators of the HIMF, both global and country data are demonstrated together per country. For each indicator, countries are sorted in descending order for coverage and capacity indicators by country data first, and then sorted by global data for those with no country data. Countries are sorted in ascending order for mortality, prevalence and incidence, risk factor indicators by country data first, and then sorted by global data for those with no country data (Fig. 7). Timeliness is shown in the figures by distinguishing colours.

Fig. 7. Examples of data demonstration in figures in the 2019 HIMF report



Note: This is a capacity indicator. Countries are first sorted in descending order by country data and then sorted by global data for the countries with no global data available.

3.3 Data limitations

As mentioned, the Framework itself and the data come with limitations. This publication is the result of a compilation exercise that provides a snapshot of data available on the HIMF indicators in the Pacific at the end of 2018. PICs may have more data that are provided for HIMF monitoring and for this report.

First, there are still several indicators with limited country data. Gaps are due to several factors. Some indicators are not routinely collected as part of countries' existing data collection mechanisms. Similar data may be available but do not match the current definition and methods required. Some indicators may rely on specific surveys that have not been implemented. And some indicators may require introducing new programmes. For example, only countries that have introduced human papillomavirus vaccine into national immunization programmes can provide coverage data for it.

Second, data comparisons among different countries are subject to be challenged. While metadata[5] were shared to familiarize

[5] Metadata are often referred as "data [information] that provides information about other data".

governments with the HIMF indicator definitions and to maximize the potential for data comparability, this report cannot ensure consistency in the reporting by the countries. For example, for some NCD indicators, some used self-designed surveys to collect data while others followed global survey standards, such as the STEPS[6] survey.

Third, comparisons between country data and global data are subject to challenge. Data series may differ in terms of definitions, data collection methods, population coverage, estimated methods used and variations from different years in different countries. Differences or gaps in the values of global and country data shown for indicators should not be assumed to accurately reflect underlying trends. In order to demonstrate the complexity and variety of the data series, examples are given in Table 2.

Fourth, longitudinal comparisons among the first and second progress report data for the past two years are challenging for at least four reasons:

1. Some data are survey data and, thus, the sampling methods and target age groups changed from year to year of survey data collection.
2. Some indicator definitions have been refined or changed from 2017 to 2019. The definition of the indicators at the global level is also a work in progress, such as the SDGs. Therefore, the HIMF indicators must be continuously revised to align with the global reporting standards. For example, indicators 4.3 and 4.4 related to water, sanitation and hygiene (WASH). The definition is refined from "Population using improved drinking-water source" and "Population using improved sanitation" to "Population using safely managed water services" and "Population using safely managed sanitation services" according to SDG definitions.
3. Some indicators have no updated data. As a result, same data from 2017 are provided for 2019.
4. Some indicators are qualitative data, making the comparison subjective and open to biases as qualitative indicators are human judgements or perceptions about a subject.

In order to demonstrate the complexity and variety of the data series, examples are given in Table 2.

Table 2. Examples for variations in country versus global data series in the 2019 HIMF report

Indicator	Differences	Global data	Country data
2.12 Contraceptive prevalence	Definition	Only modern methods of contraception are accepted	At least one method of contraception, regardless of method used
	Available year	2007–2015	2013–2017
3.4 Obesity in adolescents	Target population	10–19 years of age	13–15 years of age
2.1 Smoking prevalence	Data collected methods	A statistical model based on a Bayesian negative binomial meta-regression to standardize age as 15 years and over in the same year (2016)	Different surveys: National survey with target population 15–49 years of age STEPS* survey with target population 18–64 years of age

Note: The STEPS survey refers to the WHO STEPwise approach to NCD risk factor surveillance, which focuses on obtaining core data on the established risk factors that determine the major disease burden using a standard questionnaire and methods. Some countries reported data from the STEPS survey as their country data for some NCDs.

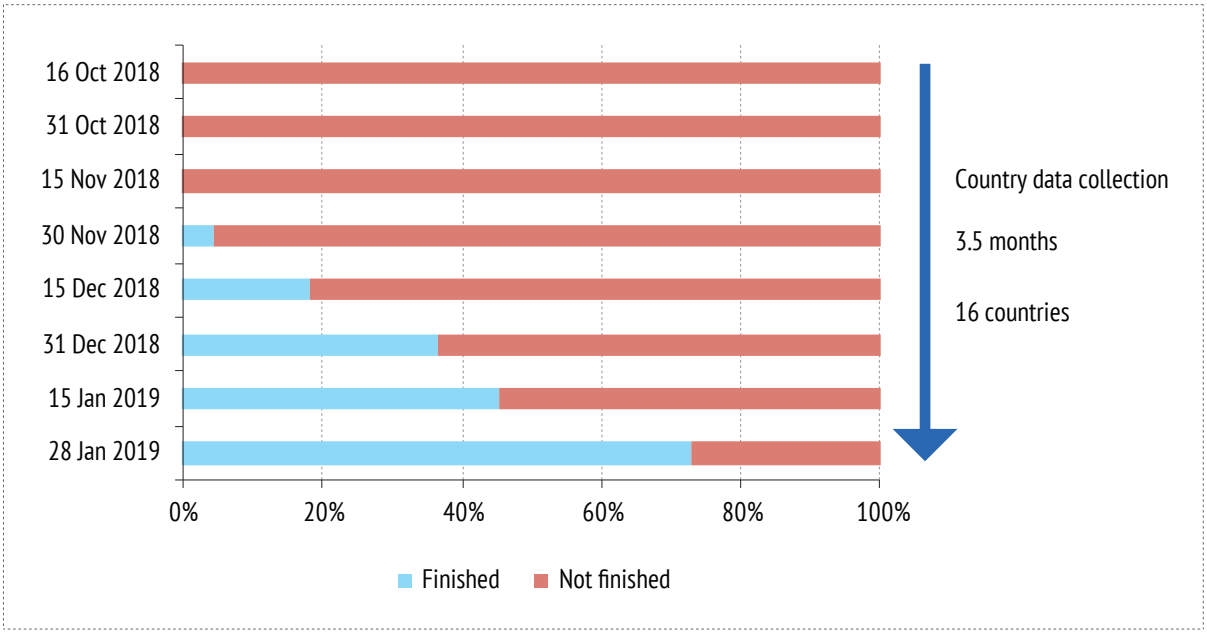
[6] STEPwise approach to surveillance. https://www.who.int/ncds/surveillance/steps/en/

3.4 Data collection and processing

Data for the HIMF are collected using the DHIS2 (District Health Information System), a data exchange online tool that has been developed and adapted by WHO for Pacific island countries to directly upload their HIMF data, and that collects also data on the SDGs and UHC indicators. The tool can be accessed and utilized simultaneously by multiple users online and is password protected. For the countries with unstable Internet connection, a back-up Excel sheet is provided that can be loaded into DHIS2. For data collection in 2018/19, five PICs preferred to use the Excel sheet. The global data as shown in Chapter 4 of the current progress report for the HIMF have been collected from publicly available sources by the WHO Division of Pacific Technical Support based in Fiji. In order to decrease the statistical variance of different data repositories from different global or regional international agencies, most of the global data of this progress report have been taken from the WHO Global Health Observatory (GHO) data repository.[7] Other global or regional databases that have been used for this report are statistical databases from United Nations Statistics Division and National Minimum Development Indicators of the Pacific Community (SPC), mostly when WHO GHO data were not available.[8] The respective sources have been referenced under each indicator.

The country data as shown in the current progress report for the HIMF were collected from countries between the middle of October 2018 and end of January 2019 (Fig. 8). Each of the 22 PICs were asked to provide the name of a country focal point for data collection, data quality checking and confirmation. Countries had difficulties keeping deadlines for data collection. One of the biggest challenges was that the data and information were collected across ministries and multiple sources within the country. In total, 16 out of 22 PICs submitted country data with the exception of American Samoa, Niue, Palau, Pitcairn Islands, Tonga, and Wallis and Futuna. There are two PICs fewer than in the first round.

Fig. 8. Country data collection process from 22 PICs



[7] World Health Organization Global Health Observatory (GHO) data repository. http://apps.who.int/gho/portal/gho.jsp

[8] United Nations Statistics Division. Demographic and social statistics. https://unstats.un.org/unsd/demographic-social/; Pacific Regional Information System, National Minimum Development Indicator Database. https://www.spc.int/nmdi

4 THE SECOND PROGRESS REPORT: STATISTICS OF CORE AND EXPANDED HIMF INDICATORS

This chapter includes the data for 47 mandatory indicators – both core and expanded – collected for the second progress report on the implementation of the Healthy Islands vision. One indicator (indicator 4.2) is excluded since only one country provided the data (Fig. 5), reflecting some of the challenges related to data gaps and complexities around indicator definitions. The report updates the work undertaken since the first progress reportSwas published in 2017 to advance implementation of the *Healthy Islands Monitoring Framework*. The progress report was submitted to the Pacific Health Ministers Meeting in August 2019.

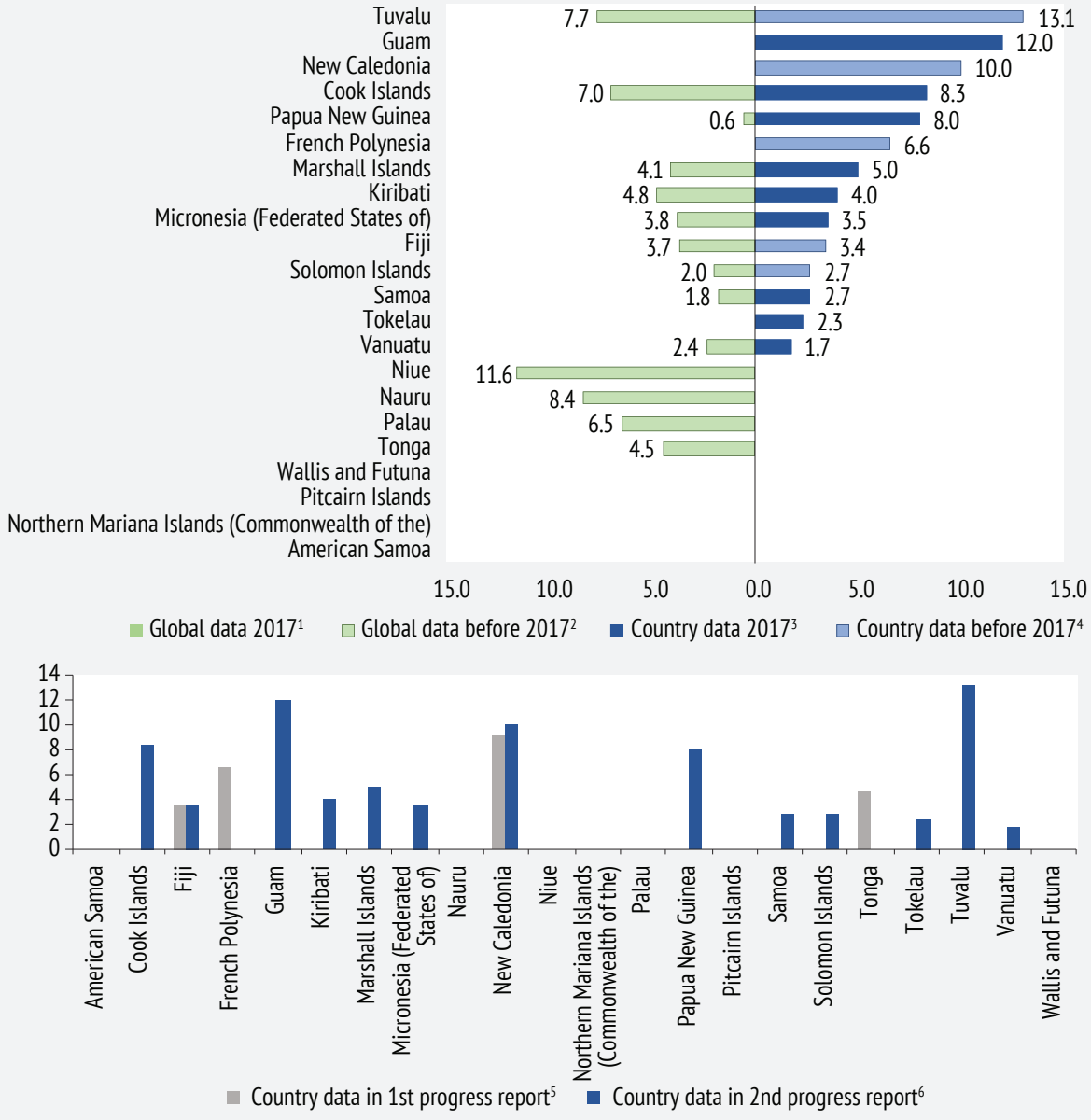
PICs were asked to validate the global estimates and provide alternative or additional country data for the report. The global data were collected from publicly available sources by WHO. For the vast majority of the indicators, country data are preferred over global data. This publication is the result of a compilation exercise that provides a snapshot of data available on the HIMF indicators in the Pacific at the end of 2018. PICs may have more data that are provided for HIMF monitoring and for this report. Also, there are several limitations of the data (refer to Chapter 3 of this report for more information). Please also refer to the accompanying footnotes for additional reporting. This applies to all data types. It is important to note that comparison between global data and country data/the first and second progress report data are subject to challenge. The data shown here are more like a demonstration rather than a comparison.

For each indicator, countries are sorted in descending order for coverage and capacity indicators by country data first, and then sorted by global data for those with no country data. Countries are sorted in ascending order for mortality, prevalence and incidence, risk factor indicators by country data first, and then sorted by global data for those with no country data (Fig. 7). Timeliness is shown in the figures by distinguishing colours.

HEALTH WORKER DENSITY

HIMF Indicator 1.1: Skilled health worker density per 1000 population

Related SDG indicator(s): 3.c.1 and 3.8.1



Notes: 1. Global data 2017 refer to data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled from 2007 to 2016. Global data resource: WHO GHO.(http://apps.who.int/gho/data/node.sdg.3-c-data?lang=en). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

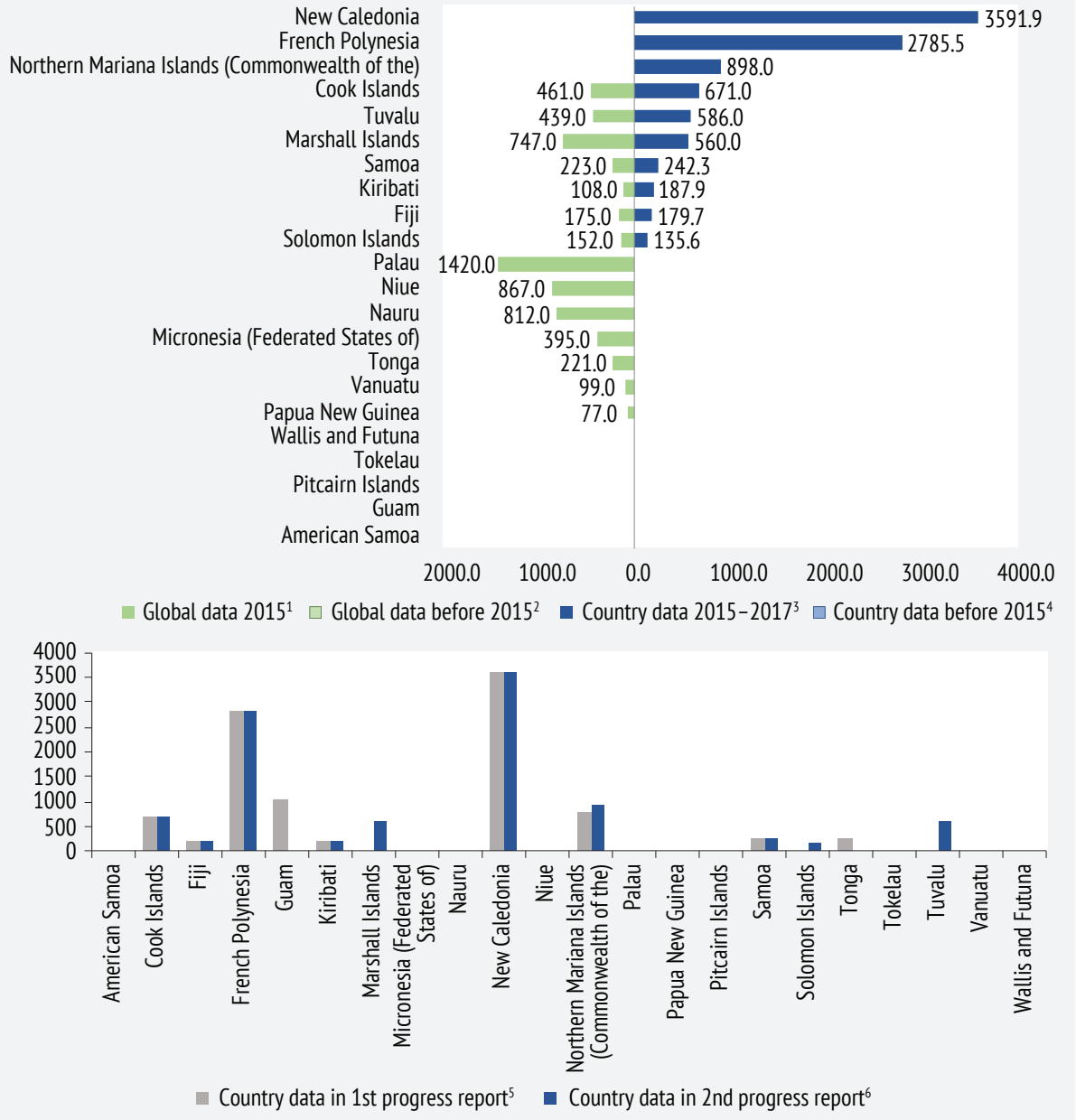
Tokelau (23.3), Samoa (27), Fiji (34), French Polynesia (65), Guam (120) and Tuvalu data need to be further confirmed.

The definition of skilled health workers includes physicians, nurses and midwives. In a comparison with the first progress report, the number of countries reporting to the second progress report increased from four to 11. Among 14 countries reporting the indicator, seven countries' health worker density is over the health worker benchmark (4.4 per 1000 population) and the other seven countries, do not reach the benchmark. Due to limited information on dentistry and pharmaceutical personnel at the country level, the global data only shows the density of physicians, nurses and midwives.

HEALTH EXPENDITURE PER CAPITA

HIMF Indicator 1.2: Per capita total expenditure on health (US$)

Related SDG indicator(s): 3.8.2



Notes: 1. Global data 2015 refer to data estimated or modelled in 2015. 2. Global data before 2015 refer to data estimated or modelled before 2015. Global data resource: World Health Statistics 2018, monitoring health for SDGs. Geneva: World Health Organization. 2018. (https://www.who.int/gho/publications/world_health_statistics/2018/en/) 3. Country data 2015–2017 refer to data collected in 2015–2017. 4. Country data before 2015 refer to data collected before 2015. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

The health expenditure includes all the annual government and nongovernmental sources of funds. The global standardized data are available for 14 countries. Three PICs, New Caledonia, French Polynesia and the Commonwealth of the Northern Mariana Islands, whose global data were not available, provided the country data.

EVIDENCE OF ANNUAL HEALTH REVIEW, PLAN AND BUDGET

HIMF Indicator 1.3: Evidence of a formally communicated, annual health plan with budget, with formal review processes in place

Related SDG indicator(s): N/A

Level	Description	2018 assessment
0	No evidence of annual health plan or annual budget	
1	There is evidence that an annual health plan is in development, or no reports or reviews are available	Papua New Guinea
2	Annual health plan with budget is developed, communicated and resourced	Tuvalu, Vanuatu
3	Annual health plan with budget is developed, communicated and resourced, and an annual review andSreport are available	Cook Islands, Fiji, French Polynesia, Marshall Islands, New CaleSonia, CommonweSlth of the Northern Mariana Islandss, Samoa, Tokelau

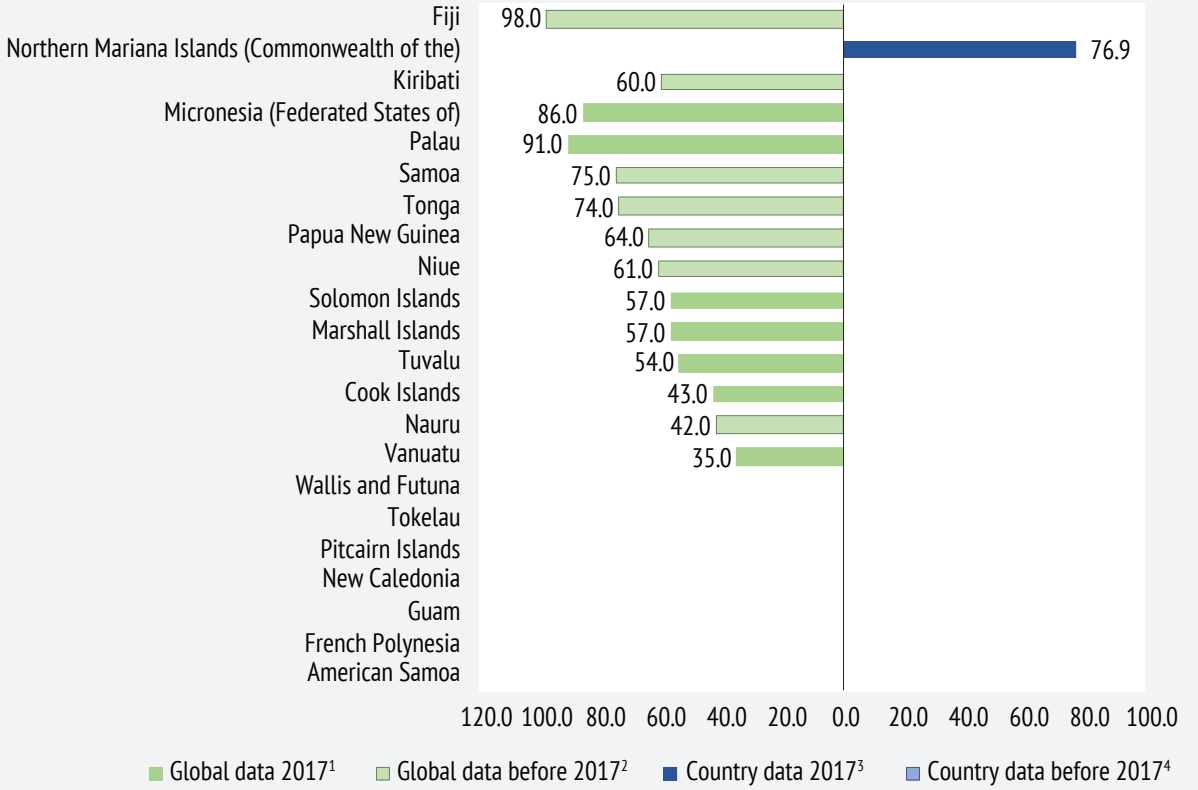
Federated States of Micronesia (5 633 930) data need to be further confirmed.

The indicator is assessed in a qualitative way to reflect the existence of a formally communicated, annual health plan with budget, with a formal review processes in 2018. Among 22 countries included, 11 countries reported the status of this indicator: nine countries at the highest level, meaning annual health plan/budget was available, annual report was available; one country had an annual health plan; and one country was developing an annual health plan. This indicator is not included in SDGs, but progress against this indicator implies how well countries use their national health policy, strategy and plan cycle in implementation

INTERNATIONAL HEALTH REGULATIONS (IHR) CORE CAPACITY SCORE

HIMF Indicator 1.4: Average of 13 core regulations core capacity that have been attained at a specific point in time.

Related SDG indicator(s): 3.d.1



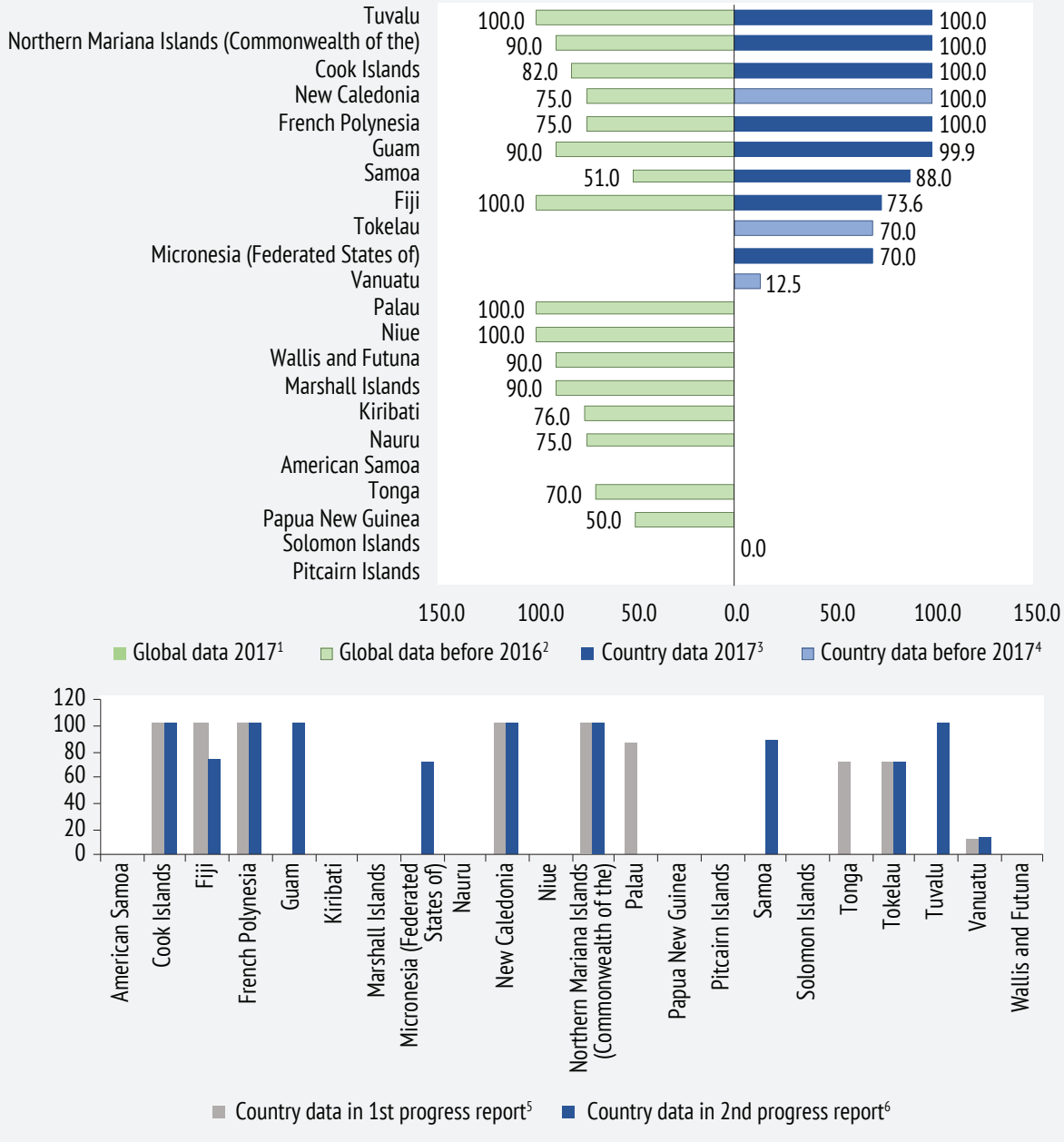
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled from 2012 to 2015. Global data resource: World Health Statistics 2018, monitoring health for SDGs. Geneva: World Health Organization. 2018. (https://www.who.int/gho/publications/world_health_statistics/2018/en/). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2015–2016.

The 13 core capacities are: (1) National legislation, policy and financing; (2) Coordination and National Focal Point communications; (3) Surveillance; (4) Response; (5) Preparedness; (6) Risk communication; (7) Human resources; (8) Laboratory; (9) Points of entry; (10) Zoonotic events; (11) Food safety; (12) Chemical events; and (13) Radio-nuclear emergencies. Four PICs, including Fiji, Kiribati, the Federated States of Micronesia and the Commonwealth of the Northern Mariana Islands, reported national data. However, the IHR (2005) score is globally standardized and hence only global data are kept except for the Commonwealth of the Northern Mariana Islands, whose global data are not available.

DEATH REGISTRATION COVERAGE

HIMF Indicator 1.5: Percentage of death that are registered (with age and sex) in a given time period

Related SDG indicator(s): 17.19.2(b)



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2000–2015. Global data resource: United Nations StatiStics Division. Demographic and social statistics . https://unstats.un.org/unsd/demographic-social/). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2011–2015. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progreSs report refer toSdata reported by PICs in 2018.

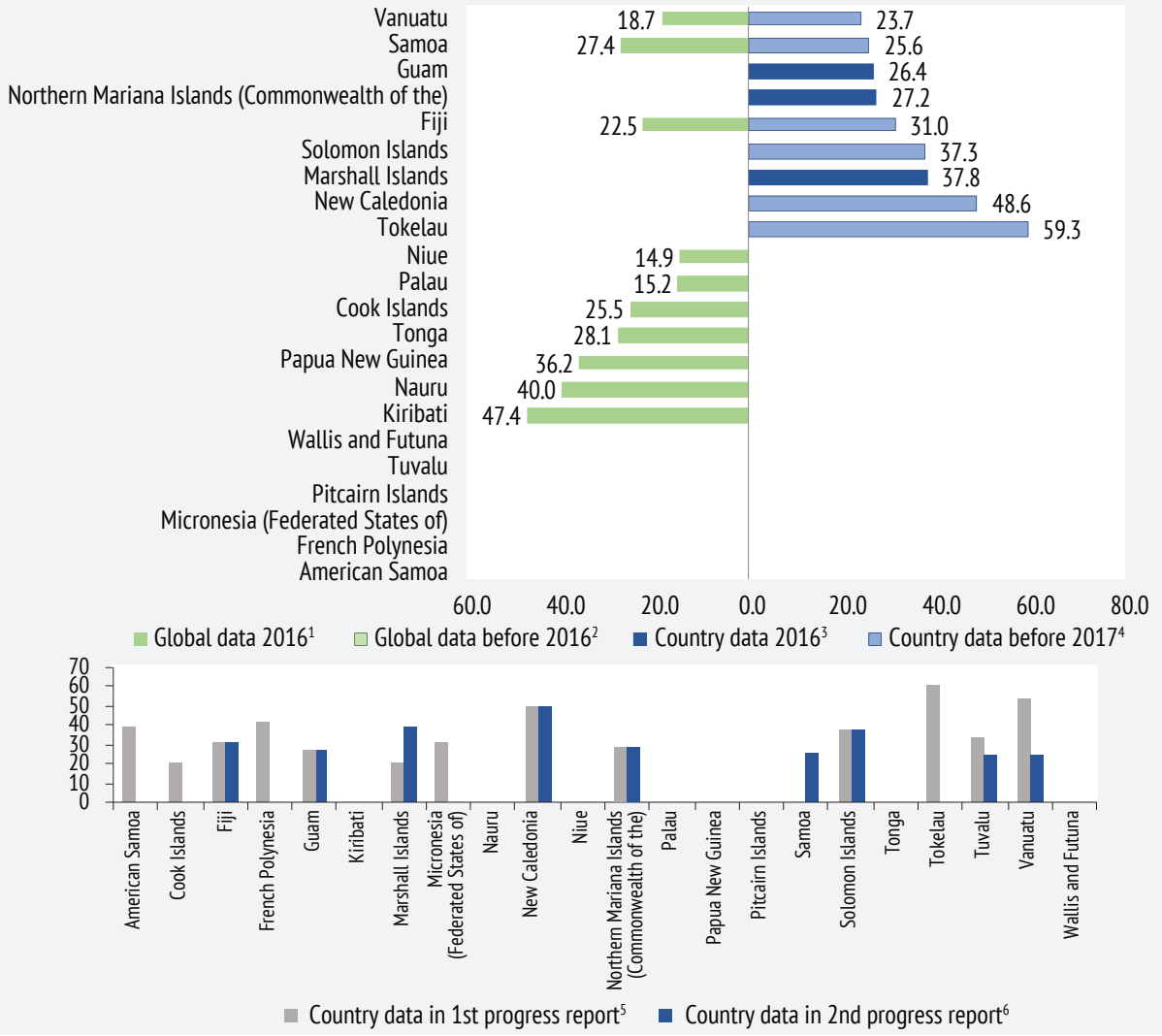
Solomon Islands data need to be further confirmed.

A total of 10 PICs reported the country data. Comparing with available global data from 2000 to 2015, the country data provide up-to-date data sourced from 2016 to 2017. Given that death registration is a basic step to monitor the status of civil registration and vital statistics (CRVS), SDG indicator 17.19.2(b) aims to achieve 80% death registration by 2030. According to the country data, the average rate is 90.2% in 10 countries, but three countries reported the indicator below 80%.

SMOKING PREVALENCE

HIMF Indicator 2.1: Age-standardized prevalSnce of tobacco smoking among persons 15 yearS and older

Related SDG indicator(s): 3.a.1 and 3.8.1



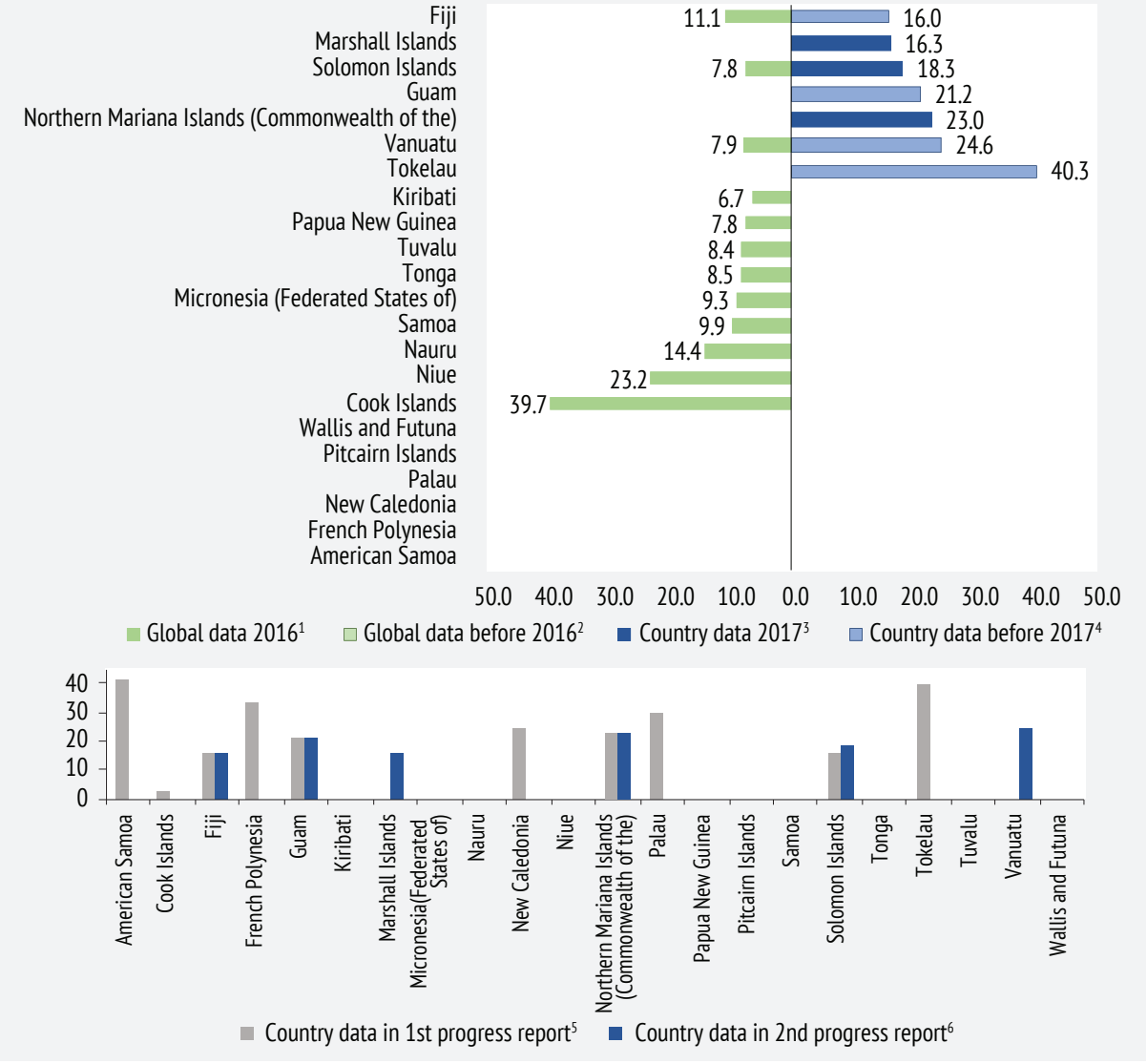
Notes: 1. Global data 2016 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2011–2015. Global data resource: World Health Statistics 2018, monitoring health for SDGs. Geneva: World Health Organization. 2018. (https://www.who.int/gho/publications/world_health_statistics/2018/en/). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2013–2015. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Country data of five countries (Fiji, Samoa, Solomon Islands, Tokelau and Vanuatu) are from the STEPwise approach to Surveillance (STEPS) survey, according to country reports. This targets ages 18 to 69 years (although previously this was 18 to 64 years); as such the data the survey produces does not align directly with this indicator which is 15 years and above. WHO produces estimates for all countries, for the 15 years above, using STEPS data and where available considering the findings from Global School-Based Health Survey which is from 12/13 years to 17 years). Estimates are not available if there were insufficient data to model/estimate the 15 years and above prevalence (e.g. multiple time points) or if the NCD survey used in country did not utilize a similar definition to STEPS for tobacco smoking. This indicator shows substantial variation in the PICs for tobacco smoking, with more than a twofold difference. PICs have committed to working towards the Tobacco Free Pacific 2025 goal, which will be more challenging for some countries than others.

HEAVY EPISODIC DRINKING

HIMF Indicator 2.2: Adults (aged 15+ or 18+ years) who report drinking six (60 g) or more standard drinks in a single drinking occasion

Related SDG indicator(s): 3.5.2



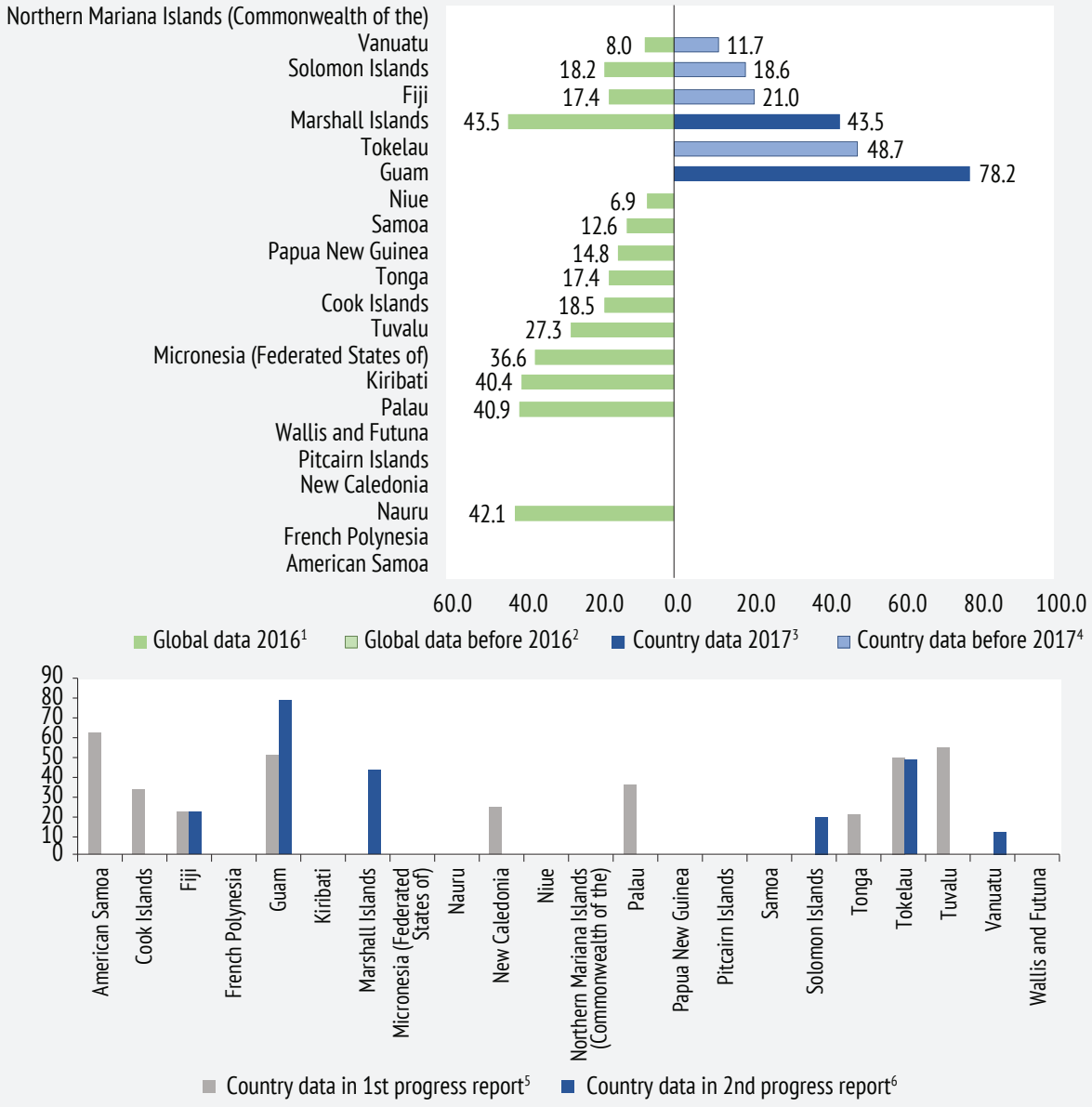
Notes: 1. Global data 2016 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO (http://apps.who.int/gho/data/view.main.52515). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2011–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Country data of four countries (Fiji, Solomon Islands, Tokelau and Vanuatu) are from STEPS survey according to the country reports. Alcohol refers to pure alcohol (beer, wine, spirits, other). Global data for patterns of alcohol consumption are mainly from STEPS surveys and from WHO estimates derived from STEPS and other relevant NCD surveys. Alcohol consumption patterns are used to indicate the level of risk to health, and they are based on frequency and total consumption of alcohol at one sitting. A standard drink refers to a measure of an alcoholic drink that contains 10 grams of alcohol. Drinking more than six units of alcohol on one occasion is extremely high risk for health, and is therefore highlighted in this indicator. There are concerning levels of this type of drinking behaviour in some of the PICs. Data from individual PICs usually show substantial gender differences in alcohol consumption with men being far more likely to consume alcohol and to consume frequently and in large quantities, than women.

INSUFFICIENTLY PHYSICALLY ACTIVE ADULTS

HIMF Indicator 2.3: Age-standardized prevalence of insufficiently physically active perSons aged 18+ years

Related SDG indicator(s): None



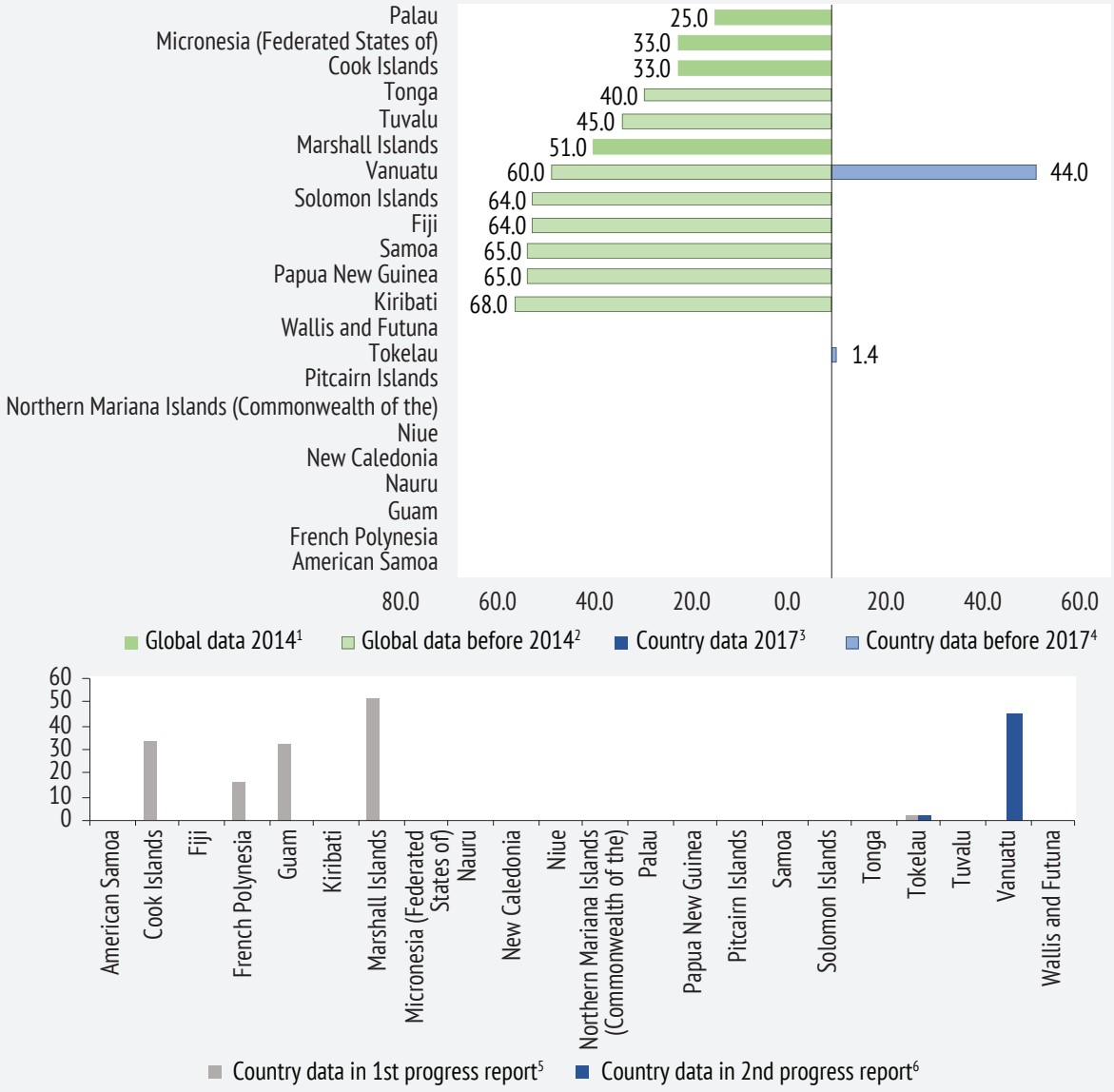
Notes: 1. Global data 2016 refer to the data eStimated or modelled in 2016 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO (http://apps.who.int/gho/data/view.main.2463). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2011–2015. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Insufficiently physically active is defined as not meeting any of the following criteria: 150 minutes of moderate-intensity physical activity per week; 75 minutes of vigorous-intensity physical activity per week; an equivalent combination of moderate- and vigorous-intensity physical activity accumulating at least 600 metabolic equivalent minutes per week (minutes of physical activity can be accumulated over the course of a week but must be of a duration of at least 10 minutes). Data are primarily from STEPS surveys (Fiji, Solomon Islands, Tokelau and Vanuatu) and other NCD surveys that measure physical activity level and duration. There is a considerable variation in the prevalence of those who are insufficiently physically active – a more than fivefold difference.

INTIMATE PARTNER VIOLENCE

HIMF Indicator 2.4: Percentage of currently partnered girls and women aged 15–49 years who have experienced physical and/or sexual violence by their current intimate partner in the last 12 months

Related SDG indicator(s): 5.2



Notes: 1. Global data 2014 refer to the data estimated or modelled in 2014. 2. Global data before 2014 refer to the data estimated or modelled before 2007–2013. Global data resource: Pacific Regionsal Information System, National Minimum Development Indicator Database (https://www.spc.int/nmdi/gender). WHO GHO: no country data but only regional data. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2011–2015. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Aggregating individual women's experiences of intimate partner violence shows the level of exposure to violence that women in relationships experience in a given population. Only Vanuatu (2011) and Tokelau (2016) reported data for this indicator. According to the global data, in 60% of the PICs over 50% girls and women aged 15–49 years experienced physical or sexual violence by their current intimate partner in the past 12 months. The definition of SDG indicator 5.2.1 includes both current and former intimate partner while HIMF 2.4 only includes current partner.

TOBACCO EXCISE TAX

HIMF Indicator 2.5: Evidence of legislation to reduce affordability of tobacco products by increasing tobacco excise taxes

Related SDG indicator(s): N/A

Score	Description	2018 assessment
–	No excise tax is collected on cigarettes	-
–	Tobacco excise tax legislation is being developed, or cigarette excise tax ⩽20% of retail price	Fiji, Marshall Islands
0	21–30% of rStail price of cigarettes is excise tax	Solomon Islands
1	31–50% of retail price of cigarettes is excise tax	Kiribati, Samoa, Vanuatu
2	51–69% of retail price of cigarettes is excise tax	Cook Islands, Guam, Commonwealth of the Northern Mariana Islands
3	⩾70% of retail price of cigarettes is excise tax	French Polynesia, New Caledonia, Tokelau

Notes: 1. Tolley H, Snowdon W, Wate J, et al. Monitoring and accountability for the Pacific response to the non-communicable disease crisis. BMC public health, 2016, 16: 958

The indicator is from the Pacific Monitoring Alliance for NCD Action (Pacific MANA) Framework. Progress towards implementation of a policy or action is scored by a "traffic light" colour scheme: red for no policy present; amber for policy under development; and green for policy in place along with a rating for further progress.[1] Only three PICs are not using taxation as a measure to reduce the affordability of tobacco. Three 3 PICs — French Polynesia, New Caledonia and Tokelau — are at the highest level. The cigarette excise tax is 71% or more of retail price. The WHO Framework Convention on Tobacco Control recommends that at least 70% of the retail price be excise tax.

EXCISE TAX ON ALCOHOLIC DRINKS

HIMF Indicator 2.6: Evidence of an inflation-adjusted alcohol excise taxation system on beer, wine and spirits

Related SDG indicator(s): N/A

Score	Description	2018 assessment
–	No alcohol excise tax is collected	Cook Islands, French Polynesia, Nauru
–	Alcohol excise taxation system is being developed based on beverage type or ethanol content	Marshall Islands
0	Alcohol excise taxation system is in place and based on beverage type or ethanol content	Commonwealth of the Northern Mariana Islands, Kiribati
1	Alcohol excise taxation system is in place and based on beverage type or ethanol content, *and* is applied across all beverage types *or* if bands are applied, excise tax is based on the ethanol content at the top of each band, and excise tax is reviewed or adjusted for inflation annually for at least one beverage type	Solomon Islands, Tokelau, Vanuatu
2	Alcohol excise taxation system is in place and based on beverage type or ethanol content, *and* is applied across all beverage types *or* if bands are applied, excise tax is based on the ethanol content at the top of each band, *and* excise tax is reviewed or adjusted for inflation annually for all beverage types	Fiji, Samoa
3	Same as for 2, *and* excise tax is stated by the Government as an important public health tool to reduce alcohol consumption/harm	New Caledonia

Notes: 1. Tolley H, Snowdon W, Wate J, et al. Monitoring and accountability for the Pacific response to the non-communicable disease crisis. BMC public health, 2016, 16: 958

The indicator is from the Pacific MANA Framework. Progress towards implementation of a policy or action is scored by a "traffic light" colour scheme: red for no policy present; amber for policy under development; and green for policy in place along with a rating for further progress.[1] The majority of PICs are utilizing excise tax to reduce the affordability of alcohol. However, levels of tax are generally low and do not rate three-star green.

EXCISE TAX ON THE RETAIL PRICE OF SUGAR-SWEETENED BEVERAGES (SSBs)

HIMF Indicator 2.7: Excise duties levied on imported and/or locally produced SSBs of at least 20% of retail price; or fiscal import tax imposed on raw materials for local producers to an equivalent level.

Related SDG indicator(s): N/A

Score	Description	2018 assessment
0	No SSB excise tax	New Caledonia, Solomon Islands
1	SSB tax legislation in development, or SSB excise tax is <20% of retail price	Fiji, French Polynesia, Samoa, Tokelau, Vanuatu
2	SSB excise tax over 20% of retail price	Cook Islands, Kiribati, Marshall Islands

Notes: 1. Tolley H, Snowdon W, Wate J, et al. Monitoring and accountability for the Pacific response to the non-communicable disease crisis. BMC public health, 2016, 16: 958

The data were suggested to further confirm.

The indicator is from the Pacific MANA Framework. Progress towards implementation of a policy or action is scored by a "traffic light" colour scheme: red for no policy present; amber for policy under development; and green for policy in place along with a rating for further progress.[1] When taxing SSBs, the amount of tax needs to be sufficient to provide a noticeable impact on price at retail so that consumers purchasing them will be affected. Levels of tax on SSBs vary markedly.

ACCESS TO ESSENTIAL NCD DRUGS

HIMF Indicator 2.8: Essential NCD drugs available and accessible in public health sector primary care facilities.

Related SDG indicator(s): N/A

Score	Description	2018 assessment
–	No essential drug list exists, or not all drugs listed are on the essential drug list	Cook Islands
–	All drugs listed are on the essential drug list	
0	All drugs listed are on the essential drug list, and a system is in place to monitor availability	Marshall Islands, Nauru, Vanuatu
1	All drugs listed are on the essential drug list, and a system is in place to monitor availability, and monitoring reports are available, and stock-outs were reported in more than 50% of facilities in the last 12 months	Fiji, French Polynesia, Tuvalu
2	All drugs listed are on the essential drug list, and a system is in place to monitor availability, and monitoring reports are available, and stock-outs were reported in less than 50% of facilities in the last 12 months	
3	All drugs listed are on the essential drug list, and a system is in place to monitor availability, and monitoring reports are available, and no stock-outs were reported in facilities in the last 12 months	New Caledonia, Commonwealth of the Northern Mariana Islands, TokelaS

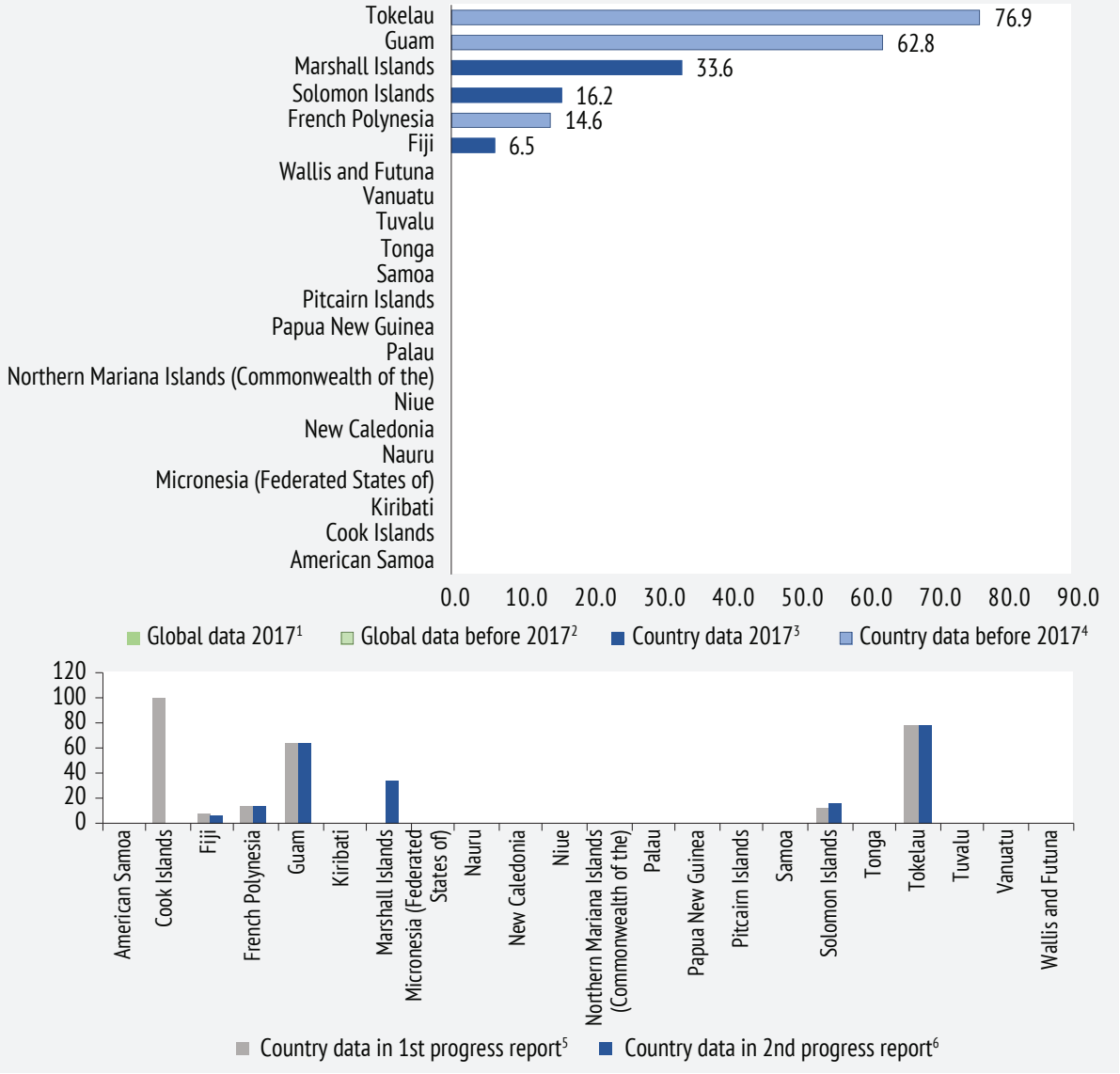
Notes: 1. Tolley H, Snowdon W, Wate J, et al. Monitoring and accountability for the Pacific response to the non-communicable disease crisis. BMC public health, 2016, 16: 958

The indicator is from the Pacific MANA Framework. Progress towards implementation of a policy or action is scored by a "traffic light" colour scheme: red for no policy present; amber for policy under development; and green for policy in place along with a star rating for further progress. The majority have essential NCD medications listed on their national essential drugs list (classified as green).[1] All the nine reporting PICs have essential NCD drugs available and accessible in public health sector primary care facilities but at different levels of implementation. Only three PICs reported that stock-outs did not occur in the past 12 months: the Commonwealth of the Northern Mariana Islands, New Caledonia and Tokelau. When stock-outs occur, patients may miss taking their medication, which can significantly affect their health and long-term prognosis.

CERVICAL CANCER SCREENING

HIMF Indicator 2.9: Coverage of the national cervical cancer screening programme

Related SDG indicator(s): 3.8.1



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2014 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2014–2015. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. World Health Organization. Improving data for decision-making: a toolkit for cervical cancer prevention and control programs. 2019.

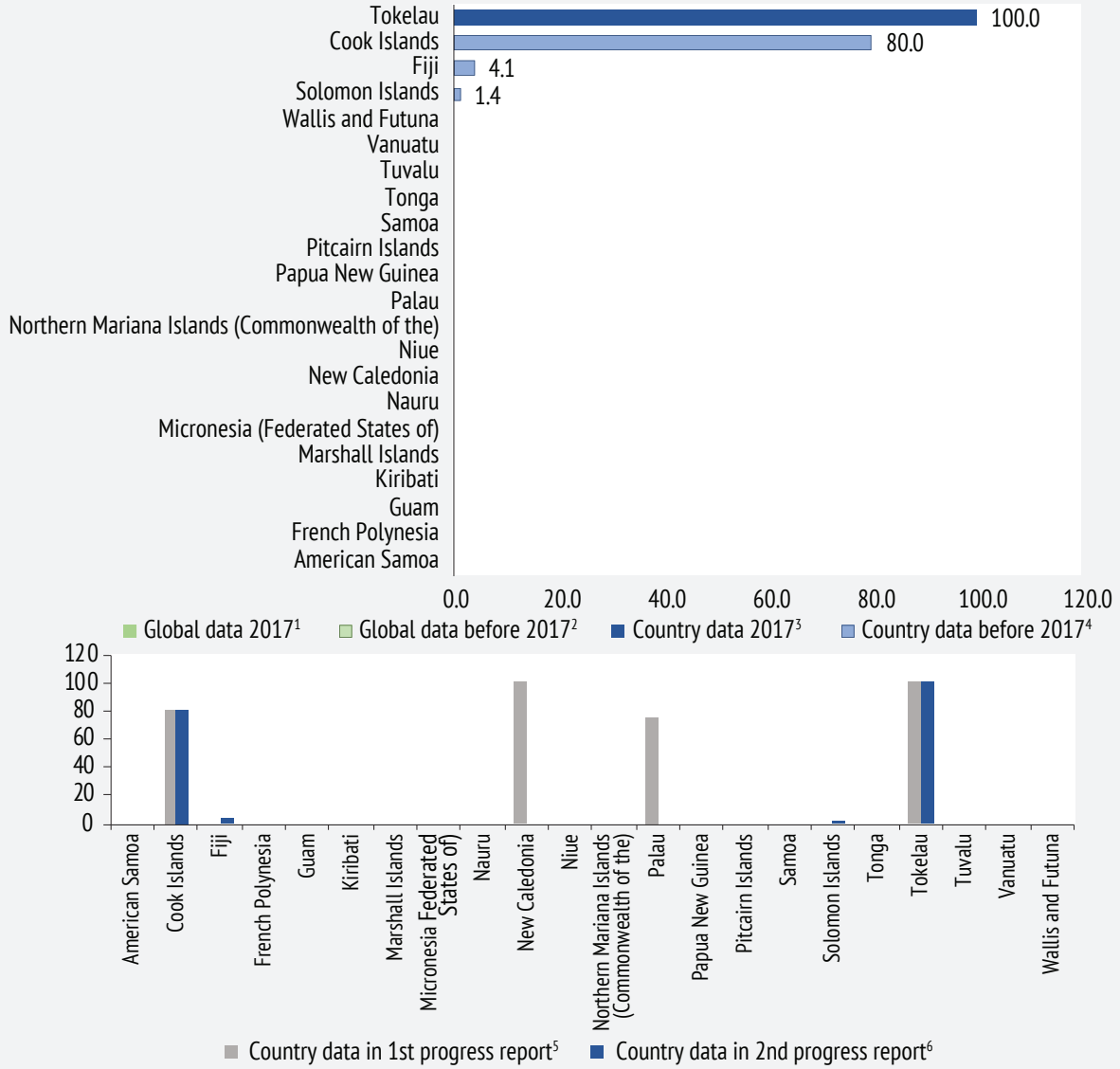
Commonwealth of the Northern Mariana Islands data (824) needSto be(Federated States of) further confirmed

Early diagnosis of cervical cancer and/or of precancerous lesions markedly affects treatment options and survival. Effective, well-designed screening programmes combined with human papillomavirus (HPV) vaccination can help in dramatically reducing cervical cancer related cases and deaths. Available screening options include an HPV test, visual inspection with acetic acid and pap smear.[7] The targeted group for screening in many countries (and the priority for screening) are women aged 30–49 years. The indicator here is women aged 30–49 years who report ever having had a screening test for cervical cancer using any of these methods. Only six PICs reported data for this indicator. While screening programmes exist in nearly all PICs, coverage and collection of data are generally weak, which limits ability to report against this indicator. Strengthening of screening programmes will allow PICs to report against this indicator.

SERVICE COVERAGE FOR PEOPLE WITH INCREASED RISK FOR CARDIOVASCULAR DISEASE

HIMF Indicator 2.10: Proportion of eligible persons receiving drug therapy and counselling to prevent heart attacks and strokes

Related SDG indicator(s): N/A



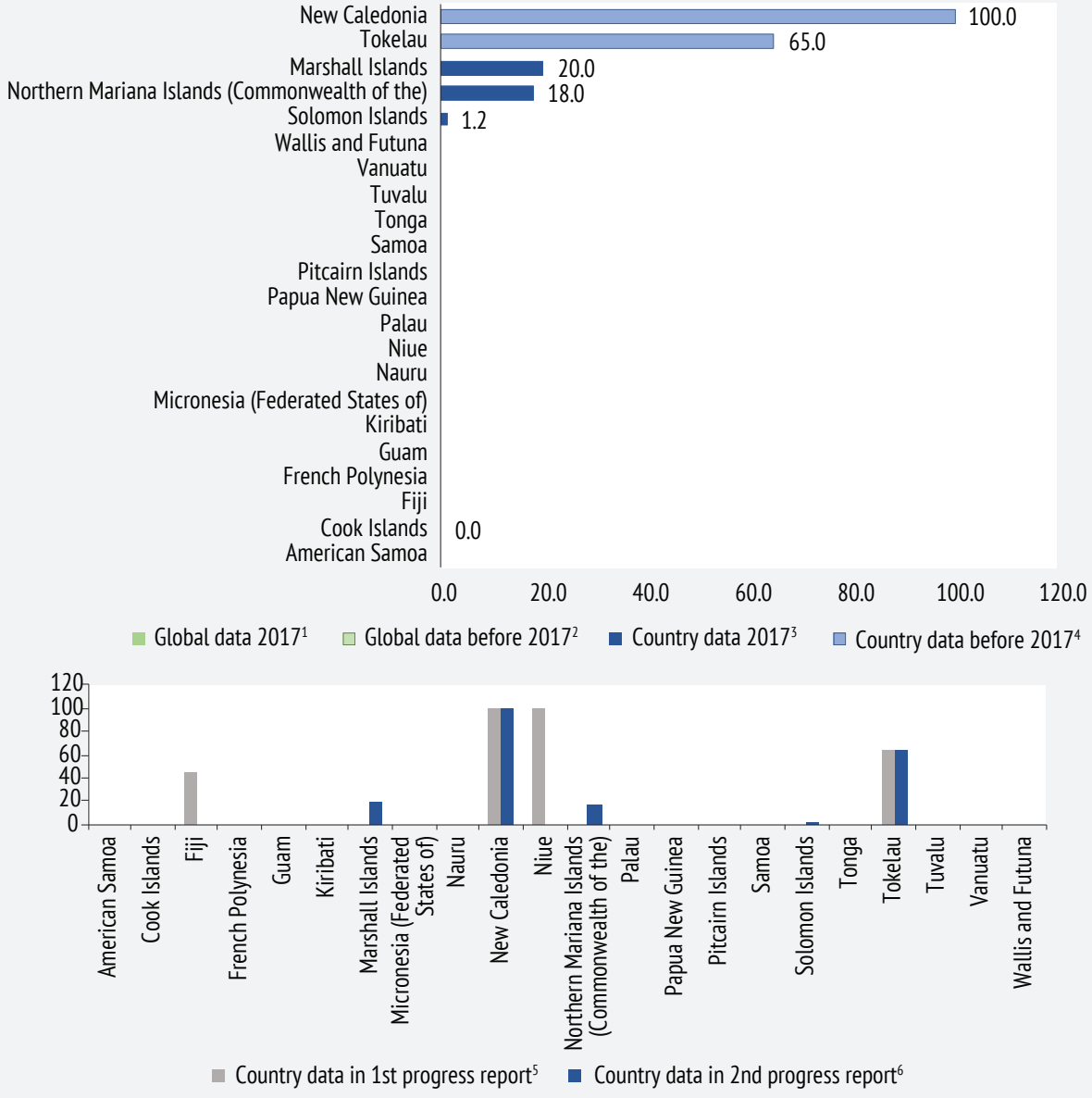
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2014 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2014–2015. 5. Country data in first progress report refer toSdata reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. World Health Organization. Noncommunicable disease Slobal monitoring framework: Indicator definitions and specifications.

This indicator shows the percentage of eligible persons – defined as aged 40 years and older with a 10-year cardiovascular disease (CVD) risk* ⩾30%, including those with existing CVD – receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and stroke. A 10-year CVD risk of ⩾30% is defined utilizing WHO/IHS risk charts.[7] These data can be collected from STEPS surveys (surveys conducted after 2015 include this) and/or health information systems (if programmed to allow this reporting). While only four PICs reported data in this round of data collection, the number of countries is expected to increase as countries undertake surveys and/or align their health information systems with NCD needs for reporting. The difference in coverage between the four reporting countries was marked. With the two smaller PICs having significantly higher coverage than the two larger PICs.

SERVICE COVERAGE FOR PEOPLE WITH SEVERE MENTAL HEALTH DISORDERS

HIMF Indicator 2.11: Percentage of people with a severe mental health disorder who are using services

Related SDG indicator(s): N/A



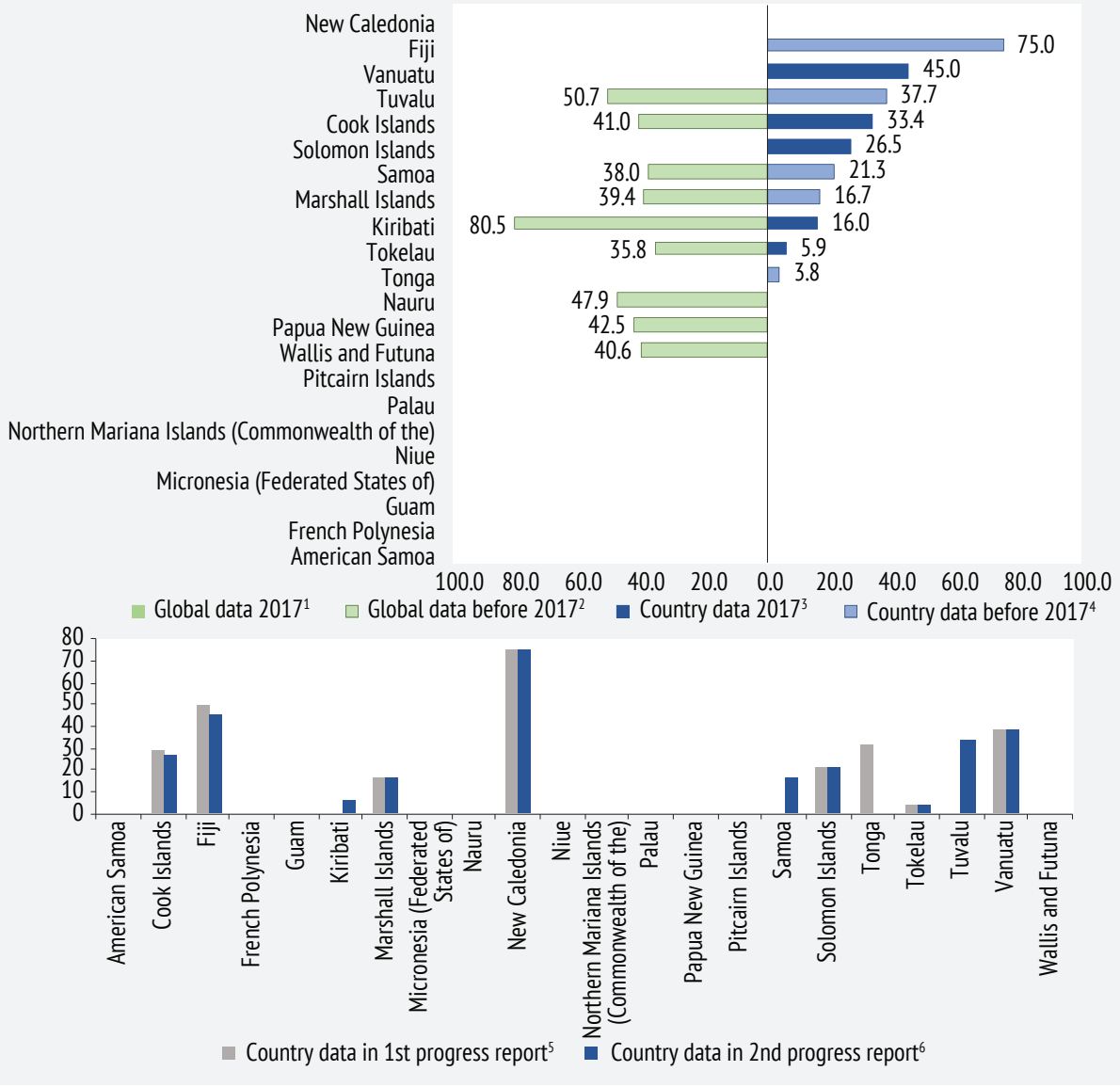
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2014 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

The Sixty-sixth World Health Assembly adopted the *Mental Health Action Plan 2013–2020* to address the challenges of bridging the mental health treatment gap. A severe mental disorder concludes psychosis, bipolar affective disorder and moderate-severe depression. Only five PICs reported data with differences varying from around 1% to 100%.

CONTRACEPTIVE PREVALENCE

HIMF Indicator 2.12: Percentage of women aged 15–49 years who are sexually active, who are currently using, or whose sexual partner is using, at least one method of contraception

Related SDG indicator(s): 3.7.1 and 3.8.1



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2014 refer to the data estimated or modelled from 2007 to 2015. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.main.REPWOMEN39). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. Creanga AA, Gillespie D, Karklins S, et al. Low use of contraception among poor women in Africa: an equity issue. Bulletin of World Health Organization, 2011, 89: 258–266.

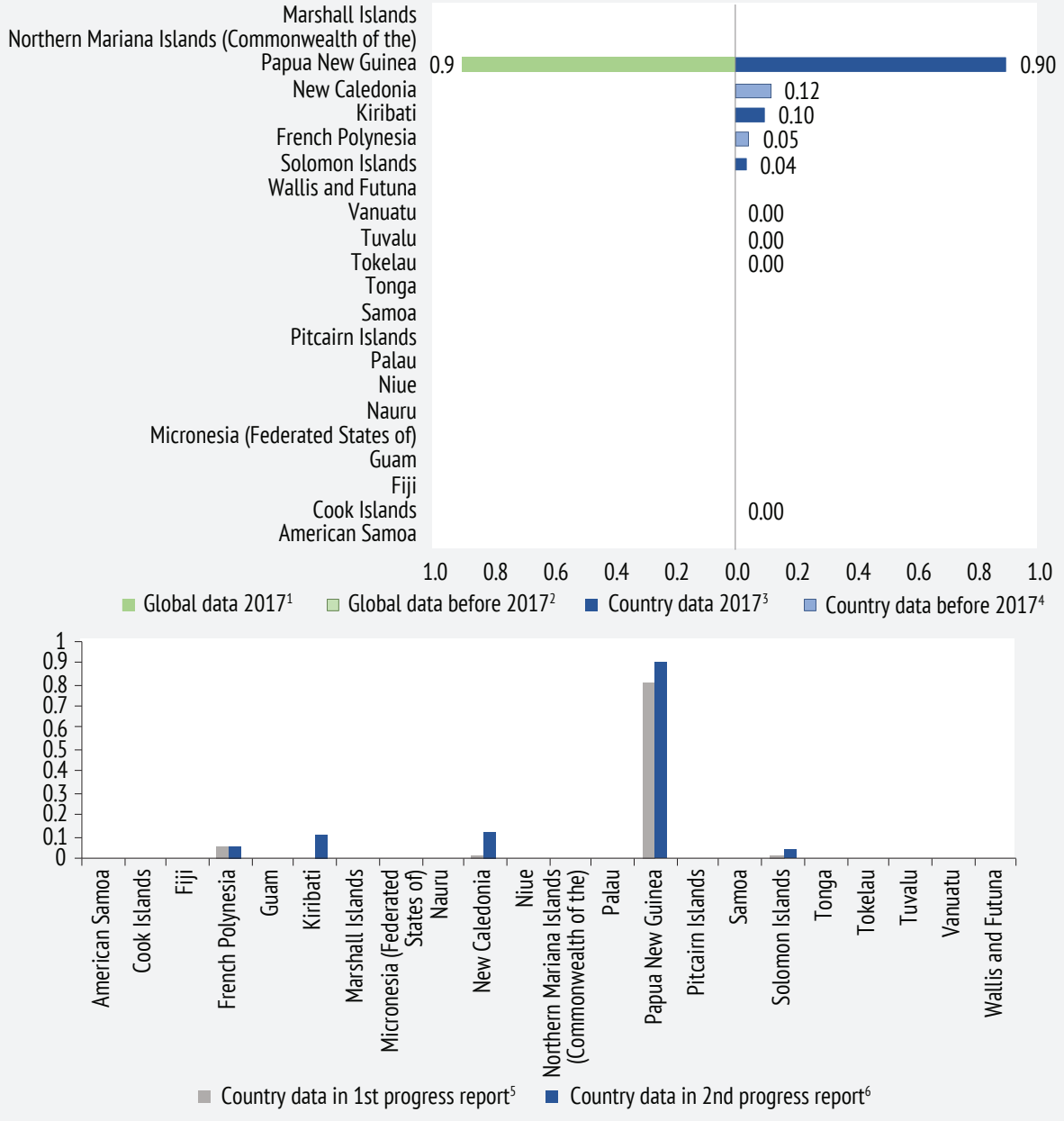
Using methods of contraception means women are considered to have a demand for family planning. Family planning helps enable women and their partners to exercise their rights to decide freely and responsibly the number and spacing of their children. It also contributes to maternal and child health by preventing unintended pregnancies and closely spaced pregnancies, which are at higher risk for poor obstetrical outcomes.[7] Levels of demand for family planning satisfied with modern methods of 75% or more are generally considered high, and values of 50% or less are generally considered very low.

Nine out of the 10 PICs reporting show very low prevalence of using contraception methods. If the data were adjusted per the definition of SDG indicator 3.7.1 to include only modern methods, the prevalence may be even lower.

HIV PREVALENCE AMONG THE GENERAL POPULATION

HIMF Indicator 2.13: Estimated number of people (aged 15–49 years) living with HIV, whether or not they have developed symptoms of AIDS in a given period of time

Related SDG indicator(s): 3.3.1



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2014 refer to the data estimated or modelled from 2017. Global data resource: WHO GHO (http://apps.who.int/gho/data/node.imr.MDG_0000000029?lang=en).
3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016.
5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer toSdata reported by PICs in 2018.

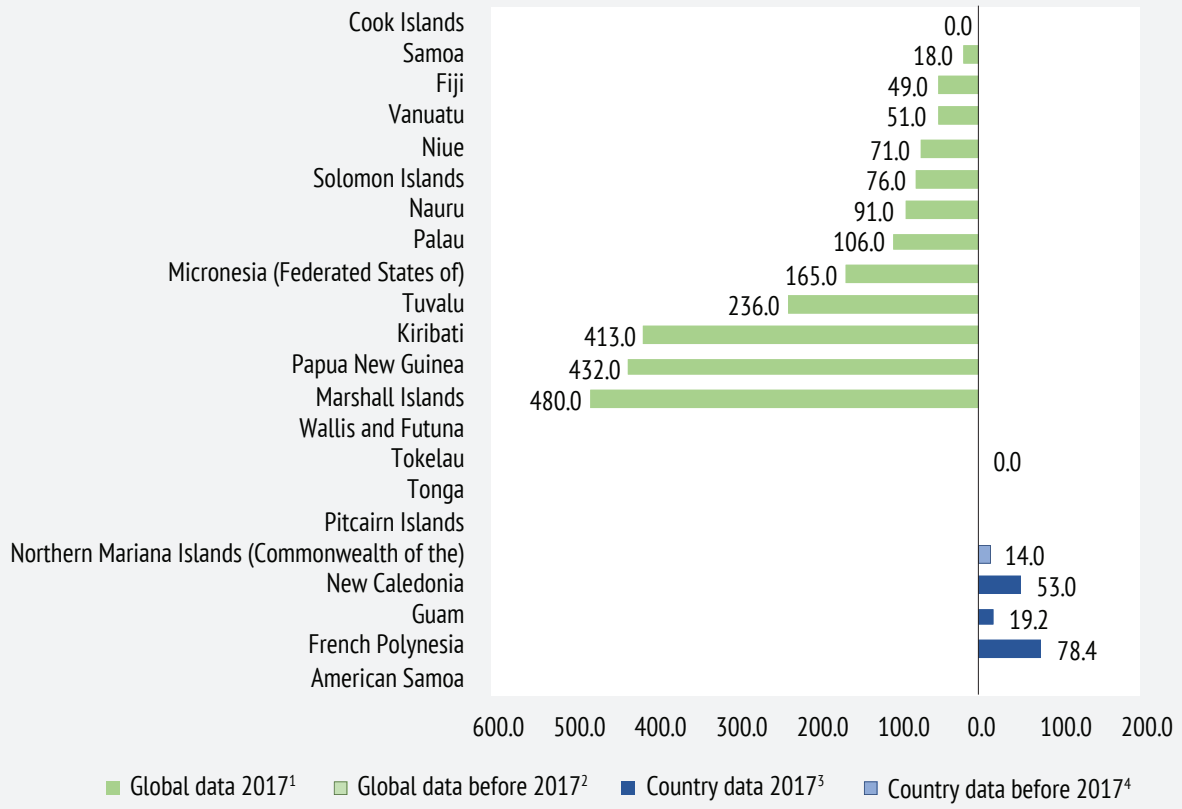
Commonwealth of the Northern Mariana Islands (14) and Marshall Islands (18.9) need to be further confirmed.

HIV/AIDS has become a major public health problem in many countries and monitoring the course of the epidemic and impact of interventions is crucial. Global data are only available for Papua New Guinea. A total of 11 PICs reported for this indicator with four (Cook Islands, Tokelau, Tuvalu, Vanuatu) reporting as 0.

TUBERCULOSIS (TB) INCIDENCE

HIMF Indicator 2.14: Estimated number of new and relapse TB cases arising in a given year per 100 000 population

Related SDG indicator(s): 3.3.2



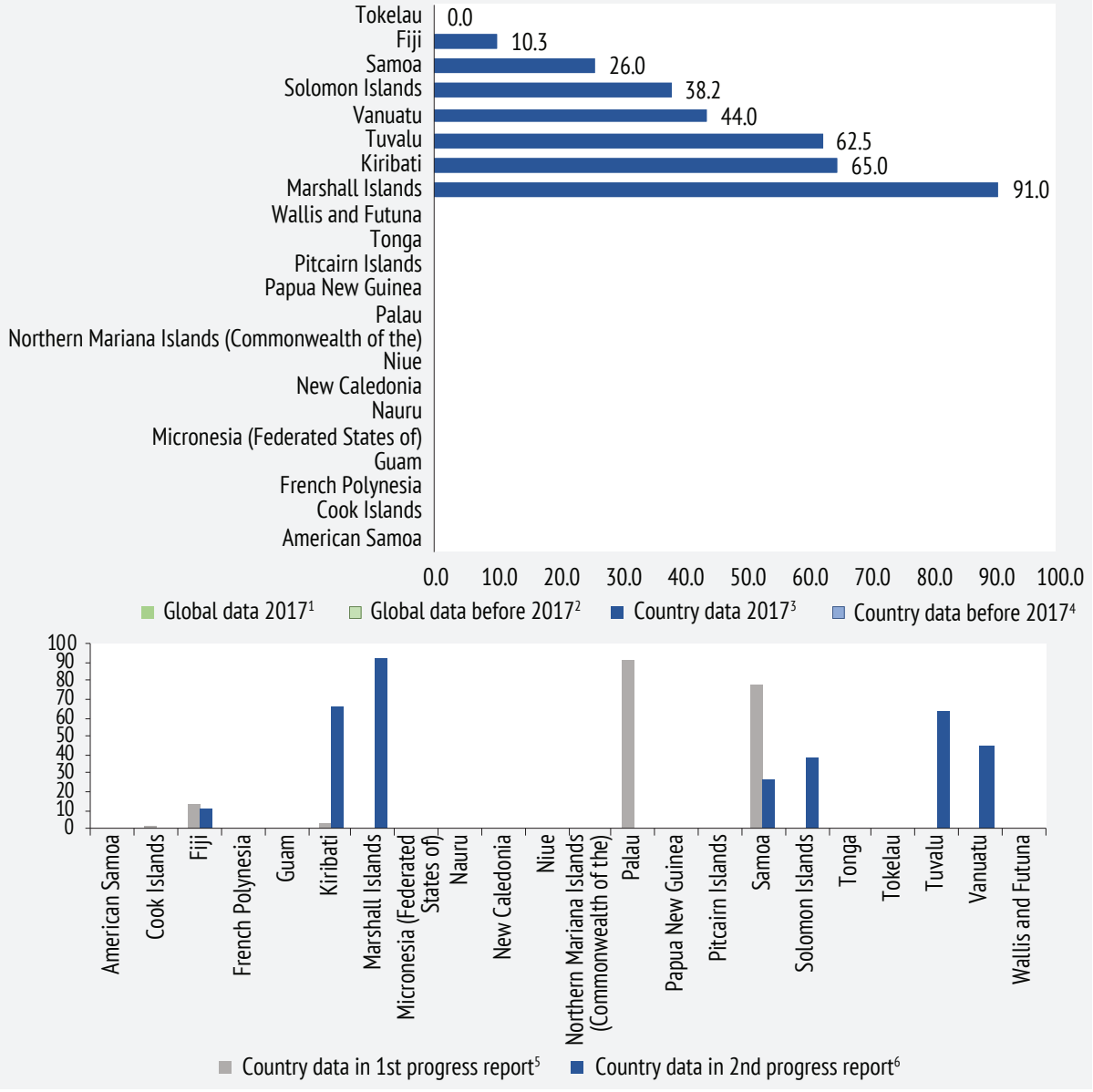
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.main.1320?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Estimates of TB incidence are produced through a consultative and analytical process led by WHO and are published annually. These estimates are based on annual case notifications, assessments of the quality and coverage of TB notification data, national surveys of the prevalence of TB disease and information from death (vital) registration systems. So only PICs without global estimated data available showed the country data. And there is no comparison of country data between the first and second progress report.

LOWER-EXTREMITY AMPUTATION AMONG PATIENTS WITH DIABETES

HIMF Indicator 2.15: Proportion of diabetes-related amputations per 100 000 population

Related SDG indicator(s): N/A



Notes: 1. Global data 2017 refer toSthe data estimated or modelled in 2017. 2. Global data before 2014 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected before 2017. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

With early diagnosis and effective management, the risk of diabetes-related limb amputations should be extremely small. However, in the PICs as patients often present late and glycaemic control and frequency of foot checks are commonly insufficient, there is a concerning level of amputations. This indicator relies on surgical records (for operations to remove foot/parts of lower limb) and prevalence of diabetes (from STEPS or similar surveys). The indicator definition focuses on lower-limb amputations, excluding digit only and exclude traumatic amputations not associated with diabetes. Seven PICs reported this indicator with considerable differences in the levels of reporting. Variations may be due to quality and effectiveness of patient management and completeness of surgical records.

MATERNAL DEATHS

HIMF Indicator 2.16a: Number of maternal deaths related to childbearing in a given time period

Related SDG indicator(s): 3.1.1

American Samoa	
Cook Islands	0
Fiji	7
French Polynesia	
Guam	0
Kiribati	1
Marshall Islands	1
Micronesia (Federated States of)	
Nauru	
New Caledonia	0
Niue	
Northern Mariana Islands (Commonwealth of the)	1
Palau	
Papua New Guinea	460
PStcairn ISlands	
Samoa	0
Solomon Islands	15
Tonga	
Tokelau	0
Tuvalu	0
Vanuatu	9
Wallis and Futuna	

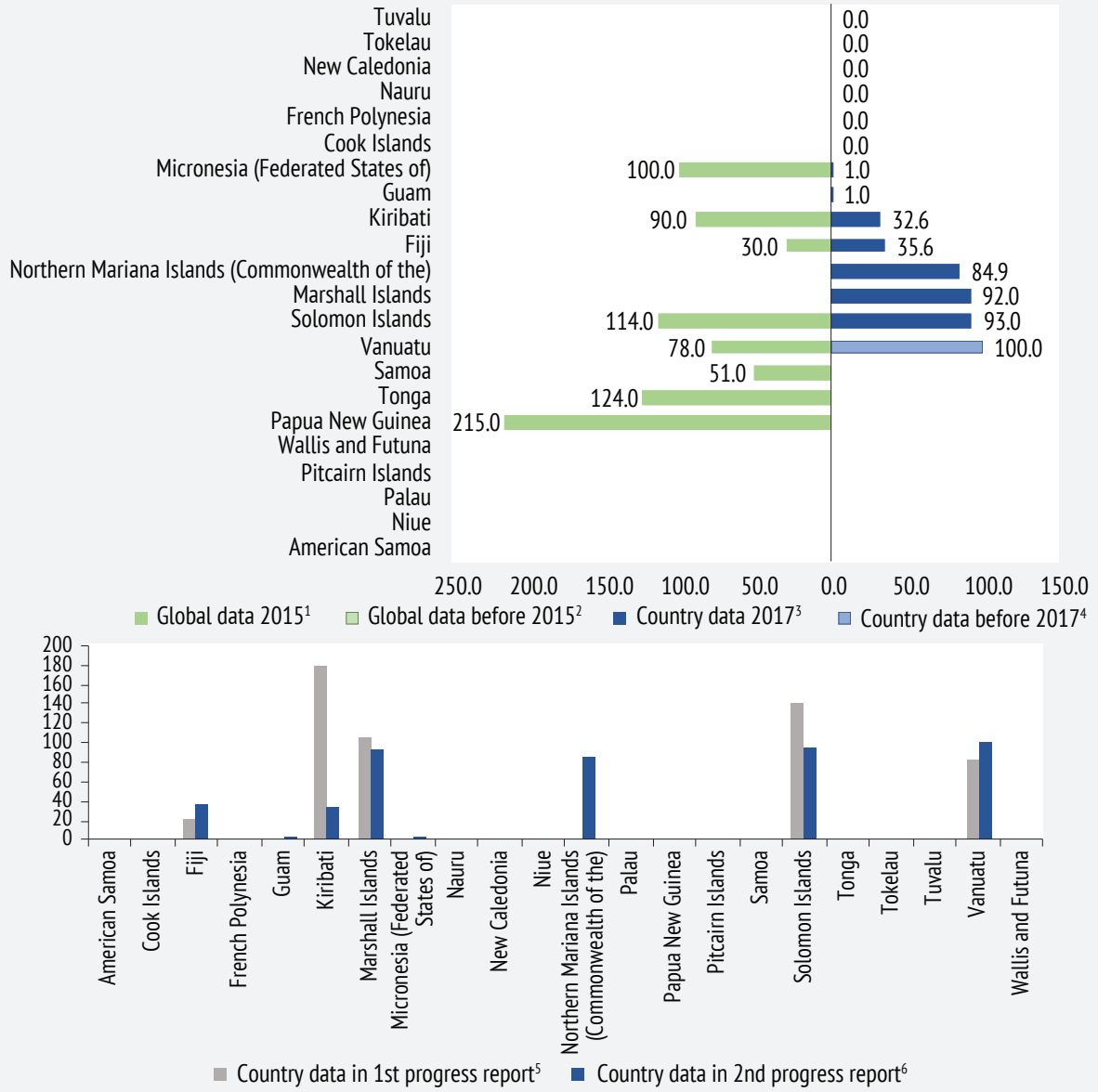
Notes: 1. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Trends in maternal mortality: 1990–2015, Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2015.

Complications during pregnancy, childbirth and postpartum are a leading cause of death and disability among women of reproductive age in developing countries. Maternal death represents the risk associated with each pregnancy. It reflects the capacity of health systems to provide effective health care in preventing and addressing the complications occurring during pregnancy and childbirth.[1] However, due to small population size, the absolute numbers of death in PICs are shown here.

MATERNAL MORTALITY RATIO

HIMF Indicator 2.16b: Number of maternal deaths related to childbearing per 100 000 live births

Related SDG indicator(s): 3.1.1



Notes: 1. Global data 2015 refer to the data estimated or modelled in 2015. 2. Global data before 2015 refer to the data estimated or modelled before 2015. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.imr.MORT_MATERNALNUM?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Trends in maternal mortality: 1990–2015, Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2015.

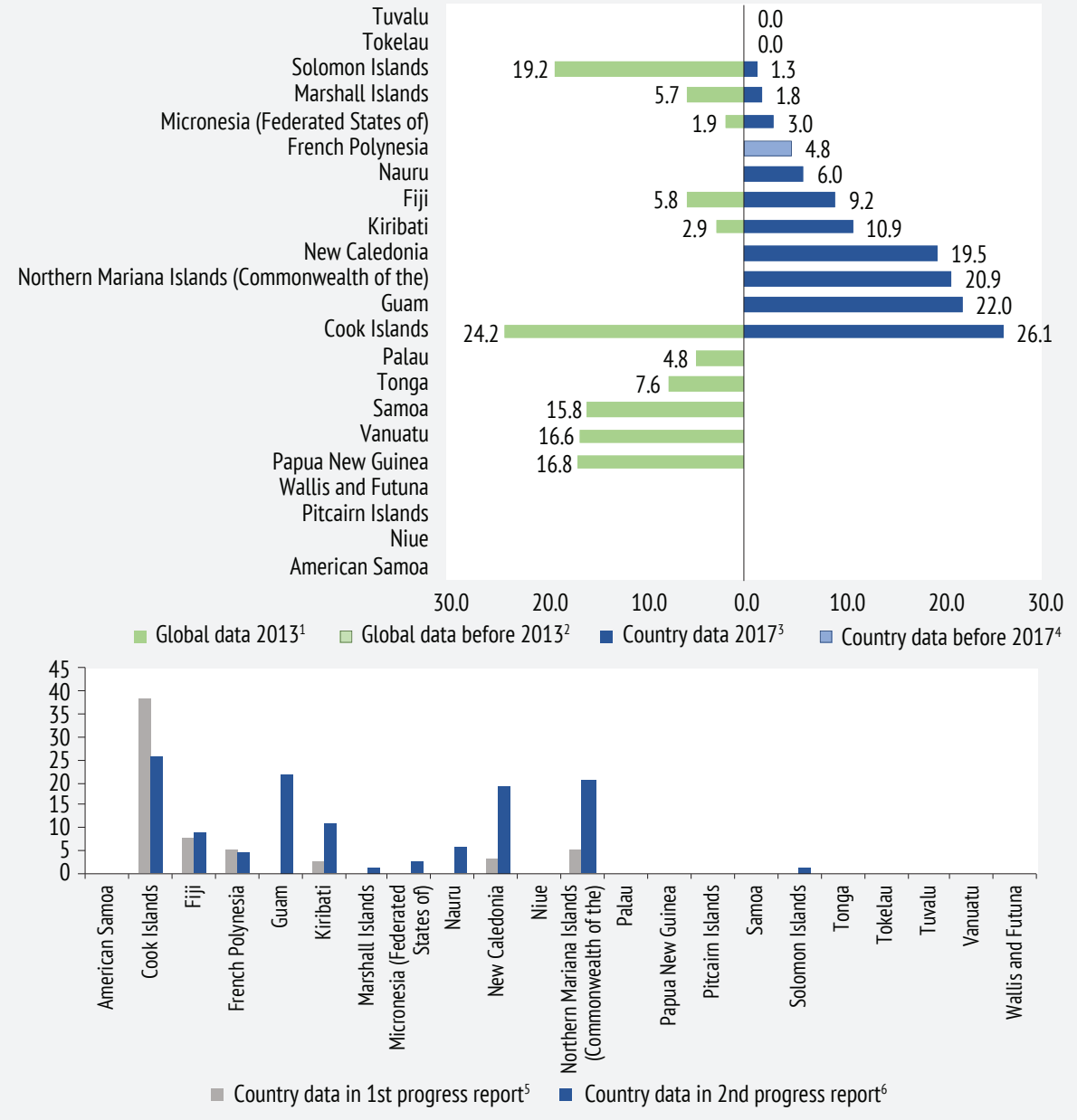
Federated States of Micronesia and Guam data need to be further confirmed.

Complications during pregnancy, childbirth and postpartum are a leading cause of death and disability among women of reproductive age in developing countries. The maternal mortality ratio represents the risk associated with each pregnancy. It reflects the capacity of the health systems to provide effective health care in preventing and addressing the complications occurring during pregnancy and childbirth.[7] The estimated ratio in the WHO Western Pacific Region is 41 per 100 000 live births in 2015. Six PICs provided country data which were not available in the global estimate.

MORTALITY RATE FROM ROAD TRAFFIC INJURIES

HIMF Indicator 2.17: Estimated road traffic fatal injury deaths per 100 000 population

Related SDG indicator(s): 3.6.1



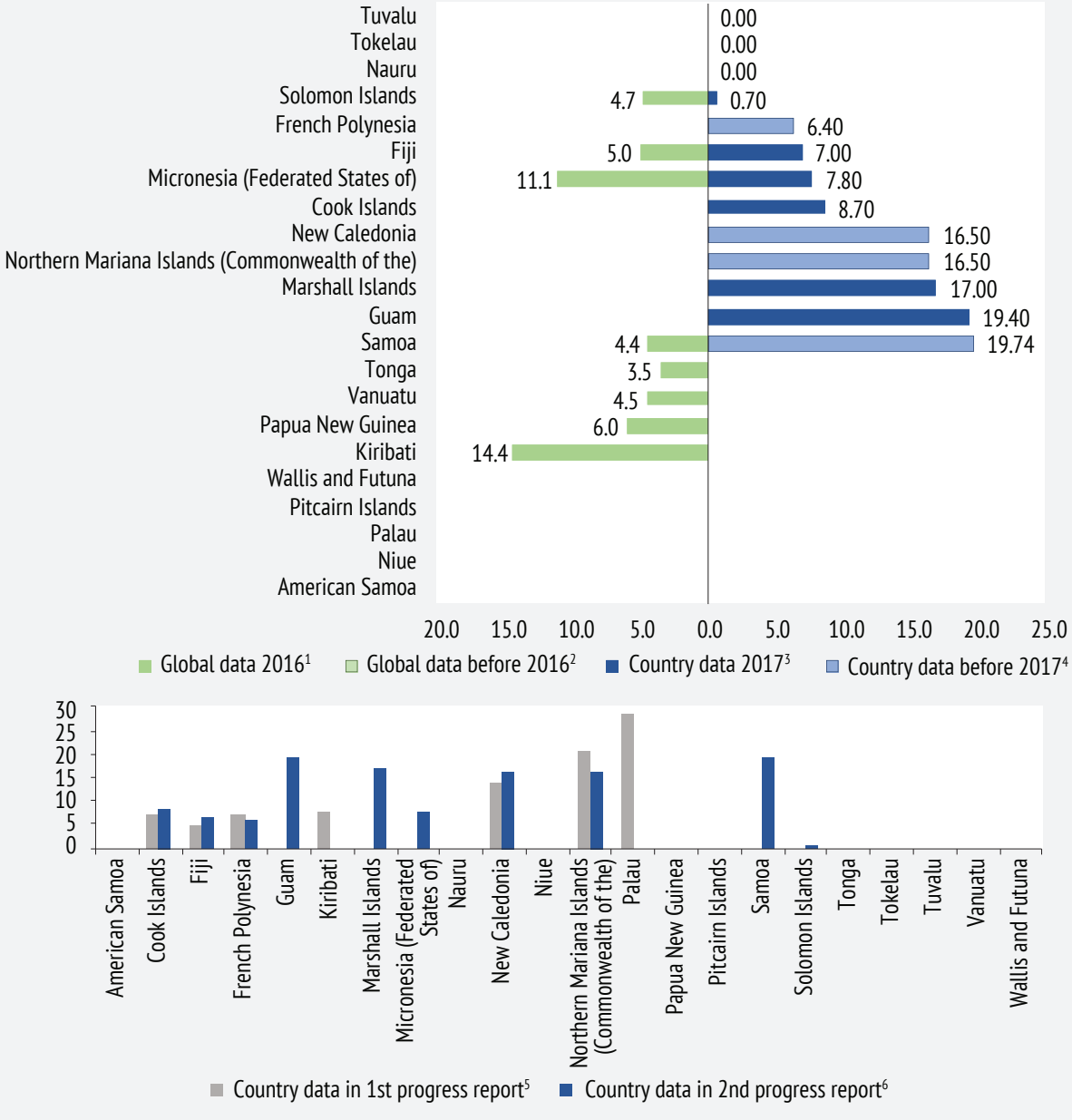
Notes: 1. Global data 2013 refer to the data estimated or modelled in 2013. 2. Global data before 2013 refer to the data estimated or modelled before 2013. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.main.A997?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected is 2014. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Provision of data for this indicator relies on the correct capture and reporting of traffic/road-related injury as cause of death, completeness of those records and the accuracy of collation of those records. The level of fatalities is commonly related to the level of urbanization, number of vehicles using roads and road safety issues including drink driving and speeding.

ADULT SUICIDE MORTALITY RATE

HIMF Indicator 2.18: Suicide rate per 100 000 population in a specified period

Related SDG indicator(s): 3.4.2



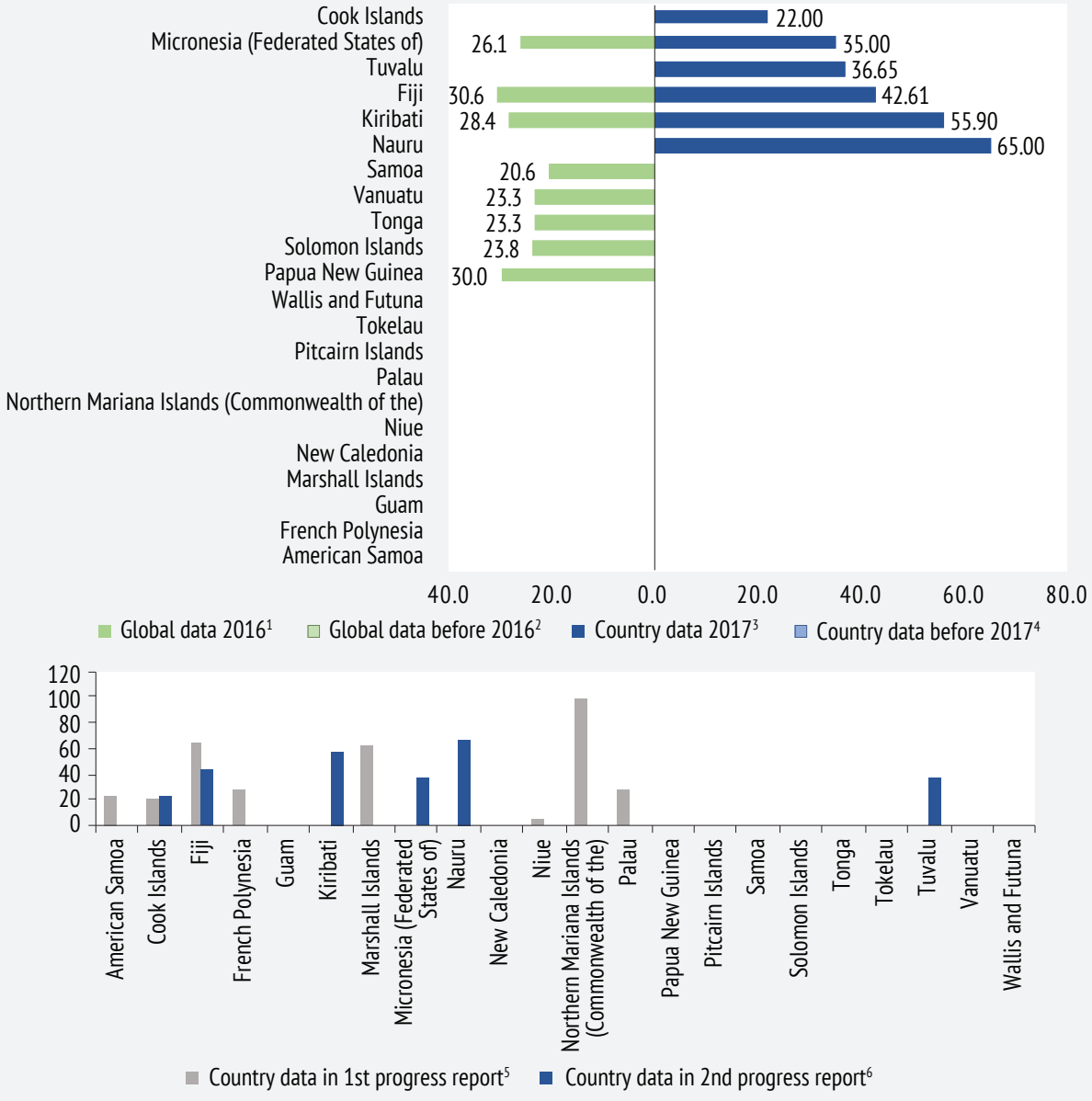
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.main.MHSUICIDEASDR?lang=en)
3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2014–2015.
5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Global data and country data are defined differently, with global data including the numbers of suicides among the whole population while the HIMF indicator only includes adults. A total of 13 PICs reported on this indicator. Marked differences can be seen among PICs. Its recognized that under-reporting of suicide as cause of death is not uncommon, as families often do not wish suicide to be recorded.

RISK OF PREMATURE DEATH FROM TARGET NCDS

HIMF Indicator 2.19: The percent of 30-year-old people who would die before their 70th birthday from cardiovascular disease, cancer, diabetes, or chronic respiratory disease, assuming that s/he would experience current mortality rates at every age and s/he would not die from any other cause of death

Related SDG indicator(s): 3.4.1



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.main.A862?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected beforeS2017. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reportedSby PICs in 2018.

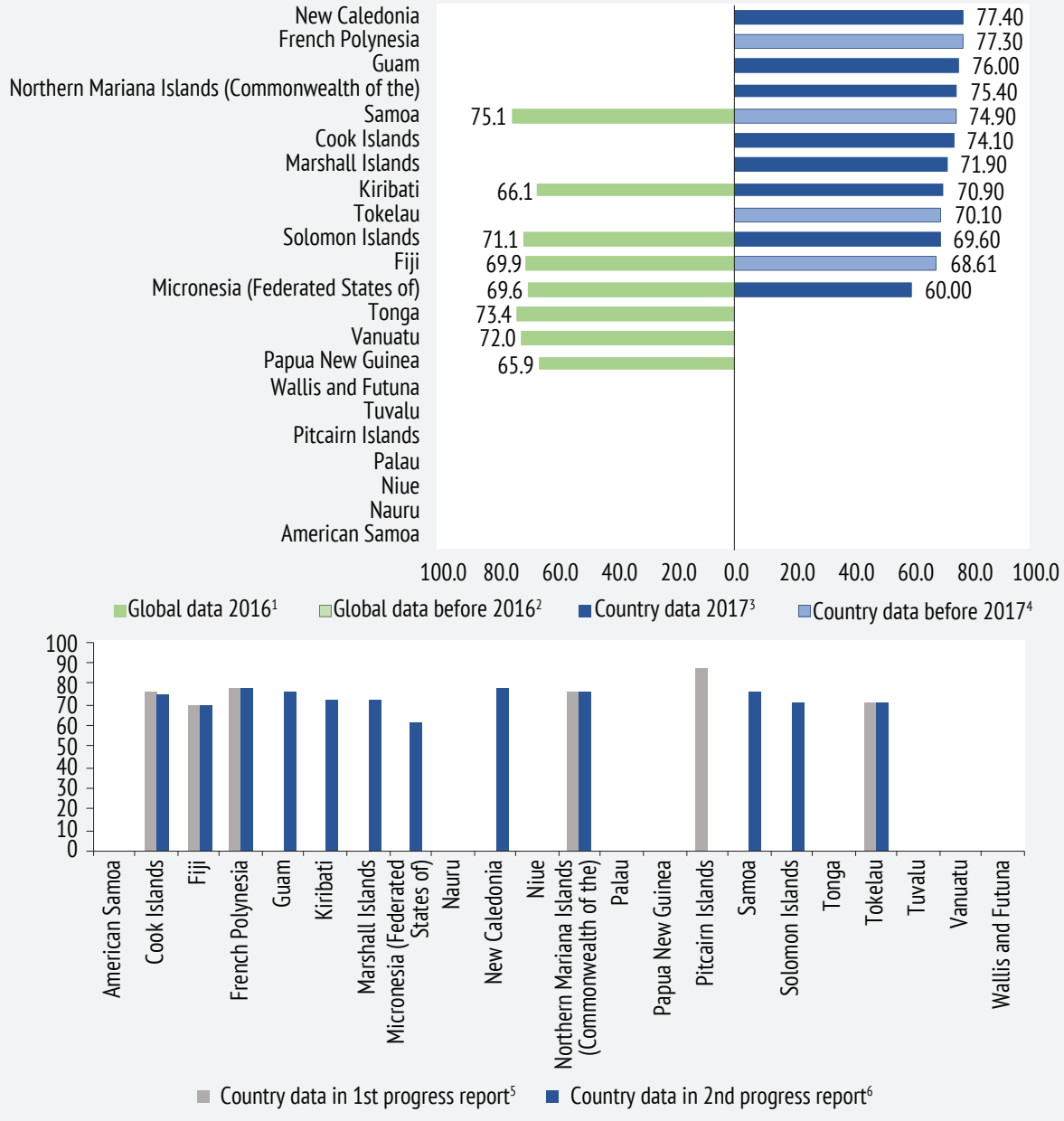
Commonwealth of the Northern Mariana Islands (159) and Marshall Islands (776) need to be further confirmed.

Premature mortality is defined globally as death before the age of 70 years. Deaths from NCDs in those less than 70 years are considered to be largely preventable through healthier lifestyles and effective NCD management. The risk of dying before the age of 70 years, therefore, is an indicator of how effective prevention and management efforts are, although there is a significant time lag from intervention and behaviour change to impact on mortality.

LIFE EXPECTANCY AT BIRTH

HIMF Indicator 2.20: The average number of years that a newborn could expect to live if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory or geographical area.

Related SDG indicatSr(s): N/A



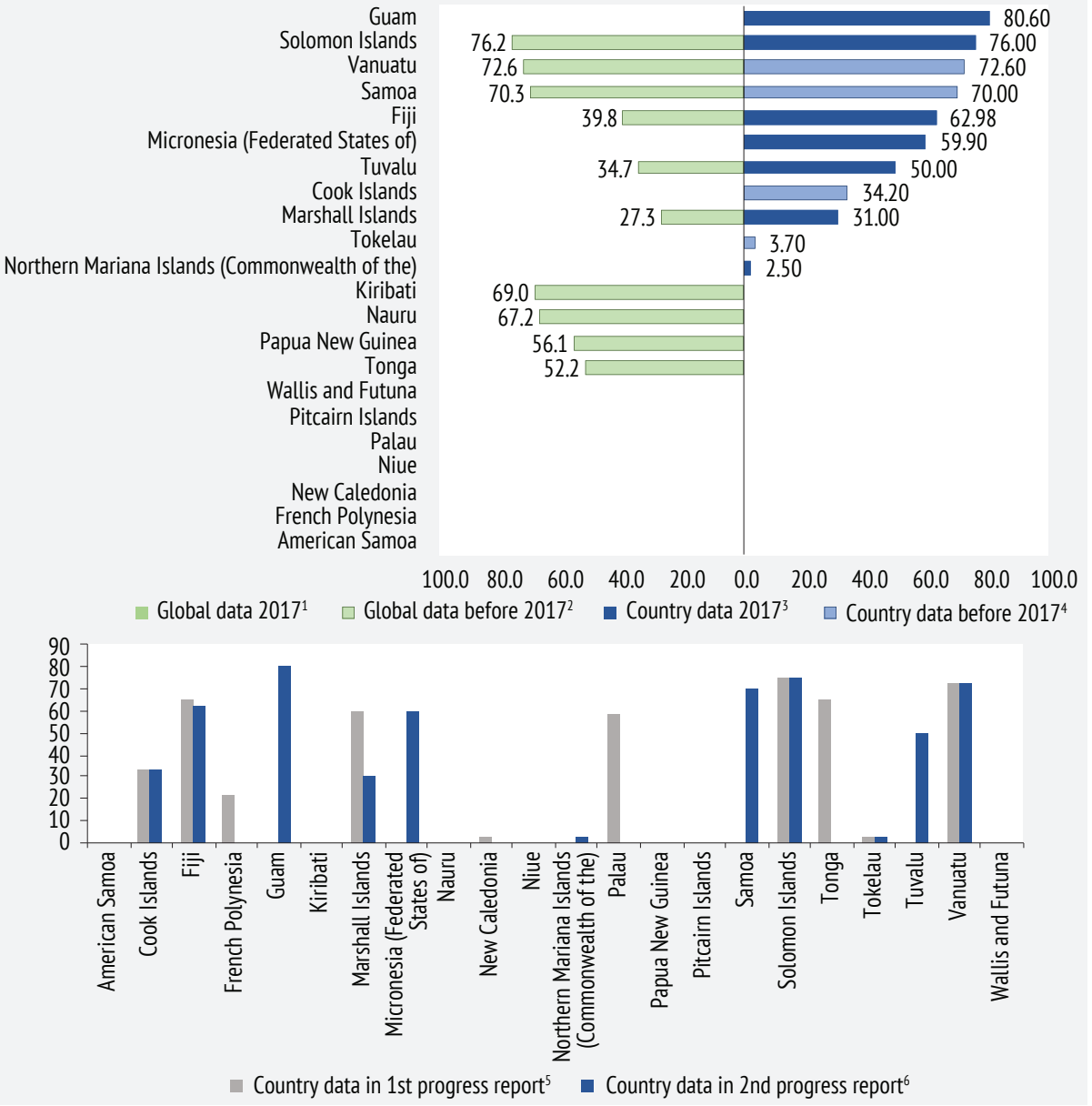
Notes: 1. Global data 2016 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO. https://www.who.int/gho/mortality_burden_disease/life_tables/hale/en/) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2015–2016. 5. Country data in first progress report refer to data reporteS by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Life expectancy at birth reflects the overall mortality level of a population. It summarizes the mortality pattern that prevails across all age groups in a given year – children and adolescents, adults and the elderly. Of the 12 reporting PICs, 75% showed the average a newborn infant could expect to live is over 70 years. Compared with the first progress report (10 countries reported), the number of reporting PICs increased to 12.

EXCLUSIVE BREASTFEEDING RATE

HIMF Indicator 3.1 : Infants aged 0–5 months who are fed exclusively with breast milk

Related SDG indicatSr(s): N/A



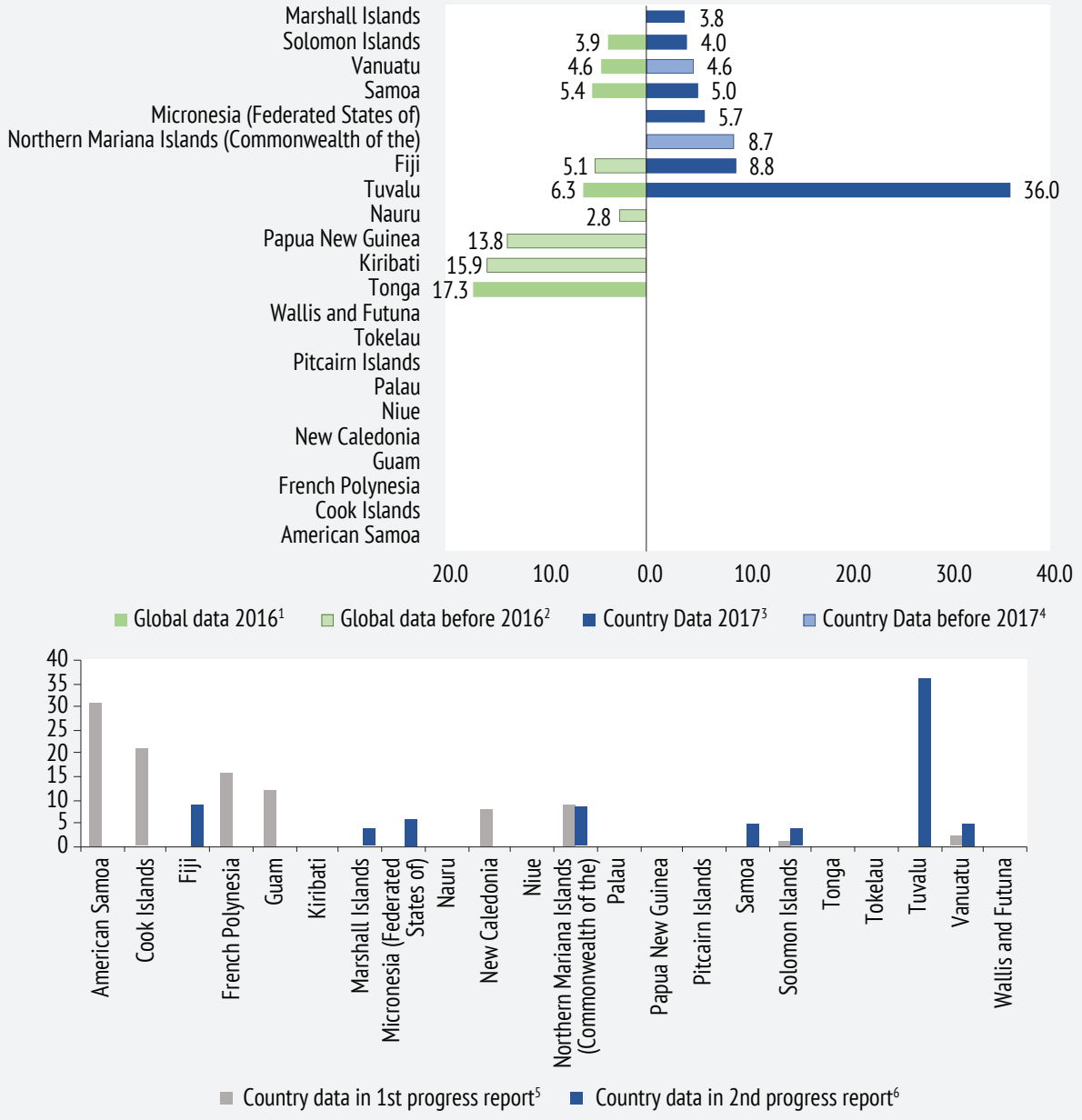
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled from 2000 to 2015. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.imr.WHOSIS_000006?lang=en). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. World Health Organization. Long-term effects of breastfeeding: a systematic review. 2013.

It is recommended that babies be exclusively breastfed for the first six months of life and that breastfeeding then continues for at least two years, supplemented with other foods. Exclusive breastfeeding is the single most effective intervention to improve the survival of children. Improving infant and young child feeding practices is critical to improved nutrition, health and development of children.[7] This indicator shows substantial variation between PICs, with a number of PICs having a worrisome less than 50% rate of exclusive breastfeeding. The extremely low rates reported in the Commonwealth of the Northern Mariana Islands and Tokelau, in particular, show substantial issues with infant feeding practices.

CHILDREN WHO ARE OVERWEIGHT

HIMF Indicator 3.2: Percentage of overweight (weight-for-height above +2 standard deviStions of the WHO Child Growth Standards median)Samong children aged 0–5 years

Related SDG indicator(s): 2.2.2



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled from 1985–2007. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.main.CHILDOVERWEIGHT?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2014. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

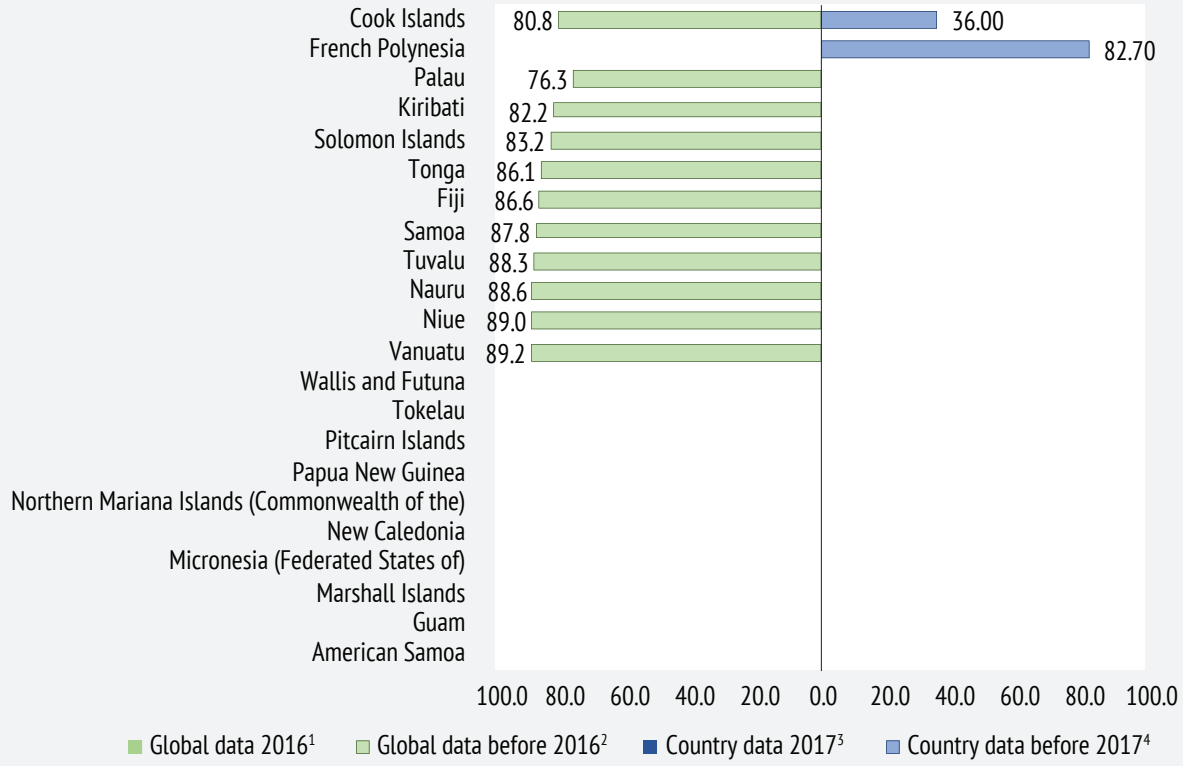
The data for Tuvalu warrants further confirmation.

Child growth is the most widely used indicator of nutritional status in a community and is internationally recognized as an important public health indicator for monitoring health in populations. Data for this indicator are usually derived from Demographic Health Surveys or clinic record data (if complete). Young children who are overweight are more likely to become overweight adolescents and adults, and this carries substantial health risk.

INADEQUATE PHYSICAL ACTIVITY IN ADOLESCENTS

HIMF Indicator 3.3: Adolescents (aged 13–15 years) participating in less than 60 minutes of moderate to vigorous intensity physical activity daily

Related SDG indicator(s): N/A



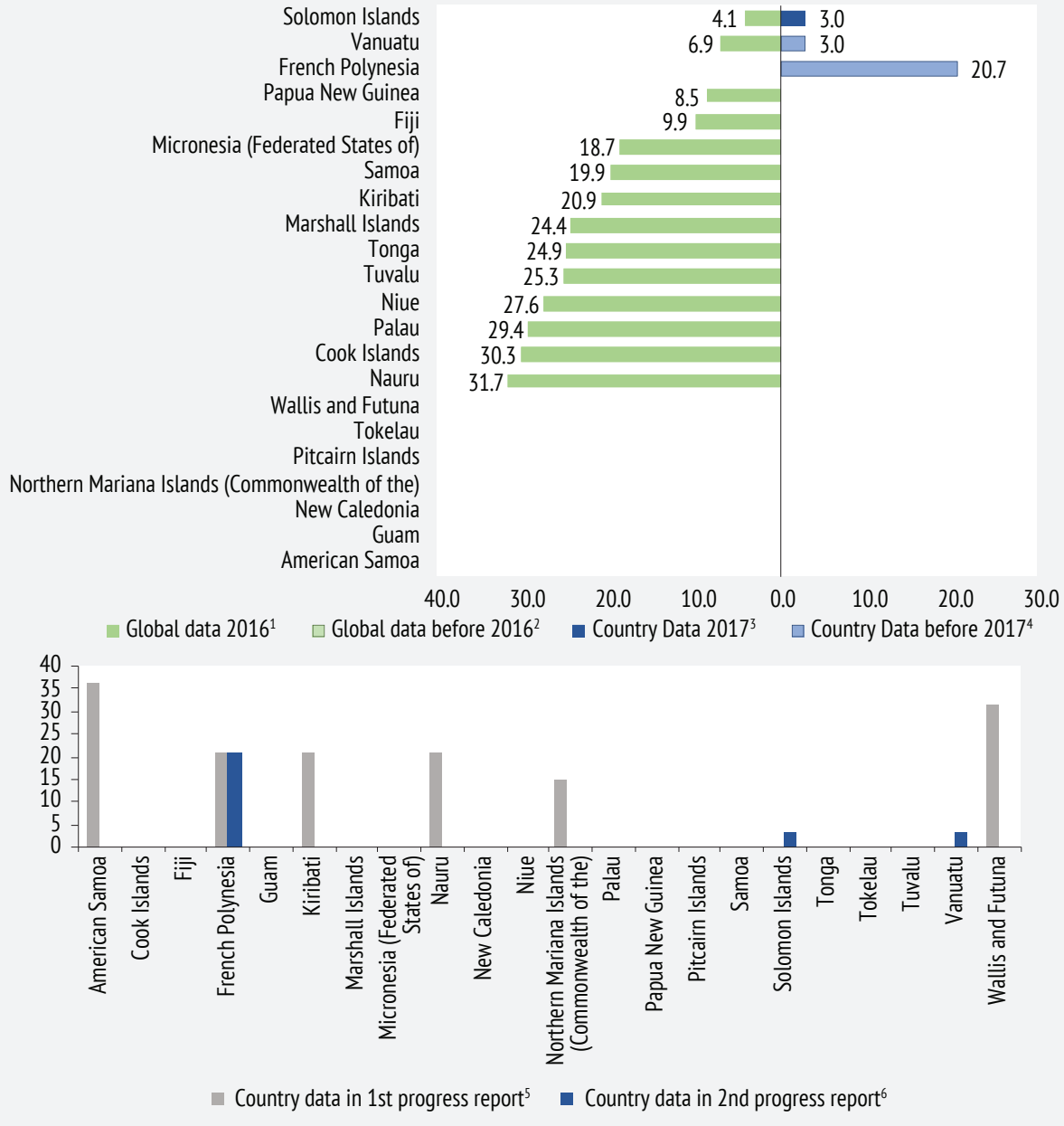
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2014 refer to the data estimated or modelled before 2017. Global data resource: WHO GHO (http://apps.who.int/gho/data/view.main.2463ADO) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.
7. World Health Organization. Global Recommendations on Physical Activity for Health. 2010. Geneva. (https://www.who.int/dietphysicalactivity/publications/9789241599979/en/).

Physical inactivity is now recognized as the fourth leading risk factor for global mortality.[7] The global data are based on self-reported questionnaires and main data resources are from the Global School-based Student Health Survey, the Health Behavior in School aged Children, and other national surveys. The estimated age group is 11–17 years old, which is different from the HIMF. Only two PICs reported data for this indicator.

OBESITY IN ADOLESCENTS

HIMF Indicator 3.4 : Percentage of obese (body mass index (BMI)-by-age more than +3 standard deviations from the Sean of the WHO Child Growth Standards) among adoleScents aged 13–15 years

Related SDG indicator(s): 2.2.2



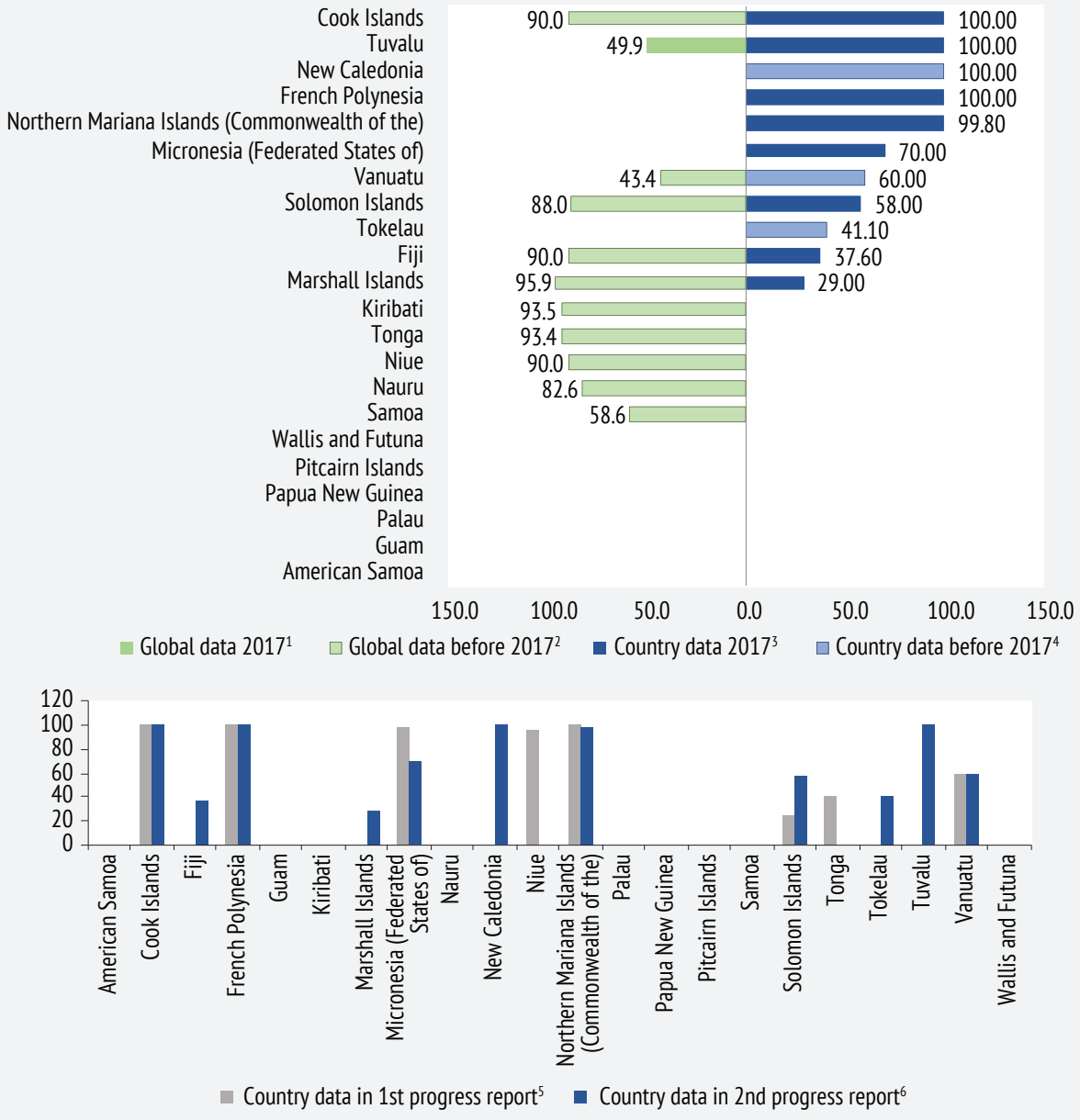
Notes: 1. Global data 2016 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.imr.NCD_BMI_PLUS2C?lang=en)
3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016.
5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

The target population of global data (10–19 years of age) and country data (13–15 years) are different. The age of targeted adolescent of the former one is 10–19 while the latter is 13–15. Only three PICs reported data for this indicator. According to global data, over 71% of the PICs with global data available showed an obesity rate of around or over 20%.

BIRTH REGISTRATION COVERAGE

HIMF Indicator 3.5: Estimated level of coverage of birth registration

Related SDG indicator(s): 17.19.2(b) and 16.9.1



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled in from 2007–2015. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.imr.WHS9_91?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

This indicator dictates the coverage of birth registration. A total of ten countries reported this indicator, and five countries had an indicator below 100%. The regional average value of this indicator is 73.5%. Given that birth registration is a basic step to cover all children for access to all kinds of public services, SDG indicator 17.19.2(b) aims to achieve 100% birth registration by 2030.

EVIDENCE OF HEALTHY FOOD POLICIES IN SCHOOLS

HIMF Indicator 3.6: Evidence of nationally endorsed policies relating to the provision and promotion of healthy food choices in schools

Related SDG indicator(s): N/A

Score	Description	2018 assessment
–	No government (Ministry of Health or Education) policies or guidelines	Nauru, Tokelau, Tuvalu
–	The Ministry of Health and/or Education are developing policies or guidelines	
0	There is a mandatory government policy or guideline that covers 1 area Sisted	New Caledonia, Solomon Islands
1	There is a mandatory government policy or guideline that covers 2 areas listed	Cook Islands
2	There is a mandatory government policy or guideline that covers 3 areas listed	French Polynesia, Marshall Islands
3	There is a manSatory government policy or guidelineSthat covers 4 areas listed	Commonwealth of the Northern Mariana Islands, Vanuatu

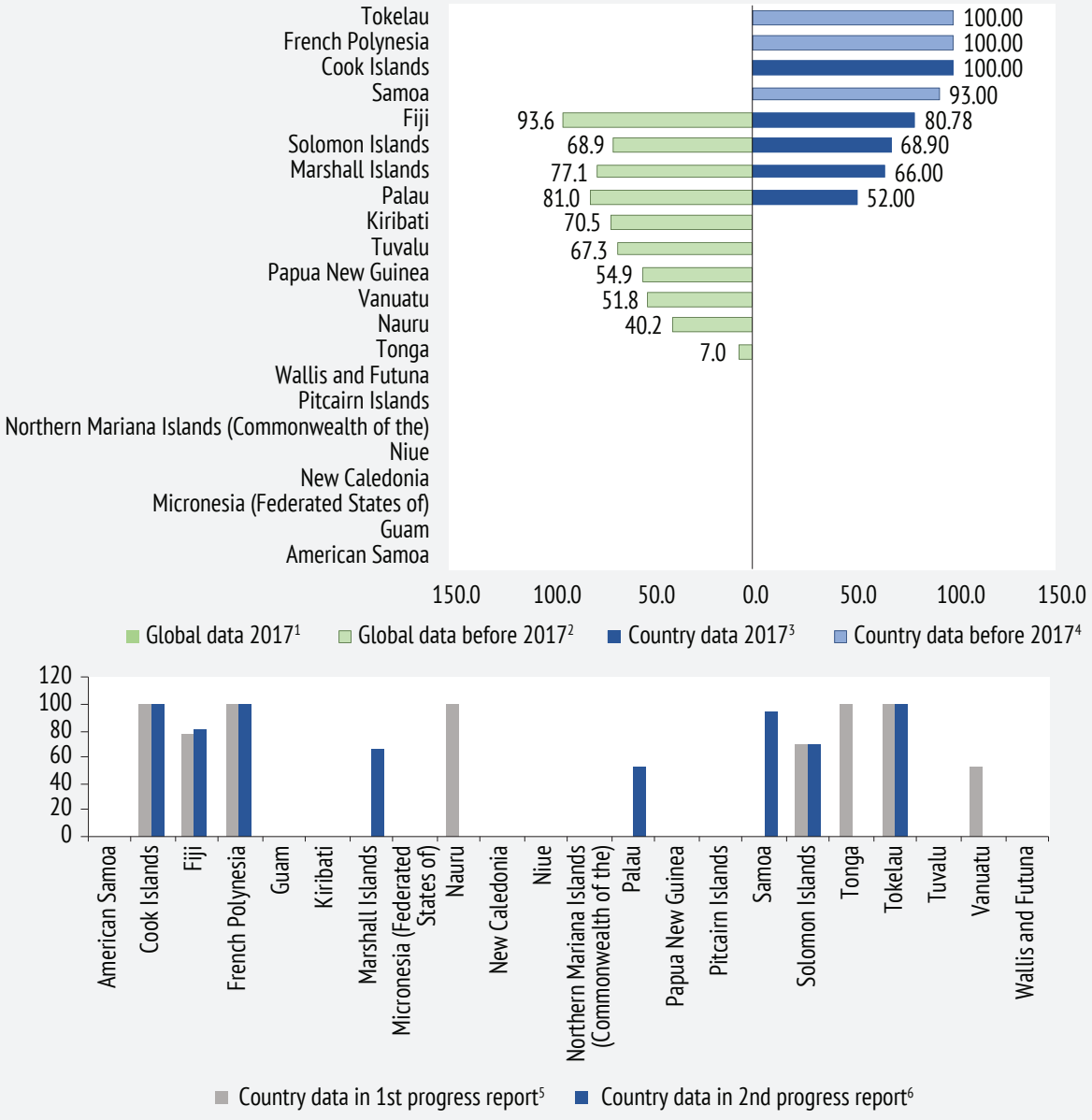
Notes: 1. Tolley H, Snowdon W, Wate J, et al. Monitoring and accountability for the Pacific response to the non-communicable disease crisis. BMC public health, 2016, 16: 958.

The indicator is from the Pacific MANA Framework. Progress towards implementation of a policy or action is scored by a "traffic light" colour scheme: red for no policy present; amber for policy under development; and green for policy in place.[1] Five PICs among the 10 reporting PICs have a mandatory government policy or guideline that covers at least one area listed in the last row of the table above. However, most of the policies reported did not cover all aspects of food provision and supply in schools. These could be further strengthened. Enforcement of any policies is also critical to impact. This indicator only assesses presence of indicator, not enforcement.

ANTENATAL CARE COVERAGE

HIMF Indicator 3.7: Women aged 15–49 years with a live birth in a given time period who received antenatal care, four times or more

Related SDG indicator(s): 3.8.1



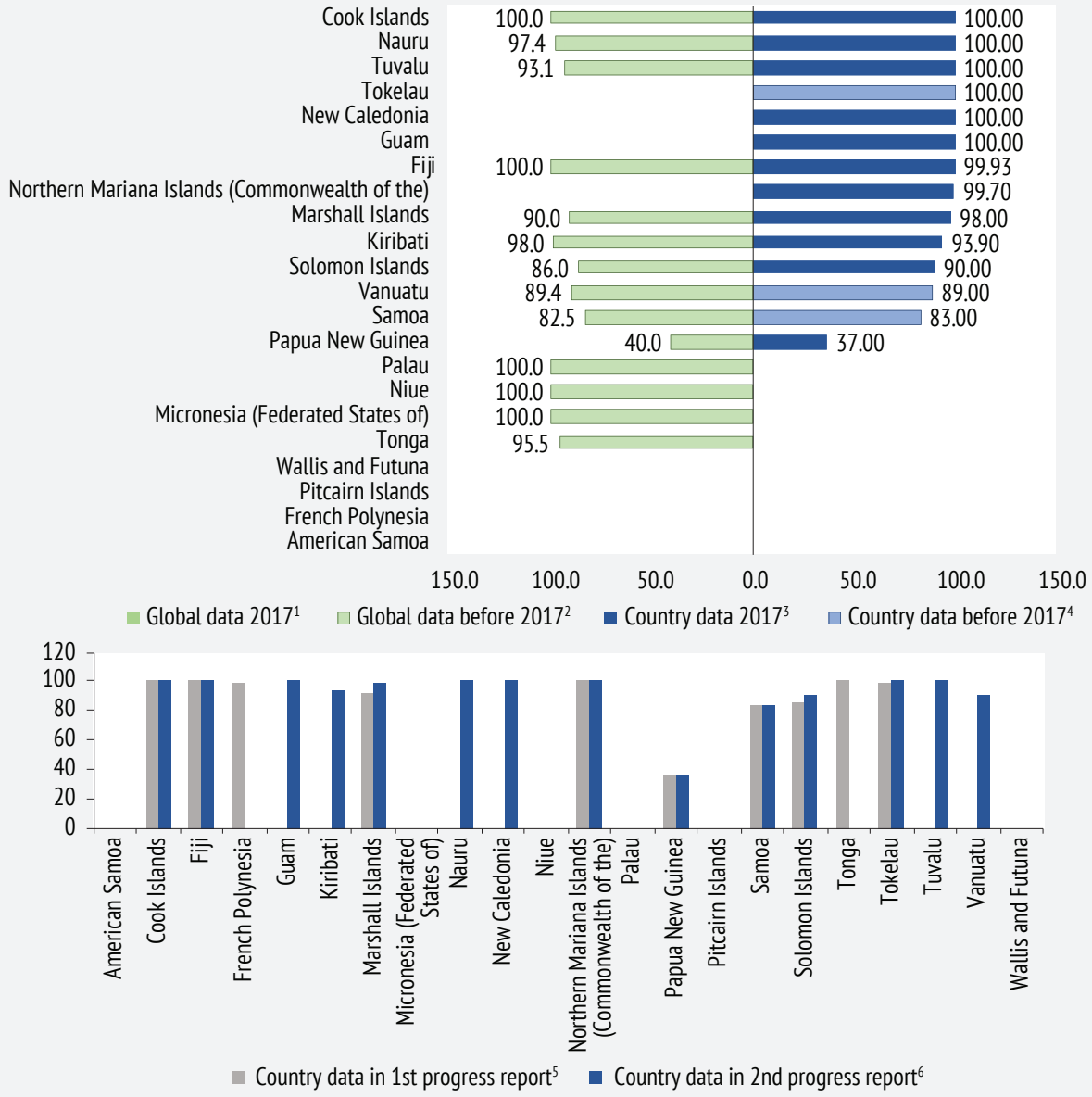
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017 is from 2002–2013. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.imr.WHS4_154?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2014–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Antenatal care coverage is an indicator of access and use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that are vital to their health and well-being and that of their infants. Receiving antenatal care at least four times increases the likelihood of receiving effective maternal health interventions during the antenatal period. This is one of the indicators in the *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) Monitoring Framework.*

BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL

HIMF Indicator 3.8: Percentage of live births attended by skilled health personnel during a specified time period (usually one year)

Related SDG indicator(s): 3.1.2



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2007–2015. Global data resource: WHO GHO. http://apps.who.int/gho/data/node.main.SKILLEDBIRTHATTENDANTS?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

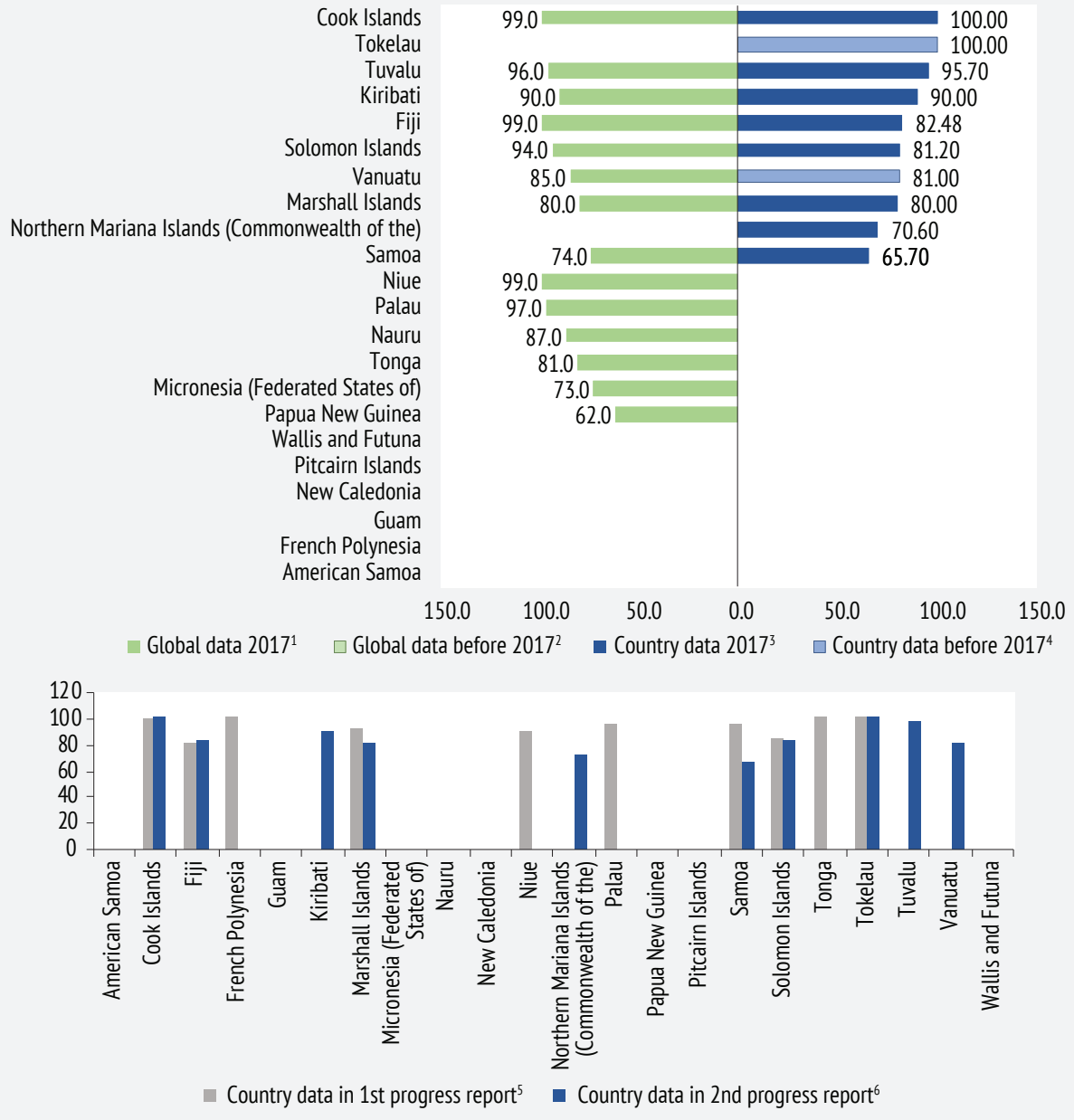
Federated States of Micronesia data (1509) need to be further confirmed.

All women should have access to skilled care during pregnancy and childbirth to ensure prevention, detection and management of complications. This indicator measures the percentage of live births attended by skilled health personnel (physicians, nurses or midwives). The country data show that eight out of 14 PICs included had percentages higher than 99%. However, the figure was less than 90% in three countries, meaning a significant portion of women do not have access to skilled health personnel for giving birth or antenatal care.

IMMUNIZATION COVERAGE FOR DTP3

HIMF Indicator 3.9: Number of children one year of age who have received three doses of vaccine against diphtheria, pertussis, tetanus (DTP3) in a given year

Related SDG indicator(s): 3.8.1



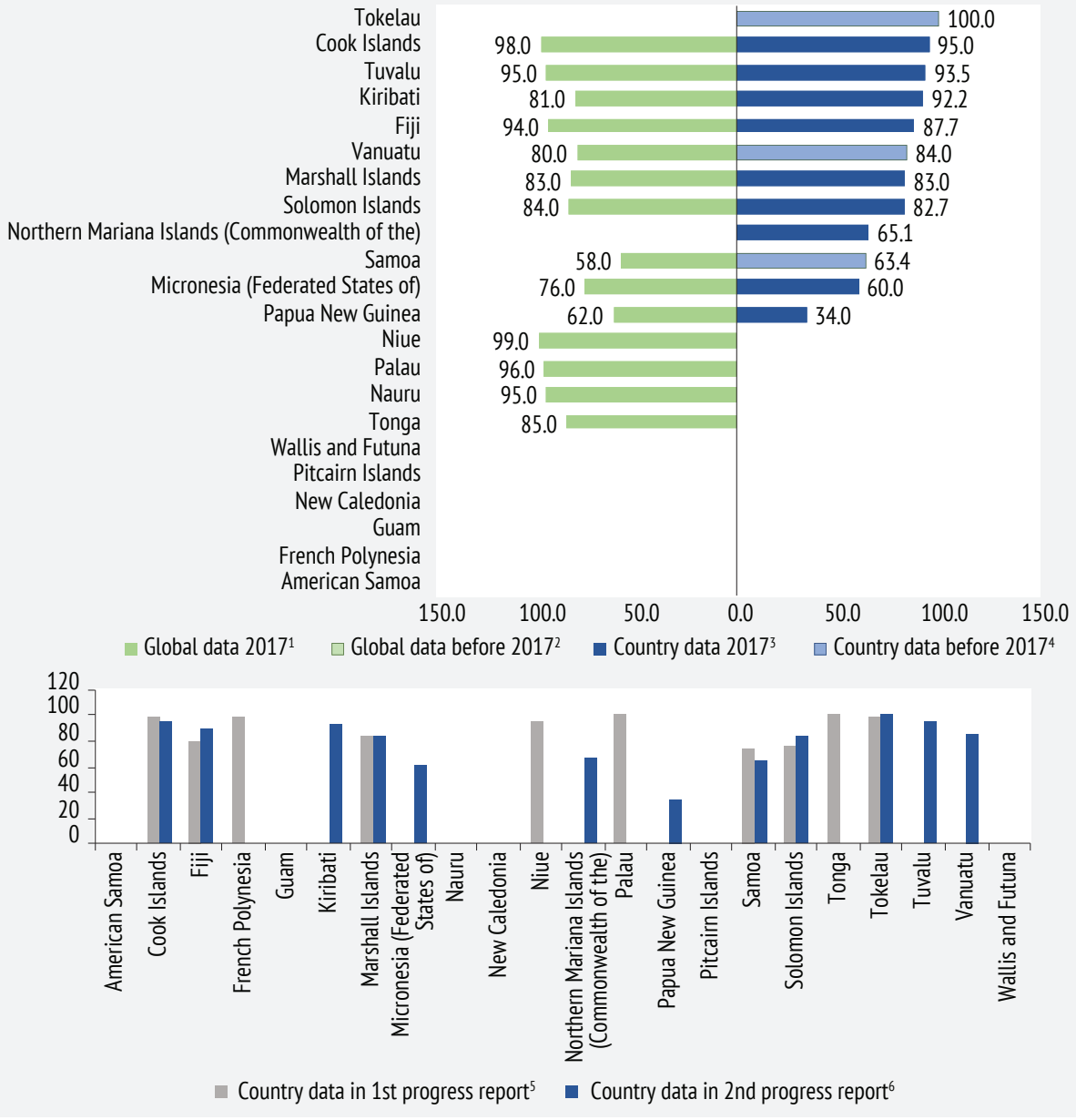
Notes: 1. Global data 2016 refer to the data estimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO. (http://apps.who.int/gho/data/view.main.81200?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2014–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

A key component of the *Global Vaccine Action Plan* is strengthening routine immunization services to achieve 90% national routine immunization coverage for programme vaccines including diphtheria and tetanus toxoids and pertussis containing vaccine (DTP). Completing three doses of DTP vaccine in infants can effectively reduce the risk of infection of the three diseases. Only four of the 10 PICs reporting reached 90% coverage.

IMMUNIZATION COVERAGE FOR MEASLES

HIMF Indicator 3.10: Percentage of children at one year of age who have received at least one doSe of measles-containing vaccine in a given year.

Related SDG indicator(s): N/A



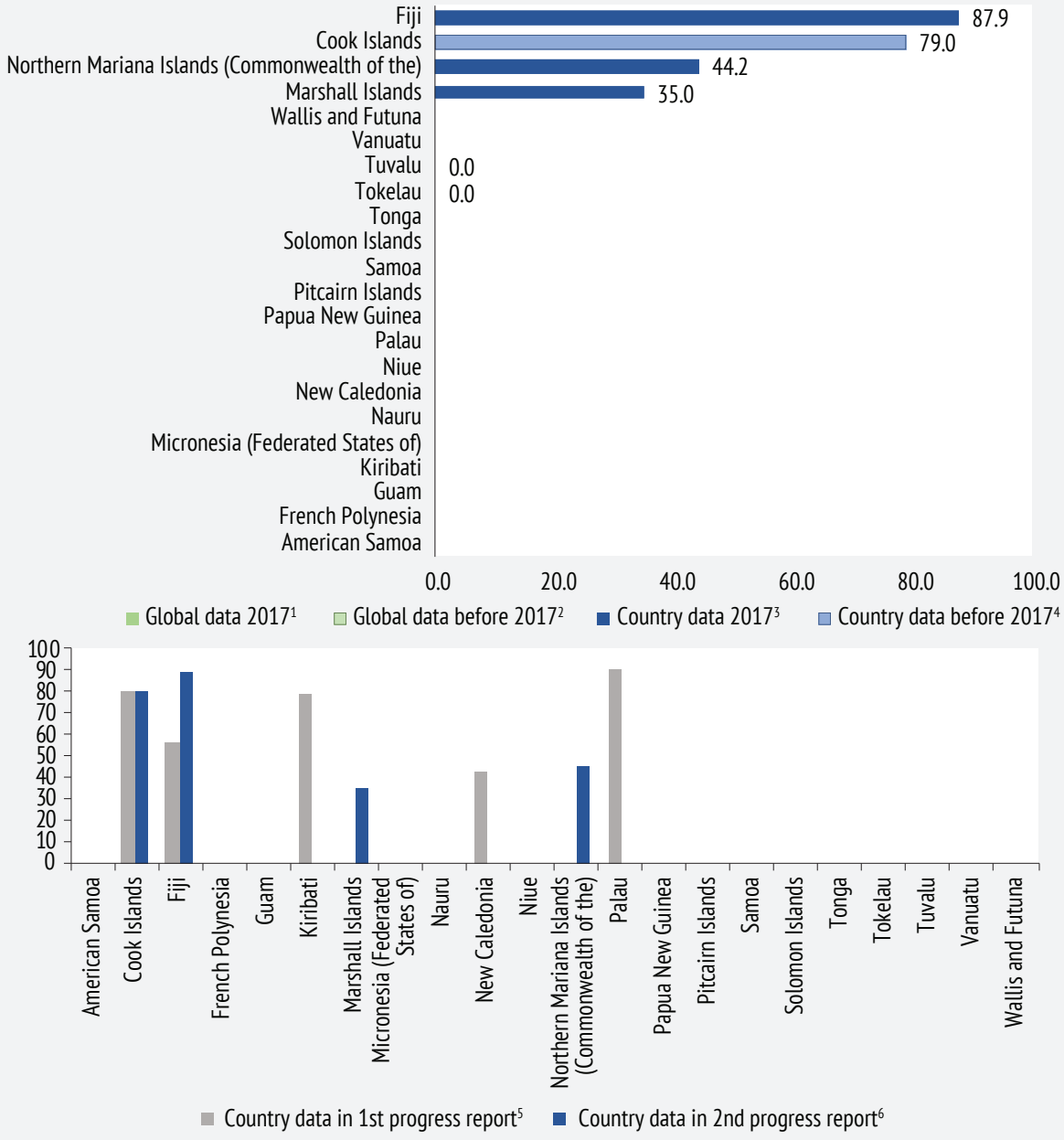
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017. Global data resource: WHO GHO. (http://apps.who.int/gho/data/view.main.81100?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2014–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.
7. World Health Organization. Measles vaccines: WHO position paper, 2017.

Population immunity must be >93–95% in all districts to prevent measles epidemics. Reaching and maintaining high immunization coverage remains the cornerstone of effective measles control. The coverage targets depend on national goals for disease control. In countries aiming at reducing mortality from measles, immunization coverage should be ≥90% at the national level. Countries aiming at measles elimination should achieve ≥95% coverage with both doses in every district.[7] Only one third of the 12 PICs reporting data reached to 90% coverage of one dose of measles-containing vaccine.

HUMAN PAPILLOMAVIRUS (HPV) VACCINE COVERAGE AMONG ADOLESCENTS

HIMF Indicator 3.11: Female adolescents under 15 Sears of age who have had 2 doses of HPV vaccine

Related SDG indicator(s): N/A



Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected IN 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Ten PICs had introduced HPV in their routine immunization schedule until 2017. Each country has a different approach targeting different sexes and age groups. A few PICs, including Solomon Islands and Tonga, have conducted pilots or are planning to introduce routine immunization. Six PICs including Cook Islands, Fiji, the Marshall Islands, the Commonwealth of the Northern Mariana Islands, Tokelau and Tuvalu reported data for HPV coverage. The reported coverage varied from 0% to nearly 90%.

HIV PREVALENCE AMONG PREGNANT WOMEN

HIMF Indicator 3.12: Pregnant women aged 15–24 years who are tested for HIV during an antenatal care (ANC) visit and have positive test results

Related SDG indicator(s): N/A

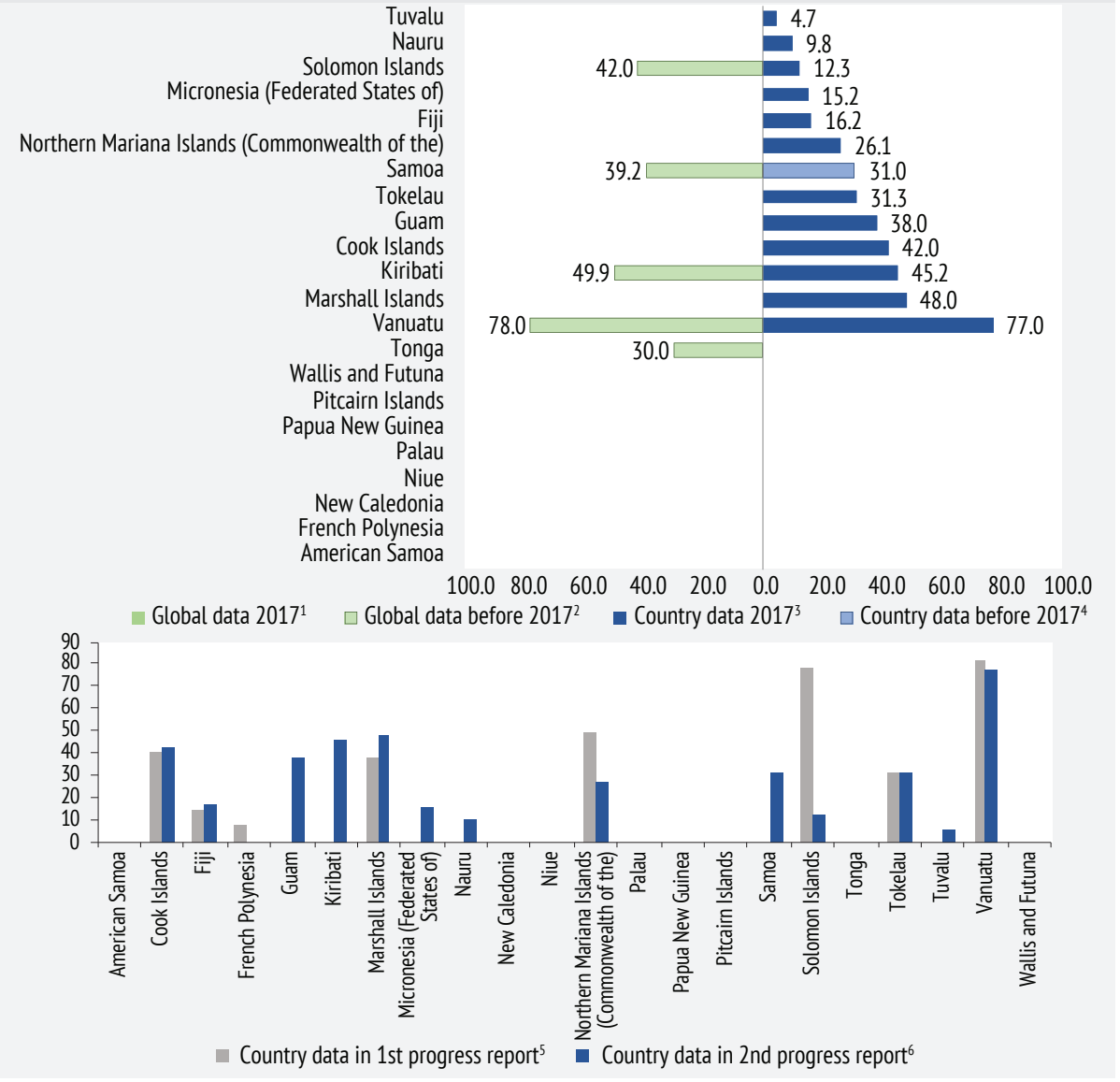
American Samoa	
Cook IslanSs	0
Fiji	
French Polynesia	0
Guam	
Kiribati	
Marshall Islands	0
Micronesia (Federated States of)	
Nauru	
New Caledonia	
Niue	
Northern Mariana Islands (Commonwealth of the)	0
Palau	
Papua New Suinea	
Pitcairn Islands	
Samoa	0
Solomon Islands	
Tonga	
Tokelau	0
Tuvalu	0
Vanuatu	0
Wallis and Futuna	

No global data are available. Eight PICs reported this indicator as 0.

ADOLESCENT BIRTH RATE

HIMF Indicator 3.13 : Annual number of births to women aged 15–19 years per 1000 females in that age group

Related SDG indicator(s): 3.7.2



Notes: 1. Global data 2017 refer to the data eStimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled in 2007–2011. Global data resource: WHO GHO. (http://apps.who.int/gho/data/node.sdg.3-7-data?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected In 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

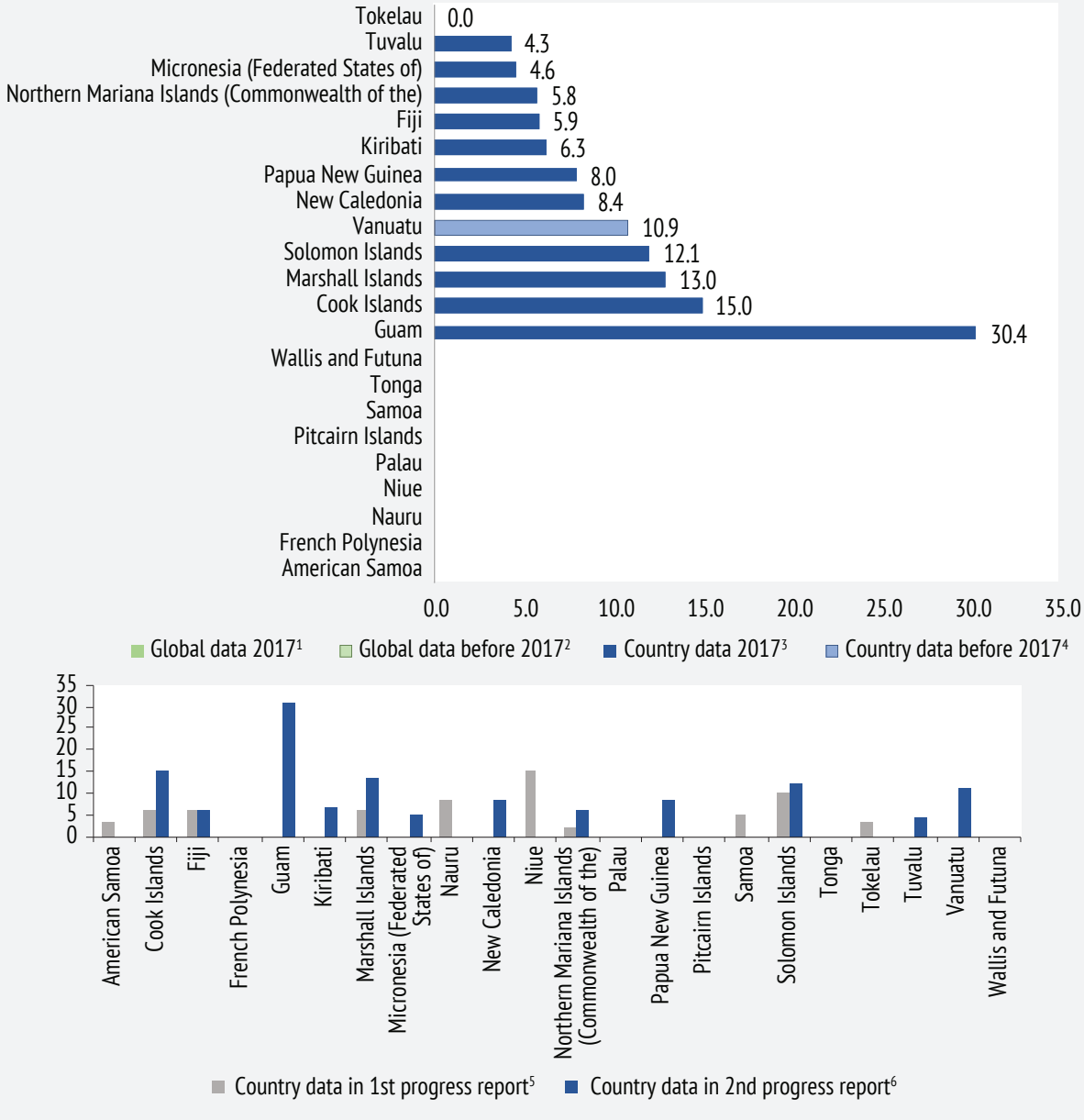
7. Gibbs CM, Wendt A, Peters S, et al. The impact of early age at first childbirth on maternal and infant health. Paediatr Perinat Epidemiol. 2012, 26: 259–284.

Women who become pregnant at early age in their reproductive lives are subject to higher risks of complications or even death during pregnancy and birth.[2,7] Their children are also more vulnerable. Therefore, preventing births very early in a woman's life is an important measure to improve maternal health and reduce infant mortality.[7] Furthermore, women having children at an early age experience a curtailment of their opportunities for socioeconomic improvement, particularly because young mothers are unlikely to keep on studying and, if they need to work, may find it especially difficult to combine family and work responsibilities.[2] The adolescent birth rate also provides indirect evidence on access to pertinent health services since young people, and in particular unmarried adolescent women, often experience difficulties in access to sexual and reproductive health services. Over 80% of the 13 PICs reported data showing the adolescent birth rate is around or over 10 per 1000 women.

LOW BIRTHWEIGHT AMONG NEWBORNS

HIMF Indicator 3.14 : Number of live-born infants with weight less than 2500 grams at birth

Related SDG indicator(s): N/A



Notes: 1. Global data 2017 refer to the data eStimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. United Nations Children's Fund and World Health Organization. Low birthweight: Country, regional and global estimated. New York: United Nations Children's Fund; 2004.

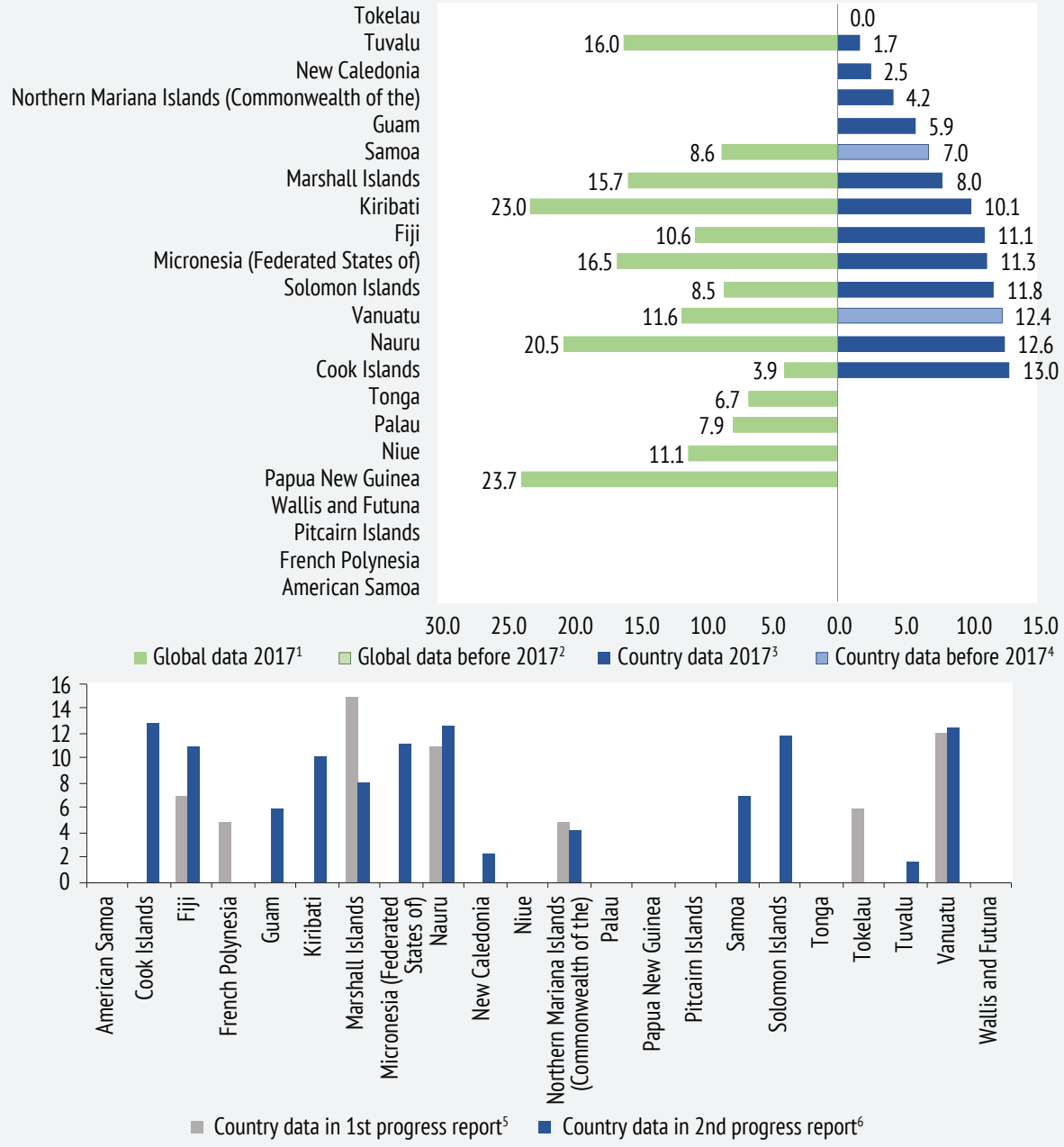
Guam data need to be further confirmed.

A baby's low weight at birth is either the result of preterm birth (before 37 weeks of gestation) or due to restricted fetal (intrauterine) growth. Low birthweight is closely associated with fetal and neonatal mortality and morbidity, inhibited growth and cognitive development, as well as chronic diseases later in life. Many factors affect the duration of gestation and fetal growth, and thus, the birthweight. They relate to the infant, the mother or the physical environment and play an important role in determining the birthweight and the future health of the infant.[7]

NEONATAL MORTALITY RATE

HIMF Indicator 3.15: Probability that a child born in a specific year or period will die in the first 28 completed days of life if subject to age-specific mortality rates of that period, expressed per 1000 live births.

Related SDG indicator(s): 3.2.2



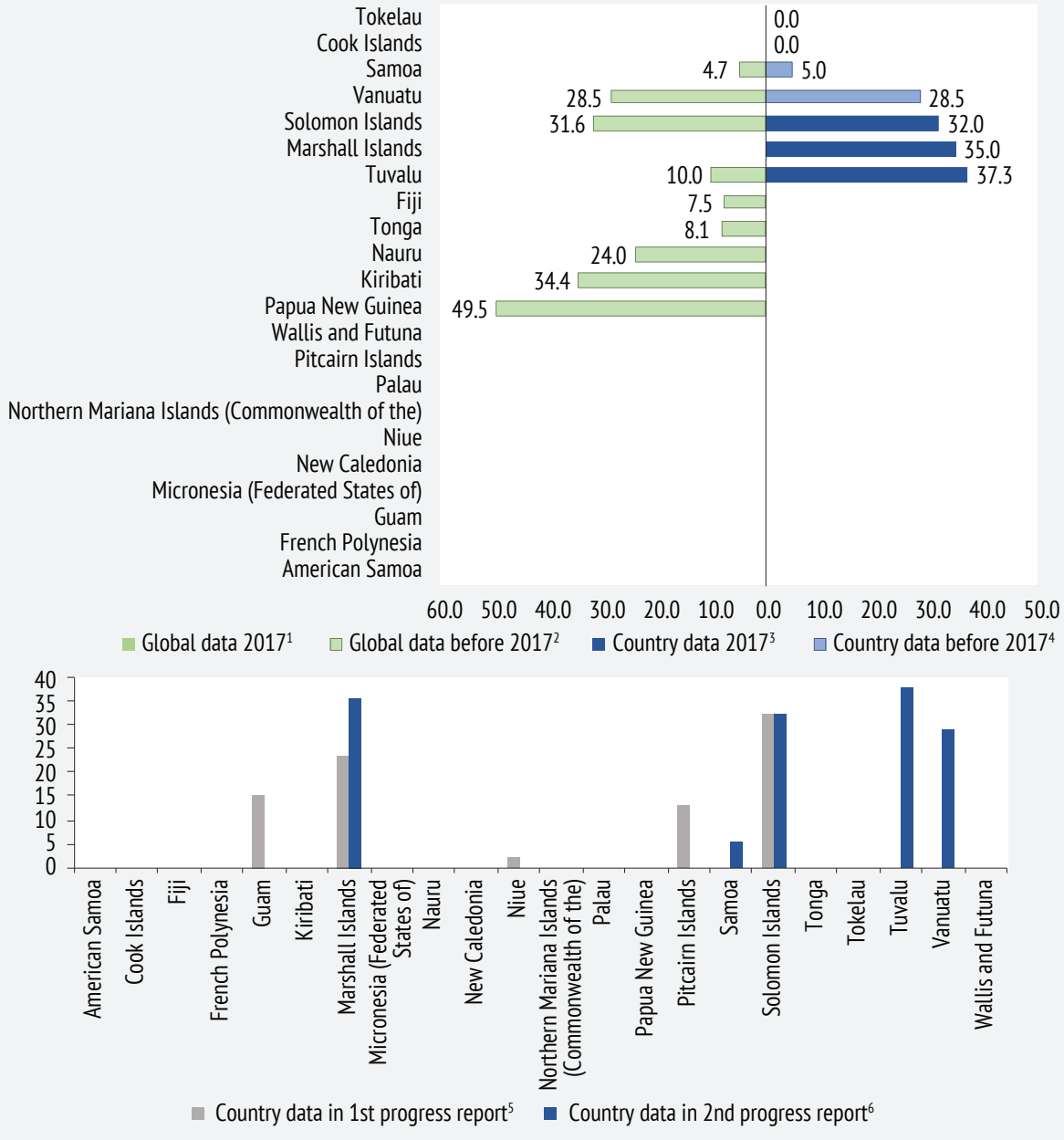
Notes: 1. Global data 2017 refer to the data estimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017. Global data resource: WHO GHO (apps.who.int/gho/data/node.main.525?lang=en). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

Mortality during the neonatal period accounts for a large proportion of child deaths, and is considered to be a useful indicator of maternal and newborn neonatal health and care. Generally, the proportion of neonatal deaths among child deaths under the age of 5 years is expected to increase as countries continue to witness a decline in child mortality. Nearly 43% of the 14 PICs reported data showing the neonatal mortality rate is over 10 per 1000 live births.

CHILDREN WHO ARE STUNTED

HIMF Indicator 3.16: Percentage of stunted (height-for-age less than -2 standard deviations of the WHO Child Growth Standards medianS among children aged 0–5 years

Related SDG indicator(s): 2.2.1



Notes: 1. Global data 2017 refer to the data eStimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled from 1985–2015. Global data resource: WHO GHO (http://apps.who.int/gho/data/node.sdg.2-2-data?lang=en). 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected from 2013–2014. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress reportSrefer to data reported by PICs in 2018.

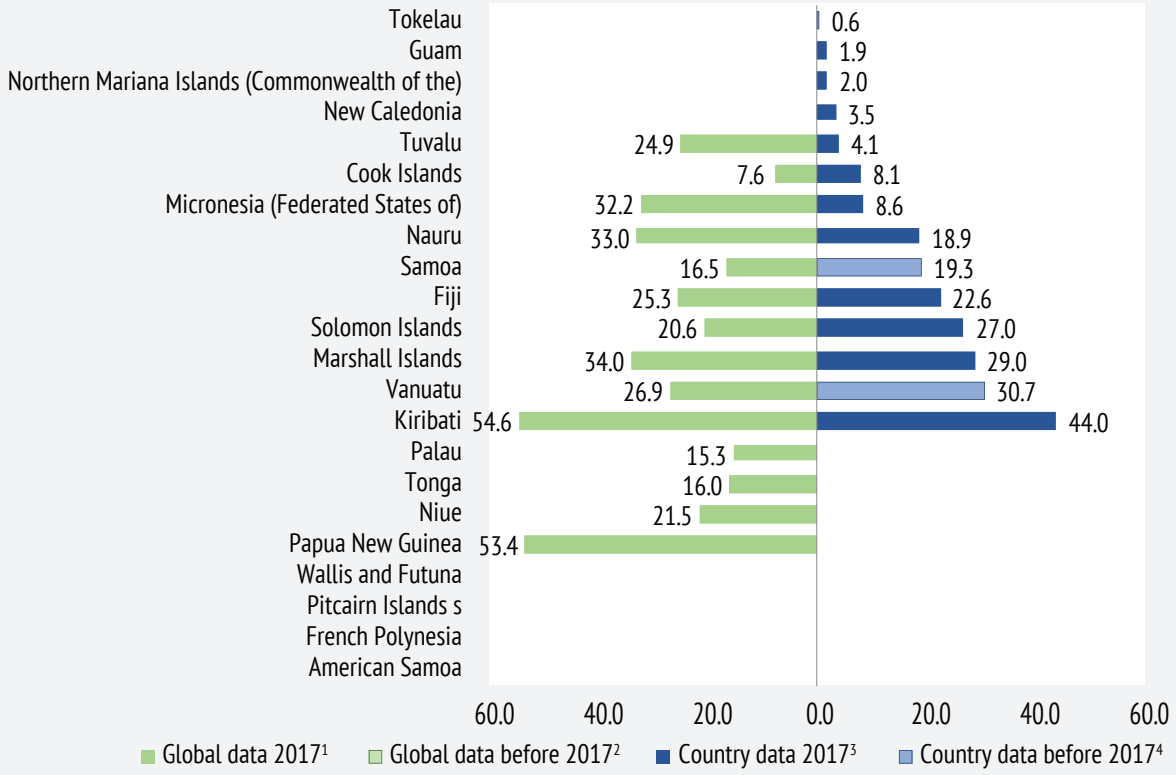
Tuvalu data need to be further confirmed.

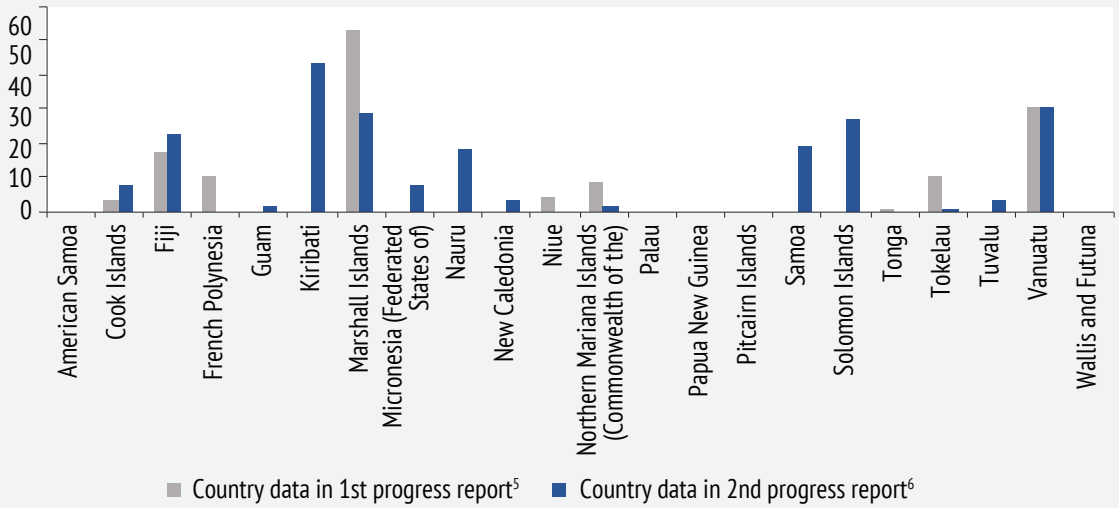
Child growth is the most widely used indicator of nutritional status in a community and is internationally recognized as an important public health indicator for monitoring health in populations. In addition, children who suffer from growth retardation as a result of poor diets and/or recurrent infections tend to have a greater risk of suffering illness and death. Around 60% of the seven PICs reported the percentage of children stunted is over 25%.

UNDER-5 MORTALITY RATE

HIMF Indicator 3.17: The probability of a child born in a specific year or period dying before reaching the age of 5 years, if subject to age-specific mortality rates of that period, expressed per 1000 live births.

Related SDG indicator(s): 3.2.1





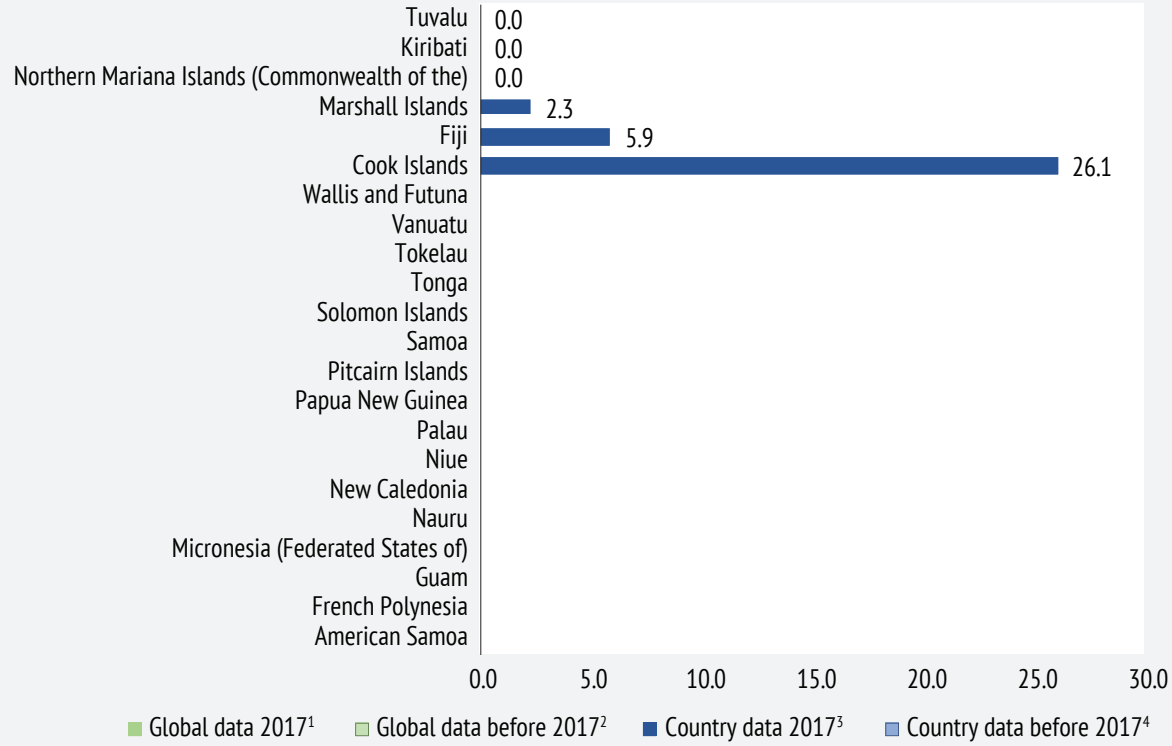
Notes: 1. Global data 2017 refer to the data eStimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected IN 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

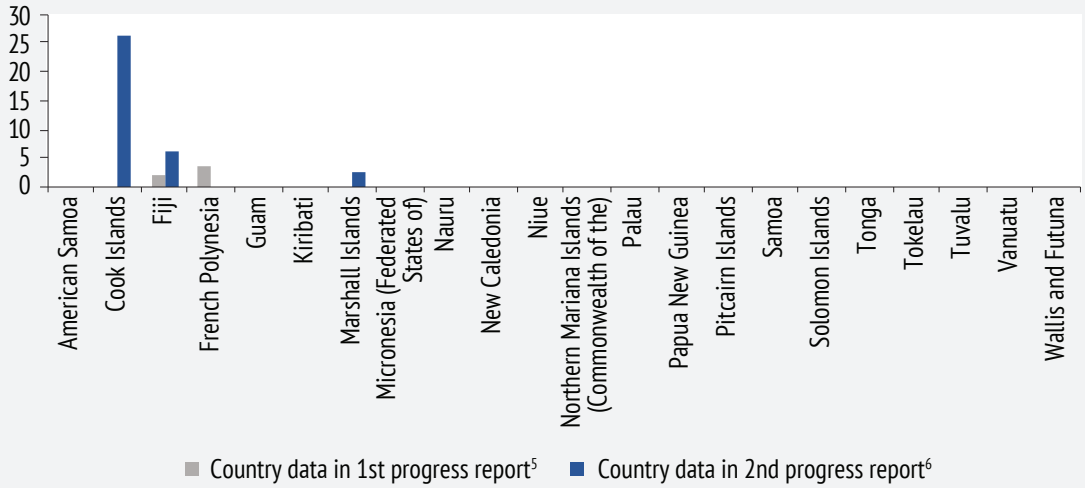
The under-5 mortality rate measures child survival. It also reflects the social, economic and environmental conditions in which children (and others in society) live, including their health care. Half of the 14 PICs reported data around or over 20%.

CHILD AND ADOLESCENT SUICIDE MORTALITY RATE

HIMF Indicator 3.18: Suicide rate per 100 000 population in a specified period time period (usually one year) for children and adolescents (aged less than 18 years)

Related SDG indicator(s): 3.4.2





NoteS: 1. Global data 2017 refer to the data eStimated or modelled in 2017. 2. Global data before 2017 refer to the data estimated or modelled before 2017. 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected in 2015. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress reportSrefer to data reported by PICs in 2018.

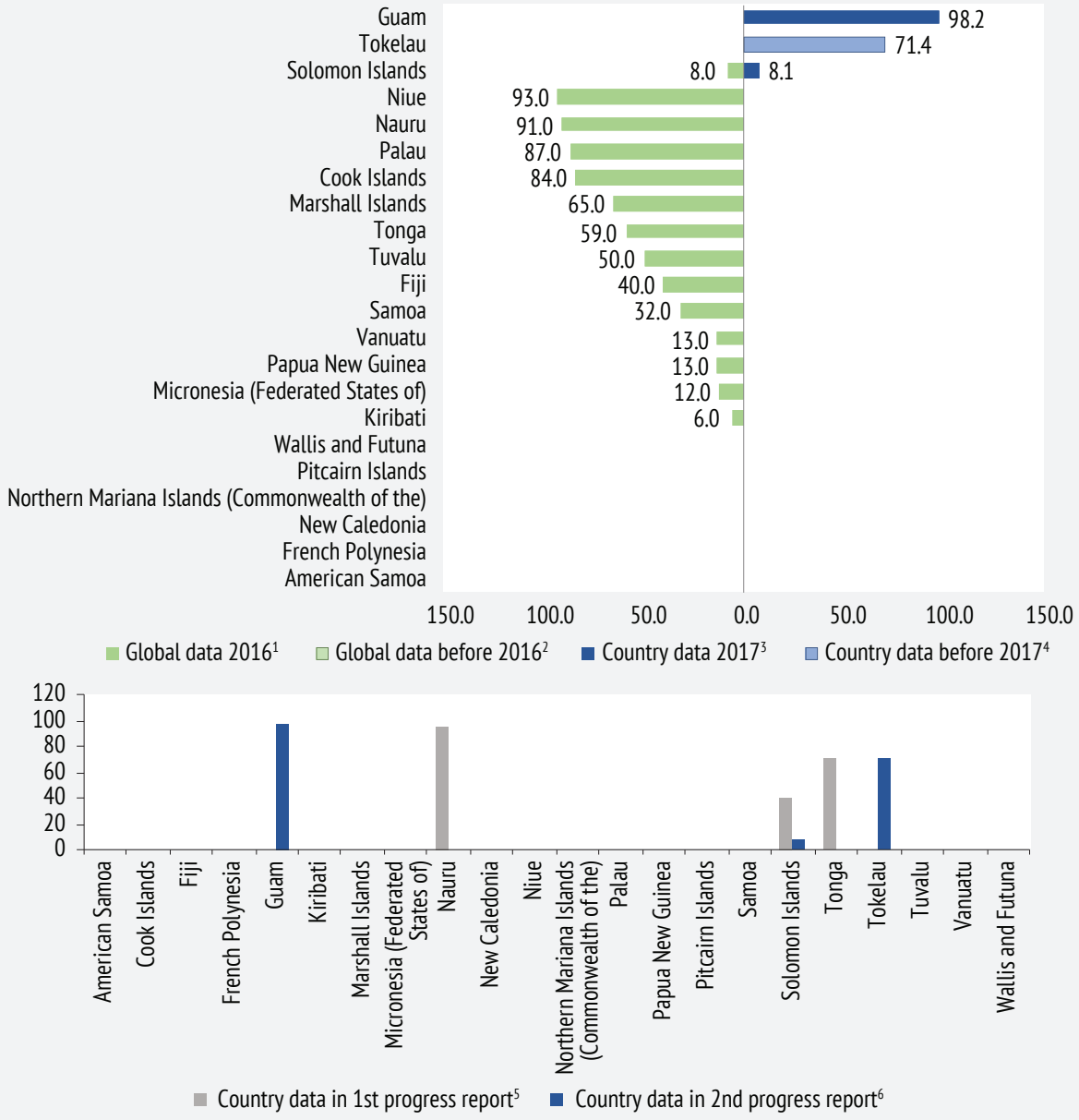
Cook Islands data need to be further confirmed.

Only six PICs were able to report on this indicator. Child and adolescent suicide has been recognized as a substantial issue in the Pacific islands; however, data availability is limited. This indicator relies on accurate cause of death reporting and that the summary data are produced annually.

PROPORTION OF POPULATION WITH PRIMARY RELIANCE ON CLEAN FUELS AND TECHNOLOGY

HIMF Indicator 4.1 : PerceStage of households/population with primary reliance on clean fuels and technologies for cooking/heating/lighting where clean is defined by the recommendations set forth in the *WHO Guidelines for Indoor Air Quality: Household Fuel Combustion*.

Related SDG indicator(s): 7.1.2



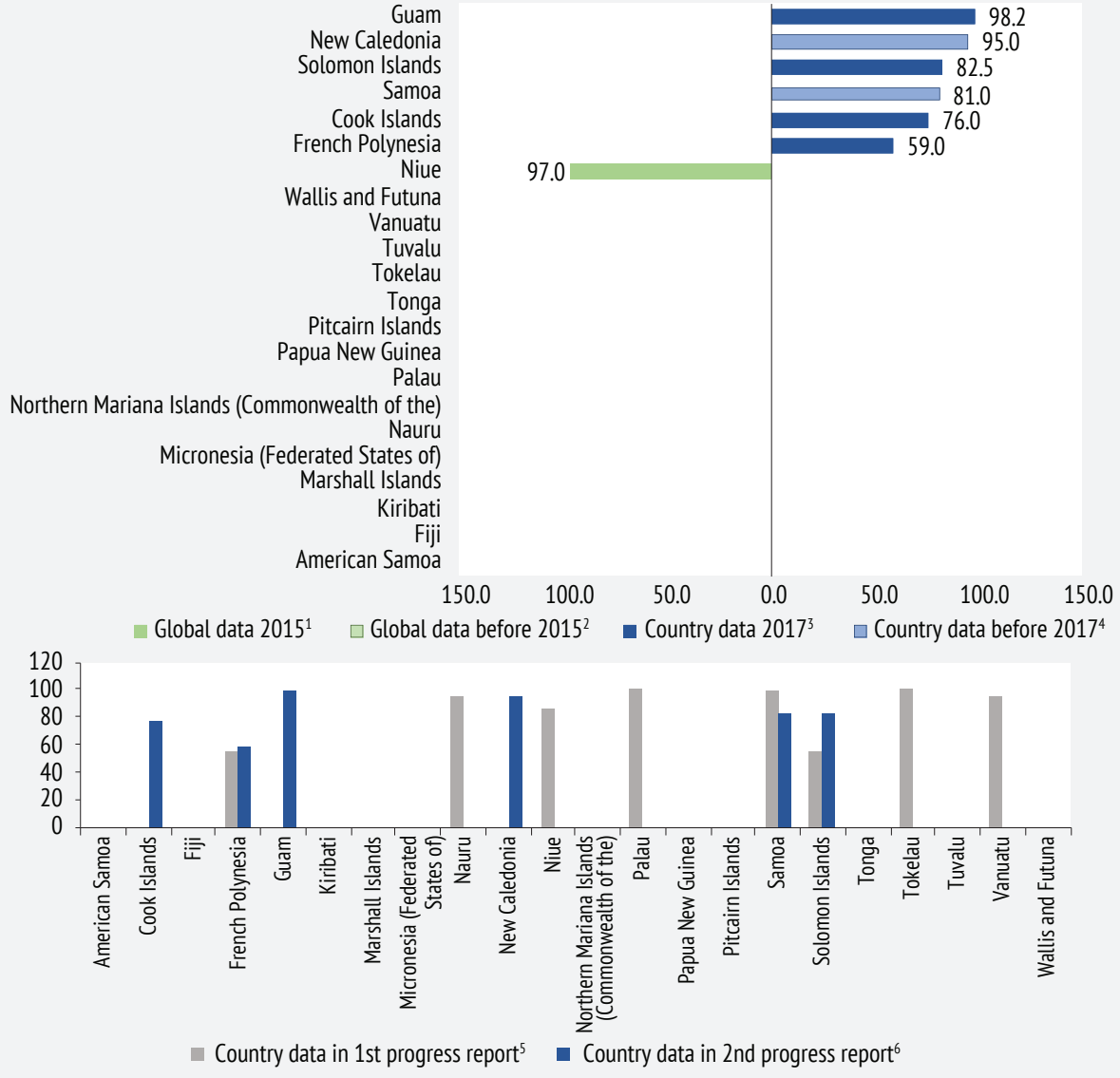
Notes: 1. Global data 2016 refer to the data eStimated or modelled in 2016. 2. Global data before 2016 refer to the data estimated or modelled before 2016. Global data resource: WHO GHO (http://apps.who.int/gho/data/node.main.SDGFUELS712?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected In 2016. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018.

The use of solid fuels and kerosene in households is associated with increased mortality from pneumonia and other acute lower-respiratory diseases among children, as well as increased mortality from chronic obstructive pulmonary disease, cerebrovascular and ischemic heart diseases, and lung cancer among adults.[2] Only three PICs reported the proportion of households/population with primary reliance on clean fuels and technologies.

POPULATION USING SAFELY MANAGED DRINKING-WATER SOURCES

HIMF Indicator 4.3 : Population using an improved drinking-water source (piped water into dwelling, yard or plot; public taps or standpipes; boreholes or tube wells; protected dug wells; protected springs, rainwater, packaged or delivered water) which is located on premises, available when needed, and free of faecal and priority chemical contamination.

Related SDG indicator(s): 6.1.1



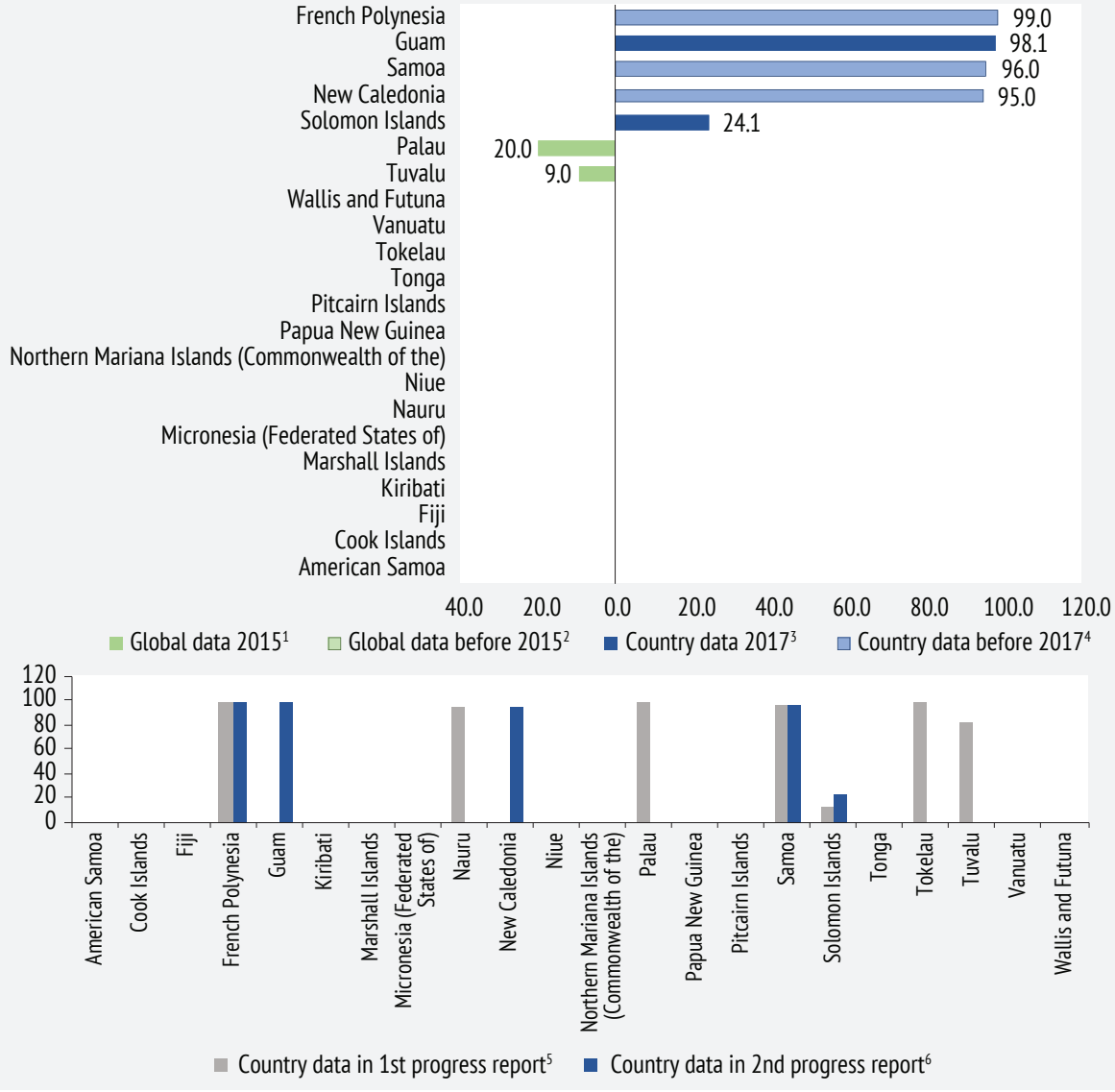
Notes: 1. Global data 2015 refer to the data eStimated or modelled in 2015. 2. Global data before 2015 refer to the data estimated or modelled before 2015. Global data resource: WHO GHO (http://apps.who.int/gho/data/node.main.46?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected In 2014. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. WHO, JMP, UNICEF. Progress on drinking-water, sanitation and hygiene. 2017 update and SDG baselines.Do you mean "Source"? Please clarify.

Lack of access to adequate drinking-water services contributes to death and illness, especially in children.[7] Water-based disease transmission by drinking contaminated water is responsible for significant outbreaks of diseases. Improvement of drinking-water is a crucial element in the reduction of under-5 mortality and morbidity, and there is evidence that ensuring higher levels of drinking-water services has a greater impact.[2] Compared with the first progress report, the definition is changed from "improved" to "safely managed". A total of five PICs reported data for this indicator.

POPULATION USING SAFELY MANAGED SANITATION FACILITIES

HIMF Indicator 4.4 : Population using an improved sanitation facility (flush or pour flush toilets to sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with a slab, and composting toilets) that is not shared with other households and where excreta are safely disposed of in situ or treated off site.

Related SDG indicator(s): 6.2.1



Notes: 1. Global data 2015 refer to the data eStimated or modelled in 2015. 2. Global data before 2015 refer to the data estimated or modelled before 2015. Global data resource: WHO GHO (http://apps.who.int/gho/data/node.main.46?lang=en) 3. Country data 2017 refer to the data collected in 2017. 4. Country data before 2017 refer to the data collected In 2014. 5. Country data in first progress report refer to data reported by PICs in 2016. 6. Country data in second progress report refer to data reported by PICs in 2018. 7. WHO, JMP, UNICEF. Progress on drinking-water, sanitation and hygiene. 2017 update and SDG baselines.

Sanitation is fundamental to human development. Access to proper sanitation is also considered to be a human right, not a privilege.[7] Sanitation generally refers to the provision of facilities and services for the safe disposal of human urine and faeces. Inadequate sanitation is a major cause of disease worldwide, and improving sanitation is known to benefit people's health significantly. Safely managing sanitation can reduce diarrhoeal disease, and can significantly lessen the adverse health impacts of other disorders responsible for death and disease among millions of children. Five PICs reported this indicator.

NUMBER OF VECTOR-BORNE DISEASE OUTBREAKS

HIMF Indicator 4.5 : Number of mosquito-borne disease outbreaks in one year

Related SDG indicator(s): 6.2.1

American Samoa	
Cook Islands	0
Fiji	
French Polynesia	0
Guam	
Kiribati	
Marshall Islands	0
Micronesia (Federated States of)	
Nauru	
New Caledonia	1
Niue	
Northern Mariana Islands (Commonwealth of the)	0
Palau	
Papua New Guinea	
Pitcairn Islands	
Samoa	1
Solomon Islands	1
Tonga	
Tokelau	0
Tuvalu	0
Vanuatu	1
Wallis and Futuna	

Seven PICs reported 2017 data, and three PICs reported 2016 data for this indicator.

ANNEXES

Annex 1. Summary of key milestones of developing the HIMF

2015	March	• *The first 20 years of the journey towards the vision of Healthy Islands in the Pacific* is published. • Four Working Groups are established in preparation for the Pacific Health Ministers Meeting (PHMM) and background papers are released: (1) Strengthening leadership, governance and accountability; (2) Nurturing children in body and mind; (3) Reducing avoidable disease burden and premature deaths; and (4) Promoting ecological balance for health.
	April	• 11th Pacific Health Ministers Meeting held on Yanuca Island, Fiji. • Recommendations: Monitor progress and achievements towards the Healthy Islands vision. This requires a reporting system with operational targets and indicators based on existing indicators and frameworks, developed at the country level and supported by robust country health information systems.
	July	• Meeting of the PHMM Secretariat (WHO, SPC and Fiji Ministry of Health) to discuss timeline and principles for development of monitoring framework.
	August	• Meeting Report: *11th Pacific Health Ministers Meeting Report* is published.
	September	• Proposed indicators drafted by core working group members (technical staff from WHO and SPC) and distributed for comments. • Version 1.0 of the *Healthy Islands Monitoring Framework* developed.
	October	• Update on Monitoring Framework presented at the sixty-sixth session of the WHO Regional Committee for the Western Pacific in Guam.
2016	February	• *Healthy Islands Monitoring Framework* side meeting held for health information managers attending the Pacific Civil Registration and Vital Statistics Regional Meeting in Noumea, New Caledonia. • Version 2.0 of the Framework developed.
	March	• Version 2.0 sent to country health information managers and senior health information officers, and regional partners for comments. • Version 3.0 of the Framework developed.
	April	• Version 3.0 discussed, refined and finalized at the heads of health meeting. • Version 4.0 of the Framework developed.
	May	• Version 4.0 discussed, refined and updated by health information managers and senior health information officers at the Pacific Health Information Network's regional meeting.
	July	• Version 5.0 of the Framework developed.
	September	• Draft data collection forms developed.

Annex 1. Summary of key milestones of developing the HIMF (cont.)

2017	February	• Data collection forms refined. • Pre-population of country data. • Versions 5.1–5.3 of the Framework developed, based on data availability and standard indicator definitions used across the region.
	March	• Version 5.3 of the Framework sent to heads of health. • Data collection forms (Version 5.3) sent to country health information managers and focal points.
	April	• Heads of health meeting (25–28 April) to discuss first draft report on the *Healthy Islands Monitoring Framework.*
	May	• Version 6.0 of the Framework developed. • Draft data collection forms developed. • Data collection forms refined.
	June	• Versions 6.1–6.6 of the Framework developed, based on data availability and standard indicator definitions used across the region. • Pre-population of country data. • Data collection forms (V6.4) sent to country health information managers and focal points.
	July	• Metadata dictionary drafted. • Second draft report on the *Healthy Islands Monitoring Framework* developed.
	August	• Pacific Health Ministers Meeting: endorsement of the Framework and the first progress report in Cook Islands on August 27.
2018	April	• Heads of health meeting (April): Update on Monitoring Framework presented at Denarau, Fiji. • The heads of health modified three indicators in their annual meeting in 2018 to be aligned and harmonized with the most recent global reporting standards. • Recommendations: the heads of health entrusted the HIMF Secretariat with revising the Framework to be more in-depth along with "improving reporting methods for the 2019 reporting cycle and beyond".
	June	• *Healthy Islands Monitoring Framework* side meeting held for health information managers attending the Health Information and Pacific Health in Suva, Fiji.
	August	• Development of the Data Exchange Tool to collect and share the data through electronic tool
	September	• Collaboration with the Australian Institute of Health and Welfare to review and improve the monitoring Framework. • Proposed indicators drafted by core working group members (technical staff from WHO and SPC) and distributed for comments. • Version 1.0 of the *Healthy Islands Monitoring Framework* developed.
	October	• Data pre-population and national data collection started for the second progress report.

Annex 1. Summary of key milestones of developing the HIMF (cont.)

2019	February	• Draft second progress report developed, based on data availability and standard indicator definitions used across the region.
	March	• Version 2.0 sent to country health information managers and senior health information officers, and regional partners for comments.
	April	• Heads of health meeting (3–5 April) to discuss second draft report on the *Healthy Islands Monitoring Framework.* • Heads of health recommended to modify two additional indicators to be aligned and harmonized with the SDGs.
	May	• Second draft report on the *Healthy Islands Monitoring Framework* developed for PHMM.
	July	• *Healthy Islands Monitoring Framework* side meeting held for health information managers attending the Health Information and Pacific Health in Noumea, New Caledonia.
	August	• Pacific Health Ministers Meeting in French Polynesia to discuss final second draft report on the *Healthy Islands Monitoring Framework.*

Annex 2. Proposed changes in indicators

HIMF Indicator	Issues detected	Recommendation
2.12 Contraceptive prevalence Definition: Percentage of women aged 15–49 years who are sexually active, who are currently using, or whose sexual partner is using, at least one method of contraception. (Number of women of reproductive age (15–49 years old) using or partner using a contraceptive method/Number of fecund women, aged 15–49 years, married or in a union who have a demand for family planning. (Women are considered to have a demand for family planning if they want to delay, space or limit childbearing).	Current family planning indicator under SDG is "Unmet need for contraception" (SDG3.7.1)	Replace with "Unmet need for contraception" (SDG3.7.1) as better measure of true coverage which currently an "optional" indicator Percentage of women of reproductive age (15–49 years) who are married or in-union who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1) (Number of women aged 15–49 who are married or in-union who use modern methods/total number of women aged 15–49 who are married or in-union in need of family planning)
1.5 Percentage of deaths that are registered (with age and sex) in a given time period (one year) 3.5 Birth registration coverage: estimated level of birth registration	Indicators are not fully aligned with SDG indicator. The introduction of indicator 17.19.2 (b) as part of the SDG global framework reflects the recognition of the fundamental role of the civil registration system to the functioning of societies, and the legal and protective advantages that it offers to individuals. The essential purpose of civil registration system is to furnish legal documents of direct interest to individuals	Replace 1.5 and 3.5 to SDG Indicator 17.19.2 (b): Proportion of countries that have achieved 100% birth registration and 80% death registration. Indicator 17.19.2(b) has two parts: the first concerning the birth registration and the second concerning the death registration of each individual country or area. The country reported information on availability and completeness of birth and death registration data at the country level to the United Nations Demographic Yearbook via the Demographic Yearbook Vital Statistics questionnaire and accompanying metadata. The national level of completeness of birth and death registration is provided by the National Statistical Offices of all countries and areas to the United Nations Statistics Division as part of the annual data collection for the United Nations Demographic.
4.5 Number of vector-borne disease outbreaks	Country completion rate of 41% in the first progress report Definitions differ for outbreaks, and vectors are not the same across countries making cross-country comparison meaningless.	Consider modifying this indicator to report on based-on and comparable existing surveillance data, for example: "The cumulative number of cases by disease by year (disaggregated by clinically compatible and lab confirmed cases)". Define a list of mosquito-borne diseases for reporting on this indicator with case definitions. If this indicator is to be retained, it is recommended to make it "core" rather than "complimentary" due to rapid changes in infectious disease incidence annually.

World Health Organization
Western Pacific Region

Pacific Community
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