a measure of the future

WOMEN'S SEXUAL AND REPRODUCTIVE RISK INDEX FOR THE PACIFIC 2009

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
DHS	Demographic and Health Survey
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
ICPD	International Conference on Population and Development
IMR	Infant Mortality Rate (number of children under one year who die per 1000 live births)
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio (number of maternal deaths in a year per 100,000 live births)
MTCT	Mother-to-Child Transmission
OECD	Organisation for Economic Co-operation and Development
PAI	Population Action International
PIC	Pacific Island Country
PICTs	Pacific Island Countries and Territories
PMTCT	Prevention of Mother-to-Child Transmission
PNG	Papua New Guinea
RRI	Reproductive Risk Index
SGS	Second Generation Surveillance survey
SPC	Secretariat of the Pacific Community
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmissible Infection
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization

Contents

Introduction

Pacific Island governments and their peoples have a vision of healthy islands. Islands where all people can live dignified lives, free from discrimination. These would be islands where women's empowerment and gender equality are achieved. Islands where all women and couples are able to enjoy a satisfying and safe sex life, the freedom to choose when to have children, and the comfort of knowing pregnancy and childbirth will be safe.

A Measure of the Future offers a tool for navigating a course to this future. When the sexual and reproductive health and rights of Pacific Island women are ensured, so too is a Pacific future where everybody enjoys good health, peace and equality.

The last two decades have seen a significant improvement in the sexual and reproductive health and rights[a] (SRHR) of Pacific Island women. Nonetheless, women continue to suffer death and injury from preventable reproductive health problems every year. The consequences of this ripple through Pacific families, communities, societies and economies. This fact challenges the governments of Pacific Island Countries and Territories (PICTs), development organisations and civil society groups to work harder, to work faster, and to work more cooperatively, towards ensuring that all Pacific Island women can realise their full SRHR.

a Good sexual and reproductive health is a fundamental human right. Sexual and reproductive health and rights is a phrase used to encompass the experiences of all humans in relation to their sexuality, relationships, pregnancy, childbirth, parenting and families, and they are enshrined within the international human rights framework.

b While *A Measure of the Future* uses the phrase Reproductive Risk Index, the index reflects both sexual and reproductive risk as the two are interconnected.

MEASURING RISK

A Measure of the Future builds on the 2007 Population Action International (PAI) study titled, *A Measure of Survival: Calculating women's sexual and reproductive risk. A Measure of Survival,* the fourth in a series started in 1995, developed a valuable Reproductive Risk Index (RRI) for 130 countries around the world. This provided policy makers and SRHR advocates with a powerful tool for highlighting barriers to SRHR, and for taking action towards overcoming these barriers on both a national and international level.[1]

A Measure of the Future provides an RRI and accompanying narrative that together specifically outline the SRHR issues that Pacific Island women continue to face in 21 PICTs.[b] *A Measure of the Future* was developed for Pacific policy makers and SRHR advocates to contribute to their informed action to overcome these issues, both at a national and regional level. It is hoped that such action can help move the region closer towards the achievement of the targets set out by the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs), and towards full SRHR for all Pacific Island women.

THE LIFE-CYCLE APPROACH

Like *A Measure of Survival, A Measure of the Future* utilises a 'life-cycle approach' for measuring sexual and reproductive health. This life-cycle approach uses health indicators that directly measure the four most basic stages of reproduction – sex, pregnancy, childbirth and survival. When combined, these indicators give a measure of the overall reproductive risk for women. *A Measure of the Future* follows this life-cycle approach because research shows a direct link between these four stages of reproduction and a heightened vulnerability to injury or death of women of reproductive age.

1 PAI (2007) 'A Measure of Survival: Calculating Women's Sexual and Reproductive Risk' Population Action International, Washington DC, USA

2 Commission on Social Determinants of Health and World Health Organization (2008) 'Closing the gap in a Generation: Health equality through action on the social determinants of health' WHO, Geneva, Switzerland

In total, *A Measure of the Future* utilises ten health indicators for measuring the four stages of this life-cycle approach. Through a composite of these indicators, it builds a picture of the cumulative reproductive risk to women in each of the 21 PICTs and ranks this risk by country. This ranking forms the RRI. An in-depth explanation of the RRI methodology can be found at the back of this study. The ten indicators used are outlined below.

While this life-cycle approach is robust, it is important to note that reproductive risk can, and often does, emerge prior to the onset of sexual activity and that survival does not indicate the end of reproductive risk. Research also shows that wider social determinants of health, such as levels of gender equality, literacy, employment, income distribution and poverty, can also affect the reproductive health of women.[2] This study discusses the relationship between some of these social determinants and SRHR in more detail in chapter one.

	✚ Safe and Healthy	♛ Voluntary
Sex	• Chlamydia prevalence rate women • Adolescent fertility rate • Female secondary school enrolment	• Median age at marriage women
Pregnancy	• Antenatal care coverage– at least one visit	• Use of modern contraceptive methods women
Birth	• Births attended by skilled health personnel	• Abortion policies
Survival	• MMR • IMR	

About the Pacific

The Pacific is a globally unique and hugely diverse region, ranging from the mountainous Papua New Guinea with six million inhabitants, to the tiny coral atolls of Tuvalu with a population of approximately 11,000. Pacific people speak a total of almost one third of the world's languages, highlighting the vast range of cultural and ethnic groups. There are an estimated 4.7 million women and girls living in the Pacific – approximately half the region's population. Some 55 percent of the region's entire population live in rural communities.[3] These communities are scattered across the more than 20,000 islands and 30 million square kilometres of Pacific Ocean that constitute the three sub-regions of the Pacific: Melanesia, Micronesia and Polynesia.

Across the Pacific, many countries and territories have made important progress towards improving women's access to good sexual and reproductive health. For example, vaccinations, antenatal care coverage and skilled attendance at birth have all increased.[4] Nonetheless, the PICTs are all small island developing states and each faces a unique set of challenges that affect the SRHR of Pacific Island women.

Ongoing political, economic and socio-cultural challenges impact heavily on the achievement of full sexual and reproductive health and rights for all Pacific Island women. Whilst most PICT economies have grown in recent years and extreme poverty has been less prevalent than in other developing regions, Pacific Island women are more likely to face greater hardship and have less access to income than their male counterparts.[5] Similarly, the emergence of cash economies, population growth and the unequal distribution of services have contributed to urbanisation and sped the breakdown of traditional family and community structures. These challenges are compounded further by a range of other factors including lack of access to shelter, education, clean water, electricity, and the dangers of climate change, natural disasters and a persistent lack of gender equality.[6]

The spread of Pacific communities across vast areas of ocean or mountainous interiors means that for many Pacific Island women and girls, geography presents an immediate barrier to good sexual and reproductive health. It is not uncommon for people to walk or canoe for several hours to get to health services, or have to wait several weeks or months for a supply boat to arrive.

This challenging environment means many Pacific Island women remain at risk of a wide range of poor sexual and reproductive health outcomes. Several PICTs continue to have low contraceptive prevalence rates, high teenage fertility rates, increasing rates of sexually transmissible infections (STIs) including HIV, poor access to antenatal care, poor access to emergency obstetric care and restrictive abortion legislation.

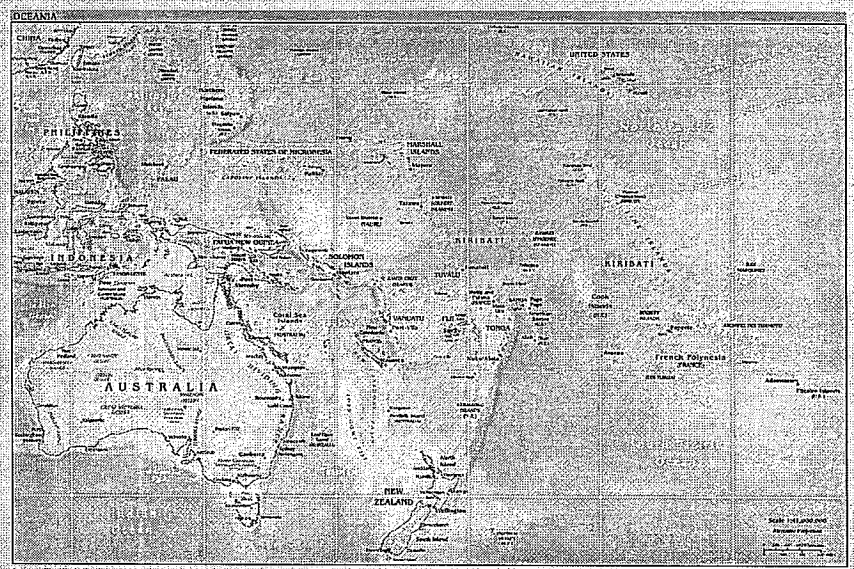
Despite the commitment by Pacific governments to improve this situation, the region's slow progress in overcoming these barriers to good sexual and reproductive health threatens the achievement of some of the recommendations set out in the Programme of Action of the IPCD. Similarly, it is now widely accepted that many PICTs may also fail to meet certain MDGs, particularly MDG 4 (the reduction of child mortality) and MDG 5 (the reduction of maternal mortality and improved access to reproductive health).[7] Such failures will inevitably mean poverty levels continue to increase unnecessarily, and that women will continue to die and suffer needlessly.

3 SPC (2009) 'Pacific Island Populations – Estimates and projections of demographic indicators for selected years' Secretariat of the Pacific Community, Noumea, New Caledonia

4 UNFPA, UNICEF, WHO (2009) 'Maternal Health in the Pacific' UN Health Agencies Submission to the New Zealand Parliamentarian's Group on Population and Development (NZPPD), Wellington, New Zealand, p. 1

5 Parks W., Abbott D., Wilkinson A. (2009) 'Protecting Pacific Island children and women during economic and food crisis: A working document for advocacy, debate and guidance' Suva, Fiji, UNICEF Pacific, UNDP Pacific Centre, UNESCAP Pacific Operations Centre, pp. 12 and 26-28

6 UNICEF (2008) 'The State of Pacific Children 2008' UNICEF, Suva, Fiji, pp. 2-5

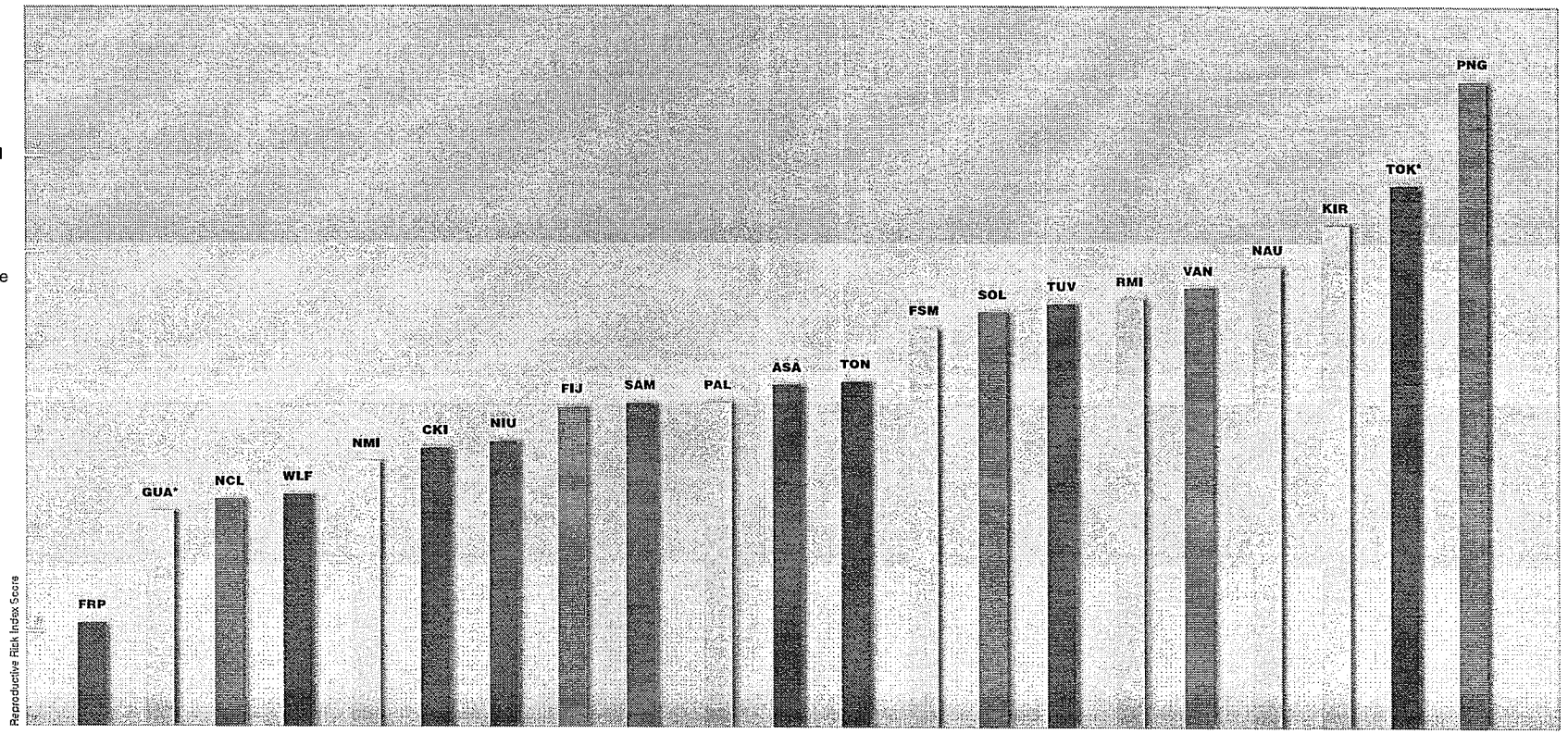


Source: *The World Factbook 2009*, Washington, DC: Central Intelligence Agency, 2009.

7 ESCAP (2008) 'A Future Within Reach 2008' United Nations Publication, Thailand, p. 12, and; UNFPA (2004) 'ICPD +10: Progress in the Pacific' UNFPA, Suva, Fiji, pp. 2, 4-5, 21 and 49

Reproductive risk in Pacific Island Countries and Territories

All 21 PICTs are grouped within one of four risk quartiles: very high risk, high risk, moderate risk and low risk. Quartiles were calculated by dividing the highest score by four. Therefore, each quartile is specific to the overall level of risk associated with the circumstances of the 21 PICTs for which data has been collected. The broad characteristics of each risk quartile are outlined below.



Micronesia
Polynesia
Melanesia

FRP – French Polynesia
GUA – Guam
NCL – New Caledonia
WLF – Wallis and Futuna
NMI – Northern Mariana Islands
CKI – Cook Islands
NIU – Niue
FIJ – Fiji
SAM – Samoa
PAL – Palau
ASA – American Samoa
TON – Tonga
FSM – Federated States of Micronesia
SOL – Solomon Islands
TUV – Tuvalu
RMI – Republic of the Marshall Islands
VAN – Vanuatu
NAU – Nauru
KIR – Kiribati
TOK – Tokelau
PNG – Papua New Guinea

VERY HIGH RISK CATEGORY

There are three PICTs in this category. Due to a lack of data, Tokelau's rank should be ignored. The remaining two countries are characterised by very high maternal and infant mortality, more restrictive abortion laws, the lowest levels of skilled care at birth, low contraceptive use, low numbers of girls in secondary school, early age at marriage and high adolescent fertility rates. Particular indicators showing very high risk include Papua New Guinea's infant mortality rate (IMR) of 57 and its maternal mortality ratio (MMR) of 733, which is significantly higher than any other PICT. Papua New Guinea also has a low level of skilled care at birth and antenatal care coverage. Similarly, Kiribati has the lowest use of contraception and the lowest female secondary school enrolment of all PICTs. Kiribati also has the region's second highest IMR.

HIGH RISK CATEGORY

There are eight PICTs in this category. They are characterised by high maternal and infant mortality, more restrictive abortion laws, low contraceptive use, some high chlamydia prevalence rates, some low antenatal care coverage and some low levels of births attended by skilled health personnel. Particular indicators showing high risk include the Republic of the Marshall Islands' very high adolescent fertility rate (the region's highest), and the Solomon Islands' and Vanuatu's high maternal and infant mortality levels. Contraceptive use is also very low in Tonga and Tuvalu.

MODERATE RISK CATEGORY

There are nine PICTs in this category. Due to a lack of data, Guam's rank should be ignored. The remaining eight PICTs are characterised by moderate levels of maternal and infant mortality, high levels of antenatal care coverage and births attended by skilled health personnel, and moderate to high levels of contraceptive use and adolescent fertility. Some PICTs in this category also have high chlamydia rates. Particular indicators showing high risk include Samoa's, New Caledonia's and particularly Fiji's high chlamydia prevalence rates, the Commonwealth of the Northern Mariana Islands' and the Cook Islands' high adolescent fertility rates, and Wallis and Futuna's and Palau's low use of contraceptives.

LOW RISK CATEGORY

There is one Pacific Island territory in this category. French Polynesia is categorised by low infant and maternal mortality, liberal abortion legislation, and high levels of skilled care at birth and antenatal care coverage. Nonetheless, improvements can still be made by reducing MMR and IMR further. The territory is also lacking data on contraceptive use and chlamydia prevalence.

**For Guam and Tokelau, not enough data was available to calculate a meaningful rank within the index. Therefore their ranking should be ignored. They have been retained in the index because what data is available may still be useful for policy makers and advocates.*

Chapter 1:
The social determinants of health

The quality of people's health is highly dependent upon their level of poverty, empowerment and wealth, which in turn is linked to their ability to access goods and services. Globally, the distribution of these is unequal.[8] In the Pacific, it is most often women and children who have the least power and wealth. While extreme poverty in the Pacific is limited to some areas of some countries, it has been growing and will continue to grow. The global economic crisis will most likely contribute to this, and the impact on women's sexual and reproductive health will be manifest in a range of ways. [9]

There is a clear link between education and improved sexual and reproductive health. When women are educated they are more able to negotiate sexual relations, use family planning services and more likely to seek out help for health related issues. In the Pacific, education has traditionally been highly valued and in many Polynesian PICTs, primary enrolment rates are over 90 percent with secondary enrolment rates close behind. Still, education in the Pacific is limited by restricted resources and this impacts on the quality of education available.[10] In particular, because sex is widely considered a taboo subject, sexuality and relationships education is often not included in curricula and teachers are not supported to provide it.[11]

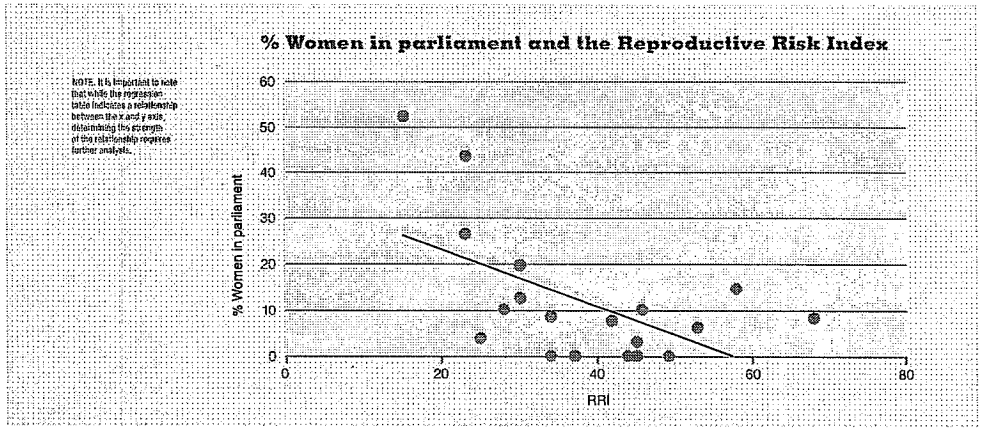
The achievement of gender equality in the Pacific will positively affect women's health. In all three Pacific sub-regions socio-cultural norms have traditionally not prescribed women and girls with equal status to men, a fact which strongly influences women's sexual and reproductive health. Manifestations of this can include arranged marriages (in some cases of children),[12] the modern-day commodification of women through bride prices, the social acceptance of unquestioned male authority (often in relation to sexual activity, the use of contraception and health), and even the acceptance of violent and abusive treatment such as rape by an intimate partner.[13] One of the barriers to changing such norms and to prioritising of women's health issues is the Pacific's low proportion of female political representatives – the lowest in the world.[14] Without women in positions with decision making power, women often lack a strong political voice.

In the absence of full gender equality, efforts must be made to increase women's social status and to improve their access to income. International research shows that women who have high social status and who have access to income are far more likely to receive quality healthcare.[15] In the Pacific, the lack of gender equality means many women and girls have both a low social status and limited access to income. For example, a 2007 study of 552 Tuvaluan women who earned money found that 13 percent did not make the decision about how it was used. The same study also found that for 598 Tuvaluan women, 16 percent had decisions about their health made solely by their husbands.[16] This indicates that healthcare may not be accessible to some Pacific Island women because they are unable to control how money is used and unable to make decisions about their own health.

Women who are able to find employment are frequently seen as part of the 'flexible' labor force and are as a result, often the first to lose work during hard economic times.[17] This can leave women with less income to spend on food and shelter, which in turn, impacts on their health. In some PICTs, women are often the sole breadwinner meaning their job loss can also significantly affect their family's wellbeing. There is growing concern that Pacific Island women's access to income will be significantly affected by the global financial crisis and that this will likely have consequences for maternal health in the region.[18]

As the Pacific continues to urbanise, efforts must be taken to ensure urban spaces promote women's safety and wellbeing. Urbanisation is a clear determinant of health. In particular, it can increase women's risk to communicable diseases such as STIs including HIV, alcohol and substance-abuse, violence, environmental health risks and poor nutrition.[19] In the Pacific, over 50 percent of the population in ten of the 22 PICTs live in urban centres – mainly capital cities.[20] In 2003 it was estimated that around 24 percent of the total Pacific population lived in slums,[21] a phenomenon which has continued to grow, particularly in Melanesia where the current annual population growth rate is two percent.[22]

Special measures must be taken to ensure that women who are isolated by geography and poverty have access to SRHR services. Women who live in rural communities of large mountainous countries like Papua New Guinea or the Solomon Islands, or who live on the outer islands of countries like the Federated States of Micronesia and Kiribati, are often isolated from adequate health information and services. A range of factors contribute to this including lack of, cost of, and reliability of transport, large distances to hospitals and clinics, and very basic or non-existent health services. This isolation significantly increases the risk of death and injury to pregnant women who need access to antenatal care, skilled birth attendants and/or emergency obstetric care.



Socio-economic factors are important to address when working to improve sexual and reproductive health.

8 Commission on Social Determinants of Health and World Health Organization (2008) 'Closing the gap in a Generation: Health equality through action on the social determinants of health' WHO, Geneva, Switzerland. p. 1

9 Parks W., Abbott D., Wilkinson A. (2009) 'Protecting Pacific Island children and women during economic and food crises: A working document for advocacy, debate and guidance' Suva, Fiji, UNICEF Pacific, UNDP Pacific Centre, UNESCAP Pacific Operations Centre. p. 7

10 UNICEF (2008) 'The State of Pacific Children 2008' UNICEF, Fiji, Suva. pp. 29-31

11 UNICEF (2005) 'The State of Pacific Youth 2005' UNICEF, Suva, Fiji. p. 8

12 UNICEF (2006) 'Violence against the girl child in the Pacific Islands region' Expert Group Meeting on Elimination of all forms of discrimination and violence against the girl child, Florence Italy. p. 7

13 Keating A. (2007) 'Gender in Pacific Island States: Literature Review and Annotated Bibliography' http://www.sivanda.org/static/Keating_pacific.htm?em=071&nditag=CE visited on 13 July 2009, and; SPC, UNFPA and Government of Samoa (2003) 'The Samoa Family Health and Safety Study' SPC, Noumea, New Caledonia, p. 46

14 UNDP (2009) 'Millennium Development Goals Report 2009' UN, New York, USA. p. 23

15 PAI (2007) 'A Measure of Survival: Calculating Women's Sexual and Reproductive Risk' Population Action International, Washington DC, USA. p. 16

16 Tuvalu and SPC (2008) 'DRAFT - Tuvalu Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia, pp. 220-224

17 Parks W., Abbott D., Wilkinson A. (2009) 'Protecting Pacific Island children and women during economic and food crises: A working document for advocacy, debate and guidance' Suva, Fiji, UNICEF Pacific, UNDP Pacific Centre, UNESCAP Pacific Operations Centre, pp. 25-29

18 Ibid.

19 Commission on Social Determinants of Health and World Health Organization (2008) 'Closing the gap in a Generation: Health equality through action on the social determinants of health' WHO, Geneva, Switzerland, pp. 60-62

20 SPC (2009) 'Pacific Island Populations – Estimates and projections of demographic indicators for selected years' Secretariat of the Pacific Community, Noumea, New Caledonia

21 Commission on Social Determinants of Health and World Health Organization (2008) 'Closing the gap in a Generation: Health equality through action on the social determinants of health' WHO, Geneva, Switzerland, p. 61

22 SPC (2009), 'Pacific Island Populations – Estimates and projections of demographic indicators for selected years' Secretariat of the Pacific Community, Noumea, New Caledonia

FOCUS 1:
SRHR for people with disabilities

People living with a disability have sexual and reproductive needs and desires just like anybody else. Good sexual and reproductive health is a human right to be enjoyed by all people, regardless of whether or not they live with a disability. Yet because of discriminatory attitudes and beliefs within society about people living with disabilities, they often face challenges in exercising their basic human rights, including those related to reproduction and sexuality.

As well as this, people living with a disability experience intersecting discriminations, depending on their sexuality, gender expression, ethnicity, and other socio-cultural and economic factors. This means that different people may experience multiple layers of discrimination. This is particularly so for women and girls living with a disability, as they also experience discrimination because they are women. Therefore, they are more likely to be survivors of sexual abuse, and have markedly decreased access to education, employment, income and assets, health services and information, and other social protection measures.

To overcome these challenges, Pacific Island people living with disabilities are increasingly uniting through organisations, such as the Fijian Disabled Persons Association, and taking action to make societies more disability-friendly. With the assistance of regional organisations, such as the Regional Rights Resource Team and the United Nations Economic and Social Commission for Asia and the Pacific, the number of these organisations is expected to grow. This will provide Pacific Island people living with disabilities more avenues for advocating both at the local and regional level for their rights – including their right to good sexual and reproductive health.

At the same time, and as a result of this advocacy, governments are making progress towards improving the rights of Pacific Island peoples living with disabilities. For example, the signing and ratification of the Convention on the Rights of Persons with Disabilities is slowly increasing. Already, many PICTs are party to other important human rights treaties such as the Convention on the Rights of the Child, which also protects the rights of children with disabilities. Many PICTs such as the Cook Islands, Vanuatu, Kiribati, PNG, Samoa and Fiji have also developed disability policies.

However, the challenge remains to more rapidly increase the number of Pacific Island governments who have fully ratified international human rights treaties, and who fully fund, implement and enforce laws and policies consistent with human rights. Donors and multilateral agencies must also support the actions of local advocates and governments to ensure people living with disabilities receive the sexual and reproductive health information and services that they need to enjoy healthy reproductive and sexual lives, free from discrimination.

Chapter 2:
Regional health systems

While the quality of health systems varies between PICTs, all can make improvements to sexual and reproductive health policies, information, services and facilities. In some instances, these improvements are urgently needed and will require significant investment. Nonetheless, given the wide range of challenges that can and do impact upon the health of Pacific Island peoples, all Pacific Island governments have made a number of remarkable health achievements. Increasing the number and speed with which these achievements are made, and maintaining those already made, is critical to providing high quality sexual and reproductive health services and information.

Pacific human resources for health require priority attention in order to improve sexual and reproductive health. Well trained, well resourced and appropriate numbers of a range of health care professionals are the basis of a functioning health system. However, many PICT health systems are affected by serious human capacity limitations. These include staff shortages, inadequate training, a lack of ongoing support and refresher training, unsupportive systems and processes, and inconsistent pay and incentives. These challenges are recognized by PICT governments and regional agencies, and a Pacific Human Resources for Health Alliance Work plan 2008-2015 has been developed to guide regional action on this issue.

These challenges are inter-related and combined, however, the key issue for service provision is the lack of nurses, midwives, doctors and specialists, such as gynecologists and obstetricians. There are several reasons for this shortage. For one, adequate numbers are not trained, and staff already working do not tend to receive professional development and refresher training opportunities, which can lead to burn-out and attrition. Second, it is difficult to attract doctors and nurses to rural communities where services are limited. Third, financial limitations and weak systems often mean health professionals face pay delays, or no pay at all. Finally, many health professionals choose to move to countries such as Australia and New Zealand where opportunities and pay are better – a phenomenon known as 'brain drain'. The result is that the average health worker density for the Pacific is around three per 1000 compared to ten or more per 1000 in New Zealand and Australia.[23]

The infrastructure of all Pacific Island health systems can be improved and expanded. All PICTs have hospitals and clinics, yet the quality of these buildings and the facilities they provide varies widely. For example, some maternity wards do not have acceptable beds and linen. Some hospitals and clinics lack fresh water, blood supplies and a regular electricity supply, and too often those best equipped hospitals and clinics are located in urban settings.[24] Poor transport and communication infrastructure compound these challenges further by limiting women's access to health facilities and hindering the coordination of supplies. Still further, many PICTs have weak health policy frameworks and are unable to monitor and enforce those they do have, particularly across geographical

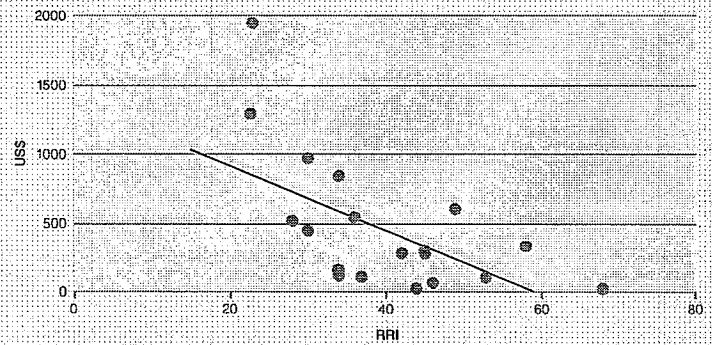
23 Negin J. (2008) 'Australia and New Zealand's contribution to Pacific Island health worker brain drain' in *Australian and New Zealand Journal of Public Health, Vol. 32 issue. 6*, http://www3.interscience.wiley.com/journal/122559902/abstract?CRETRY=1&SRETRY=0, visited on 13 July 2009, and; WHO and SPC (2009) 'Human Resources for Health and the Pacific Human Resources for Health Alliance' Eighth Meeting of Ministers of Health for the Pacific Island Countries. PIC8/10. Madang, Papua New Guinea

24 UNFPA (2006) 'Family Planning and Emergency Obstetric Care Facility Assessment in Seven Pacific Countries' United Nations Population Fund Pacific Sub-regional Office, Suva, Fiji

The Pacific must find ways to attract, retain and train a health workforce that works for women.

Per capita govt expenditure on health (US$) and the Reproductive Risk Index

NOTE: It is important to note that while the regression table indicates a relationship between the x and y axis, determining the strength of the relationship requires further analysis.



25 WHO and SPC (2009) 'Health Systems Strengthening and Primary Health Care' Eighth Meeting of Ministers of Health for the Pacific Island Countries, PIC8/5, Madang, Papua New Guinea, and; WHO and SPC (2009) 'Aid Effectiveness in the Pacific' Eighth Meeting of Ministers of Health for the Pacific Island Countries, PIC8/3, Madang, Papua New Guinea

26 WHO and SPC (2009) 'Aid Effectiveness in the Pacific' Eighth Meeting of Ministers of Health for the Pacific Island Countries, PIC8/3, Madang, Papua New Guinea

barriers. This often results in variance in standardised processes and practices.

Development organisations and donors must ensure that their activities are harmonised and aligned with those of one another, and with the specific national priorities of Pacific Island governments. Most Pacific Islands have been implementing programmes for improving maternal, newborn, child and adolescent health for decades – yet many have seen only mixed results. Human and resource limitations are linked to this but so too is the rapid increase in the number of development organisations operating in the Pacific.

While development organisations have helped PICTs to achieve many health outcomes, both their funding and management structures have also often contributed to already weak health systems becoming fragmented and siloed. For example, many externally-driven projects have been vertical in nature and disease-specific. These can contribute to the disempowerment of local staff as foreign staff take over but do not necessarily train local staff despite the rhetoric of capacity development. Vertical programmes can also cause broader health priorities to experience funding shortfalls as development organisations' attention moves to one specific condition, rather than to broader health systems strengthening.

Further, disease-specific funding has not normally targeted the long-term costs that typically makeup the majority of PICT health budgets such as salaries, supplies and infrastructure maintenance. Donor funding can also be short-term, and fluctuate, making it difficult for PICTs to effectively plan health budgets over the long term.[25] However, this is well-recognised by the international development community and change is beginning.

In 2005, world leaders came together to sign the Paris Declaration on Aid Effectiveness, where five principles for improving aid effectiveness were agreed to. These principles are country ownership, alignment, harmonisation, managing for results and mutual accountability. Since then, both the Pacific Aid Effectiveness Principles and the Accra Agenda for Action have been signed, re-affirming support for the Paris Declaration and placing greater emphasis on how aid can best be managed between partner countries (those giving aid and those receiving aid).[26]

FOCUS 2:
Will the 'diagonal approach' to health systems strengthening work in the Pacific?

Still at an experimental stage, but driven by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the 'diagonal approach' is effectively the integration of the two most common donor approaches for achieving health systems strengthening in developing countries: the 'vertical' approach and the 'horizontal' approach. Vertical approaches have tended to be disease-focused projects and whilst they can be effective in achieving their own objectives, they tend to be isolated from the broader health system, service only a small number of people and provide little if any benefit to the broader health system.

27 Ooms G., Van Damme W., Baker B., Zeitz P. and Schrecker T. (2008) 'The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems' *Globalization and Health* 2008, 4:6

The horizontal approach has traditionally been an attempt to spread funding across a health care system so that the system is strengthened with improved service delivery more effectively contributing to improved health for all. However, without strong systems already in place, they have often led to a generalized level of insufficiency and been inefficient. As well as this, strengthening systems takes many years and meanwhile people have unmet needs.

The diagonal approach is an attempt to capitalize on the strengths of both systems for the greater benefit of health systems and those who depend on them. It does so by initiating a range of vertical projects, linking them and using their combined strength to gradually build sustainable horizontal capacity through: integration, coordination, improved supplies, financing, human resource development and quality assurance. [27]

To-date, few diagonal approaches have yet been fully implemented globally, let alone within the Pacific. To definitively prove their benefits, there is a strong need to undertake research into whether the diagonal approach will provide the region with an effective process for health system strengthening by combining the disease and system focuses.

Chapter 3:
STIs, including HIV

STIs pose serious health risks. Infections such as chlamydia, gonorrhoea and syphilis can lead to infertility, foetal death, ectopic pregnancies, neonatal pneumonia and conjunctivitis. HIV can lead to death and cause complications during pregnancy. If not treated through the use of antiretroviral drugs (ARVs), HIV can be passed on to a child during pregnancy, at delivery or through breastfeeding. The most recent evidence available indicates some Pacific Islands have high STI rates and that while HIV rates are low regionally, they are increasing.[28] Nonetheless, because most PICTs have limited STI testing and surveillance capacity, and because under-reporting of cases is likely in some PICTs, STI rates differ widely between PICTs and the epidemiology of STIs across the entire region is not yet fully understood.

As knowledge of Pacific STIs including HIV, has improved, the extent and seriousness of the issue has become more clear. A series of Second Generation Surveillance surveys (SGS) carried out in six Pacific Island Countries (PICs) between 2004 and 2005, found 18 percent of all pregnant women surveyed had chlamydia. In particular, the studies revealed that pregnant women under the age of 25 years were the most at risk of STIs. For example, in five of the six countries involved at least 20 percent of surveyed women under the age of 25 years had chlamydia. In Fiji and Samoa the rates were higher than 30 percent, with a 40.7 percent infection rate in Samoa.[29] This puts them amongst the highest rates in the world.[30] More recent SGS surveys indicate that STI rates remain high and that young people continue to be most at risk of STIs.[31]

Excluding PNG, the Pacific is experiencing a limited or low prevalence HIV epidemic.[32] HIV was first reported in the Pacific in 1984 and has since spread to every PICT except Niue, the Pitcairn Islands and Tokelau.[33] With an estimated prevalence rate of around 1.5 percent, Papua New Guinea (PNG) is in the grip of a generalized epidemic which continues to worsen.[34] The most recent data show there have been over 23,000 reported cases of HIV and estimates suggest that of a total population of approximately 6 million, as many as 54,000 Papua New Guineans may be living with HIV.[35]

While prevalence rates vary widely between other PICTs, most share a range of characteristics that make their populations vulnerable to the further spread of HIV. First, the main mode of HIV transmission in the Pacific is heterosexual sex (over 50 percent) which increases the risk to the general population. Second, 29 percent of HIV transmission is attributable to men who have sex with men. Because Pacific religious and cultural beliefs predominantly stigmatise men who have sex with men, it is difficult to publicly engage and educate this group about how to protect themselves from HIV and other STIs. Third, PICTs typically have small and often mobile populations, meaning HIV can both spread easily and affect a greater proportion of a population. Fourth, research shows that risky sexual behaviour and high STI rates are common in many PICTs. This significantly increases people's risk of contracting HIV.[36]

28 UNFPA (2007) 'Current Status of Sexual and Reproductive Health: Prospects for Achieving the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals' in *Asia-Pacific Population Journal*, Vol.22, Number 3, December

29 WHO (2006) 'Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries' World Health Organization, Geneva, Switzerland, pp. 20-25

30 UNFPA (2007) 'Current Status of Sexual and Reproductive Health: Prospects for Achieving the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals' in *Asia-Pacific Population Journal*, Vol.22, Number 3, December

31 Solomon Islands Ministry of Health and SPC (2008) 'Second Generation Surveillance Survey of Antenatal Women and Youth Solomon Islands 2008', and; Vanuatu Ministry of Health and SPC 'Second Generation Surveillance Survey of Antenatal Women, STI Clinic Clients and Youth, Vanuatu, 2008', and; 'Second Generation HIV Surveillance in Antenatal Clinic Attendees and Youth, Tonga 2008' all at http://www.spc.int/hiv/downloads/second-generation-surveillance-surveys/ visited on 30 June 2009

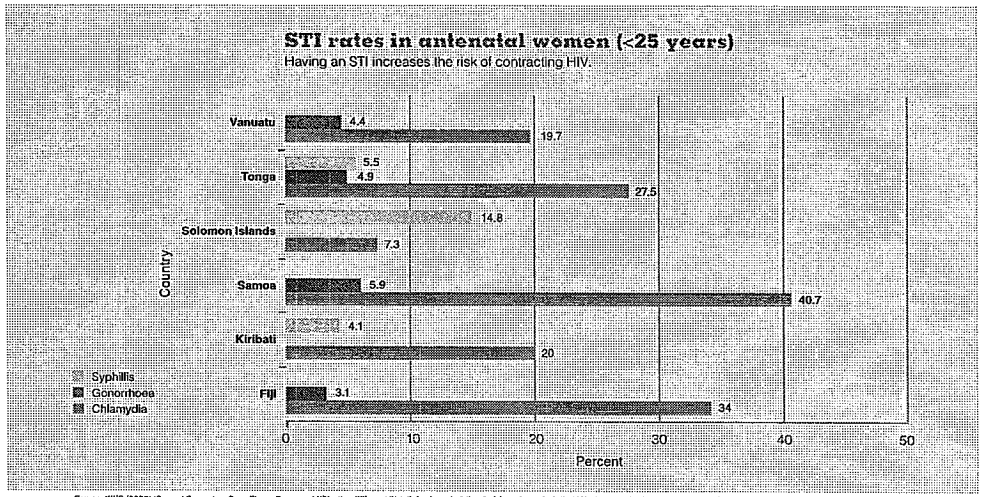
32 WHO (2006) 'Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries,' World Health Organization, Geneva, Switzerland, p. 9

33 SPC (2008) 'Cumulative reported HIV, AIDS deaths cases, incidence rates and gender, plus cases with missing details; All Pacific Island Countries and Territories to December 2008' http://www.spc.int/hiv/downloads/cumulative-reported-hiv-aids-and-aids-deaths/; visited on 21 May 2009

34 WHO, UNAIDS, UNICEF (2008) 'Epidemiological Fact Sheet on HIV and AIDS core data on epidemiology and response Papua New Guinea' http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_PG.pdf visited on 31 August 2009

35 Ibid.

Some Pacific Island Countries have STI rates that are amongst the highest in the world.



Source: WHO (2006) 'Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries' World Health Organization, Geneva, Switzerland.

c Counselling and testing for HIV is usually referred to as Voluntary Confidential Counselling and Testing (VCCT).

HIV- related activities must be integrated into sexual and reproductive health information and services, and both must be expanded in order to effectively prevent, slow and reduce the spread of STIs including HIV – particularly amongst youth. In the Pacific, the majority of SRHR and HIV services remain disconnected. International research shows that integrating HIV programmes with SRHR programmes leads to a range of positive public health benefits. These include: increased access and uptake of HIV and SRHR services, particularly amongst vulnerable population groups; decreased HIV-related stigmas; decreased duplication; increased quality of care; better protection of rights; and more effective use of human resources.[37]

However, while progress is being made, most PICTs still have limited SRHR and HIV-related services currently operating. For one, information and education about STIs including HIV is not widely available, and social, cultural and religious taboos further restrict its dissemination.[38] Both male and female condoms remain under-utilised in most PICTs,[39] exacerbated by poor access to information and education. Similarly, while facilities for diagnosing and treating STIs, including HIV[c] are available in most PICTs, they are not yet widely accessed. In part, this is because they are predominantly limited to urban centres. People may also choose not to use them for fear of stigmatisation and a lack of confidentiality. Furthermore, almost all PICTs must currently send HIV test samples overseas to Hawaii, Fiji or Australia for confirmatory tests – a process that can cause unacceptably long delays.[40]

Finally, access to ARVs and the drugs needed to treat other STIs remains imperfect, largely due to supply challenges (see Focus Box 4). Also, ARV drug recommendations can differ between US territories, French territories and PICs, making it difficult for people living with HIV to move between these islands.[41] While ARV coverage is near complete in most of the Pacific (excluding PNG), this is in part because of the low numbers of people living with HIV. In Papua New Guinea where ARV coverage is most needed, it is much worse. It is estimated that only 38 percent of all Papua New Guineans needing ARV drugs have access to them.[42]

36 Duffy S. (2009) 'HIV epidemiological update for Pacific Island countries' PASA, Number, 34, August 2009, Secretariat of the Pacific Community, p. 5

37 WHO, UNFPA, IPPF, UNAIDS, UCSF (2009) 'Linkages: Evidence Review and Recommendations' http://data.unaids.org/pub/Agenda/2009/2009_linkages_evidence_review_en.pdf, visited on 15 September 2009

38 UNICEF (2005) 'The State of Pacific Youth 2005' UNICEF, Suva, Fiji, p. 8

39 WHO (2006) 'Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries.' World Health Organization Geneva, Switzerland

40 Best S. (2009) 'Validation of HIV testing strategies utilizing simple rapid tests for Pacific Island countries' PASA, NO. 34, August 2009, Secretariat of the Pacific Community, pp. 8-9

41 Garvaz A. (2009) 'Personal communication' Secretariat of the Pacific Community

42 WHO, UNAIDS, UNICEF (2008) 'Epidemiological Fact Sheet on HIV and AIDS core data on epidemiology and response Papua New Guinea' http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_PG.pdf, visited on 31 August 2009

FOCUS 3:
What do we really know about HIV in the Pacific?

In recent years, the epidemiology of STIs, including HIV, in the Pacific has become more clear. In part this is the result of increased routine surveillance, voluntary confidential counseling and testing (VCCT) and a series of ongoing regional Second Generation Surveillance surveys. Nonetheless, surveillance is limited by under-reporting, misidentification, stigmatisation, small sample groups, difficulty attracting participants, limited testing facilities, geographical restraints and high costs. Therefore, it is not yet possible to definitively answer a number of important questions about STIs in the Pacific, particularly HIV.

For example, the Solomon Islands are Papua New Guinea's (PNG's) closest PIC neighbour and have the region's third largest population. With only 12 reported HIV cases compared to PNG's 23,000 plus,[43] big questions remain unanswered. Is surveillance missing important groups? Are other factors such as behaviours and travel patterns limiting HIV risk, or, is it a combination of both?

Similarly, it is widely accepted that all PICTs are vulnerable to the rapid spread of HIV because they have small, mobile populations with often high STI rates. However, while HIV prevalence has risen in the 25 years since it was identified in the Pacific, PNG is the only country with a generalized epidemic. Why other PICTs have not been affected like PNG is not well understood – particularly when protective measures have typically been weak across the region. Given this situation, why has so much focus been placed on HIV when other STIs are a significant risk in and of themselves, but are also a multiplier of HIV risk?

Further, there is some concern that a 'feminisation' of the Pacific HIV epidemic may be occurring.[44] This is because there are more confirmed cases of women with HIV in the Pacific than men and because during vaginal sex, women are biologically more susceptible to HIV than men.[45] However, it is possible that the data is skewed towards women because most HIV tests occur in antenatal clinics, and because women are more likely to seek testing than men. This complexity means it remains too early to know if Pacific Island women are at greater risk to HIV than men.

Ultimately, answering these and many other questions requires minimising under-reporting, and expanding VCCT and surveillance so that it reaches those groups international research suggests are most at risk of STIs, including HIV: people who engage in transactional sex, men who have sex with men, youth, servicemen/women, seafarers, and injecting drug users and their partners. When good surveillance reveals real risk, governments are able to prioritise public health initiatives and maximise their effectiveness – fighting the spread of HIV where it is high risk and fighting the spread of STIs so that HIV risk remains low, or turning attention to other SRHR issues.

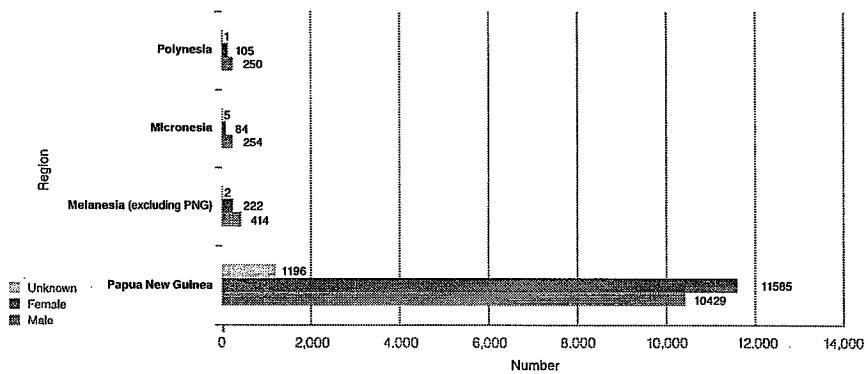
43 SPC (2008) 'Cumulative reported HIV, AIDS deaths: cases, incidence rates and gender, plus cases with missing details; All Pacific Island Countries and Territories to December 2008' http://www.spc.int/hiv/downloads/cumulative-reported-hiv-aids-and-aids-deaths/; visited on 21 May 2009

44 WHO and SPC (2009) 'Prevention and Control of HIV and AIDS and Other Sexually Transmitted Infections' Eighth Meeting of Ministers of Health for the Pacific Island Countries, PIC8/11 Rev. 1, Madang, Papua New Guinea

45 SPC (2008) 'Cumulative reported HIV, AIDS deaths: cases, incidence rates and gender, plus cases with missing details; All Pacific Island Countries and Territories to December 2008' http://www.spc.int/hiv/downloads/cumulative-reported-hiv-aids-and-aids-deaths/; visited on 21 May 2009

Cumulative reported HIV cases by sex and region

There may be more than 50,000 Papua New Guineans living with HIV.



Source: SPC (2008) 'Cumulative reported HIV, AIDS deaths: cases, incidence rates and gender, plus cases with missing details; All Pacific Island Countries and Territories to December 2008' http://www.spc.int/hiv/downloads/cumulative-reported-hiv-aids-and-aids-deaths/, visited on 21 May, 2009.

Chapter 4:
Family planning and contraception

Contraceptives are the cornerstone of family planning, allowing women to space their pregnancies, to choose the number of children they want and when to have them. Contraceptives also significantly reduce maternal mortality by preventing unintended pregnancies,[46] and condoms provide one of the only effective means for protecting against STIs, including HIV. While a wide variety of different contraceptives can be found across the Pacific region, evidence suggests many barriers still prevent their regular use.

Family planning must be given greater priority in PICT country development plans and policies. Globally, support for family planning has diminished and does not meet the demand for it.[47] While data on support and demand for family planning in the Pacific is often limited, it is thought this trend is also afflicting the region.[48] This is despite strong evidence showing that access to voluntary family planning can reduce maternal deaths by between 25 and 40 percent, and child deaths by as much as 20 percent.[49]

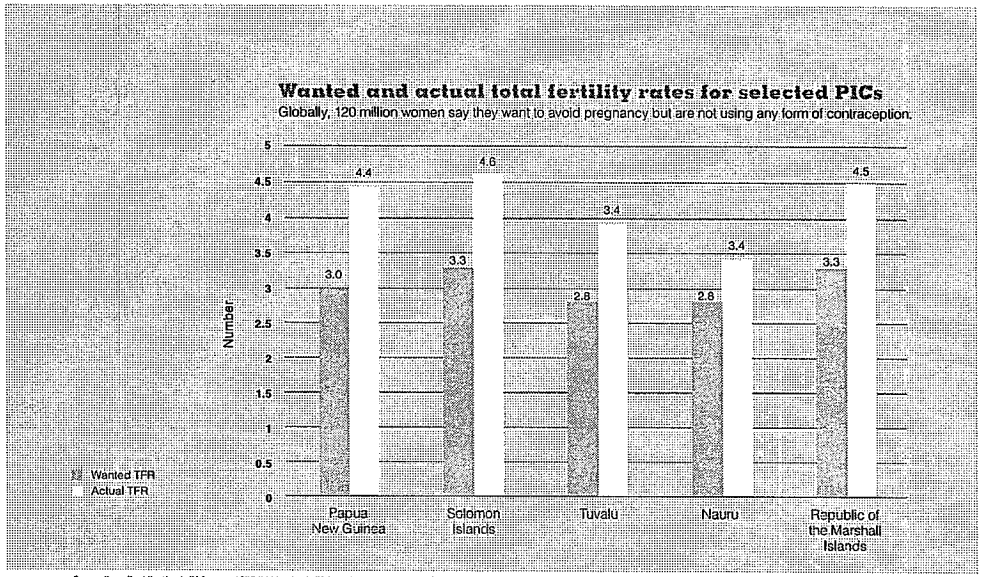
PICTs need to develop and implement better strategies for improved access to, and use of, contraceptives. Access to contraceptive information and services is severely lacking, particularly for youth.[50] For example, a 2004-2005 study of Samoan youth found that only 5.3 percent reported consistent use of condoms with their non-commercial partners in the last 12 months.[51] A 2008 study of Solomon Islands youth found that 38 percent reported the main reason they did not use a condom was because it was not easily available,[52] and a 2007 study of the Republic of the Marshall Islands found that only 16 percent of all 15 to 19 year old women surveyed reported ever using a modern form of contraception despite 37 percent being married or sexually active.[53] Further, a 2006 study of 10,353 women in PNG found that 75.9 percent were currently using no form of contraception at all.[54]

Strategies for improving contraceptive use must overcome Pacific socio-cultural taboos about sexuality. There are strong socio-cultural taboos about sexual activity across the Pacific and these often present a barrier to the use of contraceptives. Traditionally, sexual activity has been seen as a private matter not suitable for discussion in the public arena. While these beliefs have been somewhat softened by the growing necessity to discuss public health issues such as HIV, they remain sensitive. This means that sexuality and relationships education and information is not always well-disseminated through institutions such as schools, hospitals and clinics, or through family and friends. In turn, the lack of easily accessible, correct information may contribute to the spread of false information about contraceptives and what are safer sexual behaviours.[55]

Most PICT societies are deeply religious and this can also present a challenge to increasing knowledge of, access to, and use of, contraceptives. While many churches have recognised the importance of educating their members about public health issues such as STIs, including HIV, very few actively promote the use of contraceptives and almost none provide access to contraceptives.[56] Such conservative views often mean those who most need contraception and who are at most risk of STIs are also the most likely to be refused services – youth, unmarried women or men, men who have sex with men and people engaged in transactional sexual activity.

Family planning and gender equality go hand in hand. A lack of gender equality means Pacific Island women are not always able to negotiate the use of contraceptives. In the Pacific, power imbalances relating to gender roles can mean it is men who make the final decision about whether contraceptives will or will not be used. Women who refuse their partner sex on the grounds that contraceptives must be used, may be put at risk of violence, including rape. For example, recent studies in the Pacific have found that if women refuse sex, some men may feel justified in forcing sex.[57]

Conversely, the use of family planning can contribute to improving gender equality. Couples who jointly negotiate contraception use are more likely to communicate better, making decision-making more equal. Health professionals who encourage women to bring their partners to family planning clinics and involve men in discussions about contraceptive choice, can support more equal relationships between men and women. Furthermore, when women are able and supported to control their fertility they have greater freedom to engage in activities beyond child rearing, such as income-generation and politics.



Source: Republic of the Marshall Islands and SPC (2008) 'Marshall Islands Demographic and Health Survey 2007' SPC, Noumea; Tuvalu and SPC (2009) 'DRAFT - Tuvalu Demographic and Health Survey 2007' SPC, Noumea; Solomon Islands and SPC (2009) 'Solomon Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea; National Statistics Office PNG (2009) 'Papua New Guinea Demographic and Health Survey 2006' National Statistics Office, Port Moresby; Nauru and SPC (2009) 'Nauru Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea.

Improved access to a range of contraceptives will improve people's health and reduce maternal deaths.

46 WHO (2005) World Health Report 2005, WHO, Geneva, Switzerland

47 APA (2008) 'Intimate Relations: Sex, Lives and Poverty' Asia Pacific Alliance, Wellington, New Zealand

48 UNFPA (2006) 'Repositioning Family Planning in the Pacific Technical Series Paper No. 003/2006, pp. 1-2

49 World Bank (2009) 'World's progress on maternal health and family planning is insufficient' http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22241448~pagePK:64257043~piPK:437376~theSitePK:4607,00.html visited on 14 September 2009

50 WHO (2006) 'Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries' World Health Organization, Geneva, Switzerland, p. 26

51 WHO (2006) 'Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries' World Health Organization, Geneva, Switzerland, p. 75

52 Solomon Islands Ministry of Health and SPC (2008) 'Second Generation Surveillance of Antenatal Women and Youth Solomon Islands 2008 Secretariat of the Pacific Community, Noumea, New Caledonia, p. 30

53 Republic of the Marshall Islands and SPC (2008) 'Marshall Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia, p. 66

54 National Statistics Office PNG (2009) 'Papua New Guinea Demographic and Health Survey 2006' National Statistics Office, Port Moresby, p. 57

55 UNICEF (2005) 'The State of Pacific Youth 2005' UNICEF, Suva, Fiji, p. 8

56 World Council of Churches (2004) 'The Nadi Declaration: A Statement of the World Council of Churches on HIV/AIDS' Tanoa International Hotel, Nadi, Fiji, 29th March to 1st April, 2009 http://www.oikoumene.org/en/resources/documents/wcc-programmes/justice-diakonia-and-responsibility-for-creation/ehaia/declarations-and-policy-statements-on-hivaids-by-churches-and-faith-based-organisations-2001-2005/01-04-04-nadi-declaration-by-wcc-pacific-member-churches.html visited on 07 July 2009

57 Solomon Islands and SPC (2009) 'Solomon Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia; and Tuvalu and SPC (2009) 'DRAFT - Tuvalu Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia; and; Republic of the Marshall Islands and SPC (2008) 'Marshall Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia

FOCUS 4:

Reproductive health supplies

Across the Pacific, an increased focus has been placed on improving the region's reproductive health supply systems. Recently the endorsement of the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities signalled high level commitment. This must now be translated into action to overcome a range of barriers that continue to prevent individuals from having full access to basic sexual and reproductive health supplies, such as contraceptives and birthing kits.

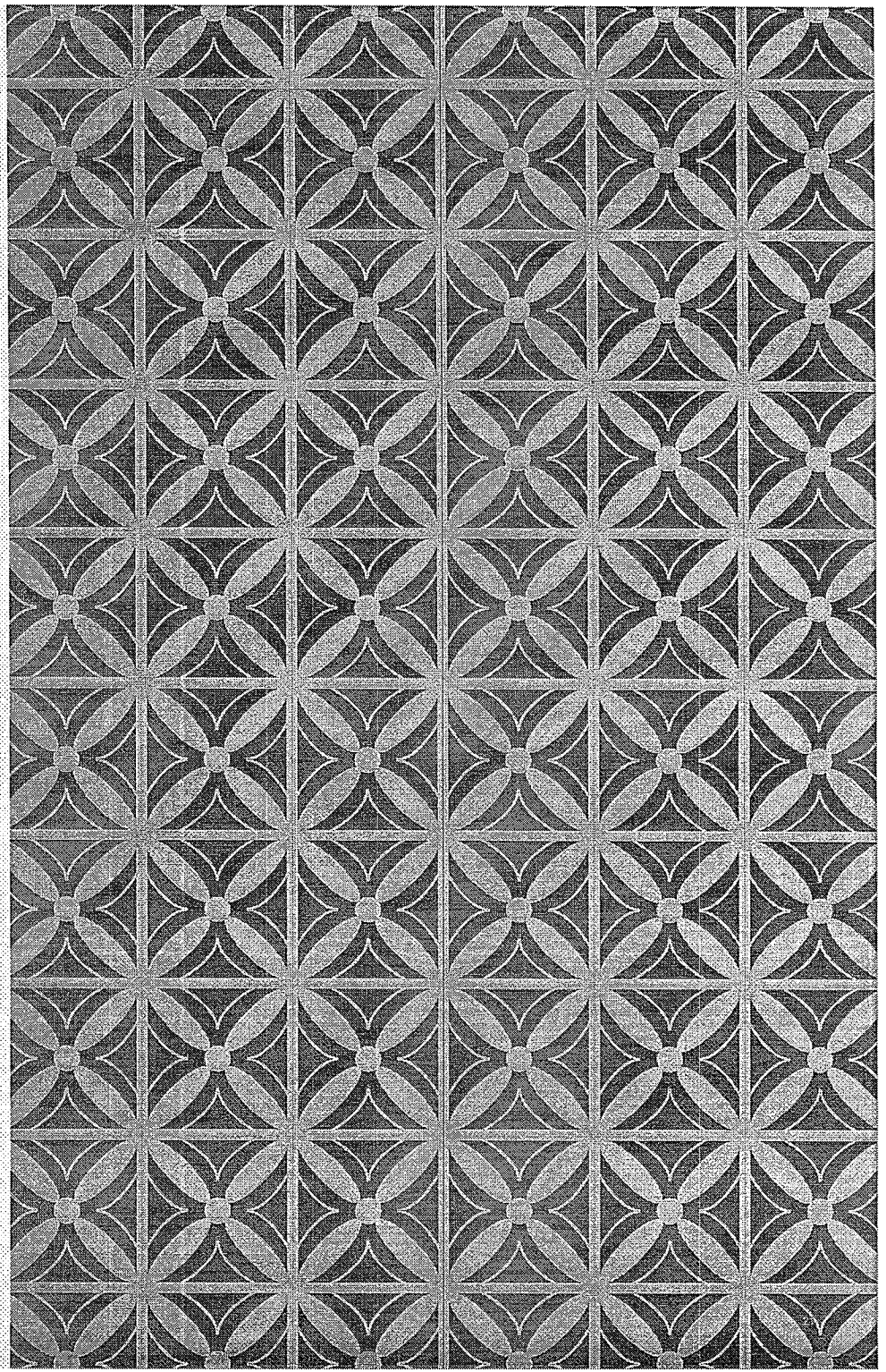
The reproductive health supply chain needs greater streamlining. The United Nations Population Fund (UNFPA) leads reproductive health supplies management. However, many other organisations, NGOs and private sector agencies also supply sexual and reproductive health supplies to PICTs – sometimes separately, or in conjunction with, UNFPA or Ministries of Health. The complex nature of this supply chain can pose management challenges for those disbursing and receiving supplies.

Staff require ongoing support, training and resources. For example, the appropriate forecasting, ordering and distribution of supplies requires experienced and trained staff. Health workers must understand changes in knowledge and attitudes in the population that might affect demand, collect accurate statistics on demand, and communicate appropriate orders to the Ministry of Health. This can be a challenging task for outer islands and rural areas where equipment and trained staff are often in short supply.

Storage infrastructure and practices must be improved. A lack of adequate infrastructure, and knowledge about how to properly store supplies, can have negative impacts. For example, storage facilities may have intermittent or no power, meaning supplies are damaged by an inability to control air temperature. Further, some facilities lack adequate storage which puts supplies at risk of being stolen, damaged or misplaced.

Communication and transport must be improved. The geographical makeup of the region presents serious communication and transport barriers to ensuring sexual and reproductive health supplies are reliable and consistent. For example, telephone, internet, maritime and aviation services, as well as road infrastructure, are often limited both on main and outer islands. This makes the distribution of supplies challenging and often reliant on expensive personnel visits. In some instances it can take months for outlets to be re-supplied while in others, supplies arrive without the intended recipient's knowledge. The time delays involved in moving supplies over great distances also increases the risk of on-route damage or expiration, increasing costs.

Regional strategies for improvement must be fully implemented. Since 2005, when the Pacific Policy Framework was agreed upon, momentum on improving reproductive health supplies has grown. It is vital that these regional agreements are implemented in all areas of all countries. Action on the implementation of the Pacific Plan objective to build regional pharmaceutical procurement systems will also assist in improving access to sexual and reproductive health supplies.



Chapter 5:
Teenage pregnancy

Teenage pregnancy can hinder a young woman's physical development and her ability to gain a full education. It is the world's leading cause of death in 15-19 year old women.[58] Teenage pregnancy also puts young mothers and their children at risk of poor health by increasing the likelihood of complications during pregnancy and childbirth, including unsafe abortion.[59] In the Pacific, conservative social and cultural practices often mean teenage mothers are at risk of stigmatisation and abuse, which deters many from seeking timely and necessary healthcare – particularly antenatal care.[60]

Most young women would prefer to delay pregnancy but many are unable to put this choice into action.

58 World Population Foundation (2009) 'Facts' http://www.wpf.org/reproductive_rights_article/facts, visited on 07 October 2009

59 WHO (2004) 'Maternal Mortality Update 2004: Delivering into good hands' WHO, Geneva, Switzerland

60 UNICEF (2008) 'The State of Pacific Children 2008' UNICEF, Suva Fiji, p. 24

61 Republic of the Marshall Islands and SPC (2008) 'Marshall Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia, and: Nauru and SPC (2009) 'Nauru Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia

62 Statistics New Zealand (2009) 'Births and Deaths: December 2008 quarter' http://www.stats.govt.nz/store/2009/02/births-and-deaths-dec05-qtr-hotp.htm?page=para002Master, visited on 29 July 2009

63 UNICEF (2009) 'Child poverty in perspective: An overview of child well-being in rich countries' http://www.unicef-irc.org/publications/pdf/rc7_eng.pdf, visited on 22 October 2009, p. 32

64 SPC and UNICEF (2004) 'Teenage Pregnancy in Tonga' http://pacific.unfpa.org/pubs/Teenage%20pregnancies%20in%20Tonga.pdf, visited on 11 June 2009

65 UNFPA (2004) 'Teenage Pregnancy in Tonga' http://pacific.unfpa.org/pubs/Teenage%20pregnancies%20in%20Tonga.pdf, visited on 11 June 2009, pp. 39-40 and 69

66 UNICEF (2005) 'The State of Pacific Youth 2005' UNICEF, Suva, Fiji

Teenage pregnancy requires urgent attention in a majority of PICTs. Available data indicates that PICTs on the whole have high rates of adolescent fertility but that these rates can vary widely between countries. For example, according to the most recently available data, the rate of births per 1000 women between the ages of 15 and 19 in the Marshall Islands was 138 while it was 69 in Nauru.[61] Comparatively, it was 33 for New Zealand in 2008.[62] (New Zealand has one of the highest adolescent fertility rates of countries in the Organisation for Economic Co-operation and Development (OECD).)[63]

Youth need to be provided with better education about the serious health risks associated with teenage pregnancy. A young woman's body is often not physically ready to endure a pregnancy. Risks to both a mother and child's health can include obstructed labour, death, a higher chance of delivering a pre term and/or low weight infant, stillbirths and infant mortality. Many young Pacific Island women are not provided with the information and services they need to understand these risks.[64]

Most young mothers would rather postpone childbirth, but need appropriate information and services to help them to do this. In 2003, a study of teenage pregnancies in Tonga found that most were unintentional. Pregnancy had occurred because youth were unprepared or unable to deal with difficult circumstances such as coercion by older men, little knowledge about how pregnancy can occur, and either little knowledge about where to obtain contraceptives and how to use them, or embarrassment in obtaining and using them. Alcohol and peer pressure were also found to be factors that led to early unprotected sex.[65]

Adolescence must be recognised as a time of transition for youth and that the onset of sexual activity is a normal part of this. However, young people are not always well prepared for the consequences that can result from sexual activity, such as unintended pregnancy. In the Pacific, cultural taboos around sexual activity and the dominant expectation that it only occurs between married partners mean Pacific youth who have premarital sex, and particularly those young women who become unintentionally pregnant, are at risk of social and cultural stigmatisation.[66] A Tongan study of teenage pregnancies found that for a number of the girls interviewed, the stigma related to their pregnancy had led them to consider, or attempt, abortion and/or suicide. It also found that most girls were exposed to intense expressions of shame by family members, which often resulted in pregnant girls hiding their pregnancies and therefore receiving less or no access to antenatal care.[67]

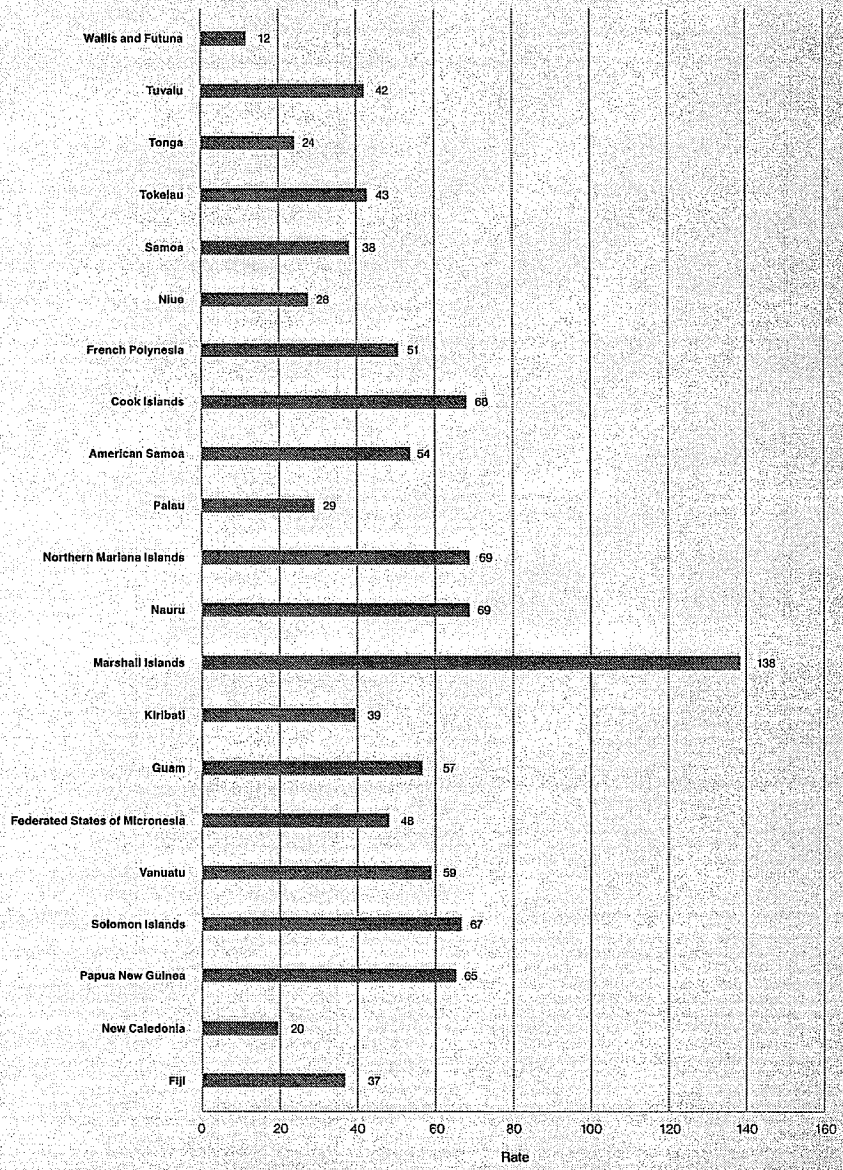
67 SPC and UNICEF (2004) 'Teenage Pregnancy in Tonga' http://pacific.unfpa.org/pubs/Teenage%20pregnancies%20in%20Tonga.pdf, visited on 11 June 2009, pp. 39-40 and 69

68 UNICEF (2005) 'The State of Pacific Youth 2005' UNICEF, Suva, Fiji

Young teenage parents need a range of support services and information to enable them to raise their children, continue their education and support their new family. Young unmarried women who become pregnant may be subjected to abuse and or ostracism from family members. If a young woman has support from her family it is likely that she will still be expected to carry out the traditional roles of women – looking after the household and raising children. These responsibilities may be prioritised over a new mother's opportunity to continue on with her education. Similarly, the birth of a child brings extra costs and young parents may be forced to spend time and money saved for educational purposes on caring for their child.[68] In worst case scenarios, a young women who becomes unintentionally pregnant may turn to sexwork as the only means available to support herself and her child – a practice that increases her risk to further unintended pregnancy, contracting an STI and experiencing sexual violence. If a father remains involved, he too will face a variety of challenging pressures that he needs support with. Therefore, it is important that teenage fathers and mothers receive support that includes parenting skills, education and childcare services, and comprehensive health information and services such as family planning.

Teenage Fertility Rate (most recent year available)

Teenage girls who are not physically mature are at greater risk of complications during pregnancy.



Source: Republic of the Marshall Islands and SPC (2009) 'Marshall Islands Demographic and Health Survey 2007' SPC, Noumea; Tuvalu and SPC (2009) 'DRAFT - Tuvalu Demographic and Health Survey 2007' SPC, Noumea; Solomon Islands and SPC (2009) 'Solomon Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea; National Statistics Office FSM (2009) 'Papua New Guinea Demographic and Health Survey 2006' National Statistics Office, Port Moresby; Nauru and SPC (2009) 'Nauru Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea; SPC (2009) 'Pacific Island Populations – Estimates and projections of demographic indicators for selected years' Secretariat of the Pacific Community, Noumea, New Caledonia.

FOCUS 5:
Pacific youth

Young people are the future of the Pacific. Of a total population of approximately 9.5 million, 56 percent are believed to be 24 years of age or less, and 37 percent are believed to be 14 years of age or less. Further, the region's median age is only 21 years.[69] The implications of so many young and fertile people are immense, and are widely felt by PICTs across the region.

There are high STI and teenage pregnancy rates amongst PICT youth, which is evidence that young people are not being provided with the quality SRHR information and services they need to navigate their exploration of sexuality and sexual activity as healthily as they can. Surveys highlight that many youth engage in a range of risky sexual behaviours. For example, condom use is often low, many youth have multiple sexual partners, buying sex and exchanging sex for goods often occurs, and sexual coercion, alcohol and poor mental health often also play a role in youth engaging in early sexual activity.[70] Even when information and services are provided, youth often face significant barriers in accessing them. In particular, the dominance of conservative views about sexuality, sexual activity and reproductive health means many Pacific Island peoples are uncomfortable with providing young people with sexuality and relationships education, and appropriate sexual and reproductive health services. This deters many young people from visiting health clinics which will provide services to youth and puts those who do attend at risk of being stigmatised. The lack of confidentiality that often occurs in very small tight-knit communities can greatly compound these issues, especially if confidentiality is not adhered to by clinic staff.

To ensure that young people can always access good sexual and reproductive health information and services, several steps must be taken.

- All people must be educated so they understand that the provision of sexual and reproductive health information and services makes young people more safe.
- Parents need education and support about how to talk to their children about sexuality and sexual activity.
- The number of SRHR providers must be increased so that services are more accessible.
- SRHR must be better integrated into the wider health care system so that they are regularly provided as a normal part of healthcare and therefore less susceptible to stigma.
- Young people must be empowered and supported to advocate for greater youth focused SRHR services.[71]

69 SPC (2009) 'Pacific Island Populations – Estimates and projections of demographic indicators for selected years' SPC, Noumea, New Caledonia

70 SPC (2007) 'An Integrated Picture: HIV and Vulnerability in the Pacific' http://www.spc.int/hivimages/stories/review%20tick%20and%20vulnerability%20integrated%20picture%20adjusted1.pdf, visited on the 19 August 2009, and; UNICEF (2005) 'The State of Pacific Youth 2005' UNICEF, Suva, Fiji

71 UNICEF (2008) 'The State of Pacific Children 2008' UNICEF, Suva Fiji, pp. 28-29

Chapter 6:
Antenatal care

For many Pacific Island women, pregnancy and childbirth continue to involve unnecessary risks. These can include long term injury from complications and in the worst cases, infant and maternal deaths. Ensuring that all Pacific Island women can easily and regularly access the recommended minimum of at least four quality antenatal care visits is one of the most effective ways to mitigate these risks.

All Pacific Island women must be able to access the recommended four or more antenatal care visits. Unfortunately, while antenatal care data is often well collected in some PICTs it is often not recorded in a manner consistent with the internationally recognised indicator of access to four or more antenatal care visits. This has forced a reliance on the more widely reported-on indicator of access to at least one antenatal care visit. Available data suggests that this indicator masks the true level of access to antenatal care in some PICTs. For example, WHO data shows that in most PICTs over 70 percent of women have access to at least one antenatal care visit.[72] Conversely, data from four of the five Demographic and Health Surveys (DHS) conducted in the Pacific shows that less then 70 percent of women have access to four or more antenatal care visits. In PNG it is as low as 55 percent and in Nauru it is as low as 40 percent.[73] It is therefore likely that while many Pacific Island women can access at least one antenatal care visit, in some PICTs access to four or more antenatal care visits could likely be significantly improved.

The quality of antenatal care services must be improved, and services must be expanded to outer islands and rural communities across the Pacific. Information on the quality of the antenatal care provided across the region is also limited. However, available data suggests that it is likely that in some instances even women who regularly access antenatal care may still not be receiving fully appropriate care. For example, two DHS found that while over two thirds of women from both the Solomon Islands and Nauru were weighed, had their blood pressure checked and a urine test, only 55 percent of Solomon Islands women and only 40 percent of Nauruan women were given information about how to recognise signs of problems during pregnancy.[74]

It is also clear that access to services is unequal. For example, services are significantly more accessible to those who live in capital cities and urban environments where well staffed hospitals and clinics are more likely to be located, and where midwives, nurses and other medical staff can more easily reach pregnant women. Alternatively, pregnant women who live in rural communities and who are isolated by ocean, mountains and forest are much less likely to be able to access regular antenatal care. Similarly, fewer medical facilities per capita and limited transport infrastructure are also significant factors that prevent women accessing antenatal care.

Good antenatal care can encourage and empower people to engage more regularly with a broad spectrum of healthcare. When women and their partners access good antenatal care they are not only screened for and educated about pregnancy-related complications, but are also exposed to a range of health services and information that can be shared with family members. These can include information on family planning and contraceptives, parenting skills, nutritional advice, and education about how to protect family members and themselves from illnesses such as malaria, dengue fever, tuberculosis, and STIs including HIV. Positive experiences at antenatal care visits promote a family's further engagement with clinics and hospitals.

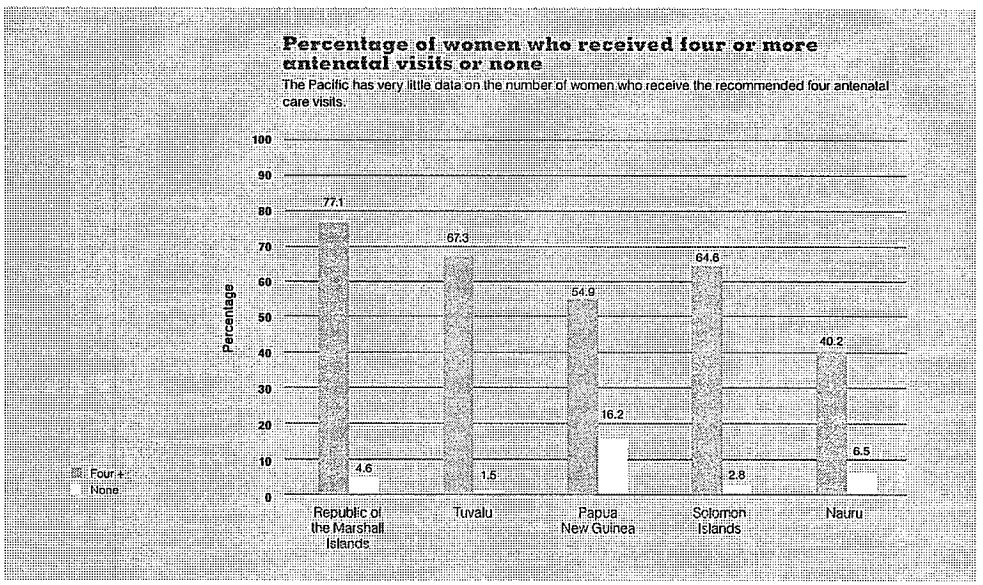
72 WHO (2009) 'Country and Health Information Profiles' http://www.wpro.who.int/NR/rdonlyres/9655EF2C-4917-458B-B9DF-BAA306EE18CD/0/42StatisticalTables08.pdf, visited on 14 July 2009

73 Tuvalu and SPC (2009) 'DRAFT - Tuvalu Demographic and Health Survey 2007' SPC, Noumea, New Caledonia; Solomon Islands and SPC (2009) 'Solomon Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia, National Statistics Office PNG (2009) 'Papua New Guinea Demographic and Health Survey 2006' National Statistics Office, Port Moresby; Republic of the Marshall Islands and SPC (2008) 'Marshall Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia, and; Nauru and SPC (2009) 'Nauru Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia

74 Nauru and SPC (2009) 'Nauru Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia, and; Solomon Islands and SPC (2009) 'Solomon Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia

Percentage of women who received four or more antenatal visits or none

The Pacific has very little data on the number of women who receive the recommended four antenatal care visits.



Source: Republic of the Marshall Islands and SPC (2008) 'Marshall Islands Demographic and Health Survey 2007' SPC, Noumea; Tuvalu and SPC (2009) 'DRAFT - Tuvalu Demographic and Health Survey 2007' SPC, Noumea; Solomon Islands and SPC (2009) 'Solomon Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea. National Statistics Office PNG (2009) 'Papua New Guinea Demographic and Health Survey 2006' National Statistics Office, Port Moresby; Nauru and SPC (2009) 'Nauru Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea.

FOCUS 6:
Including men and boys

The level of inequality between Pacific Island genders, and associated attitudes about how femininity and masculinity should be expressed, have a wide range of consequences for the sexual and reproductive health of Pacific Island women. For example, both have been linked to the spread of STIs, violence against women, levels of contraceptive use and the willingness of individuals to use health services. At a broader level, gender stereotypes and inequality both also contribute to the continuation of other practices that discriminate against women – for example, the limiting of women's access to education and employment – and towards those subjects commonly seen as 'women's issues', such as sexual and reproductive health.[75]

In several PICs, studies clearly indicate that there is a high level of discrimination and violence committed by men against women.[76] While such attitudes and behaviours are never justifiable, it is important that SRHR advocates recognise that to change discriminatory attitudes and behaviours towards women and sexual and reproductive health, men must be seen as an important part of the solution.[77] Men and boys represent half of the region's population, are a diverse group of people, and an integral part of all elements of Pacific societies, economies and cultures. Men cannot be ignored, stigmatised or excluded, and treating them as a problem risks these outcomes. Further, treating men and boys as a problem avoids recognising that many men and particularly boys, are also the victims of discrimination and violence, including sexual violence. In recent years, local NGOs and development organisations have increased education for Pacific Island men and boys on sexual and reproductive health and rights. Still, there are thousands of Pacific Island men and boys who have very limited or inaccurate knowledge of sexual and reproductive health and rights.

In gender unequal societies, men typically hold power. To effect change, men must be involved in and educated about SRHR. Using male advocates is one effective method for achieving this as they are often more likely to be listened to by other men. Research shows that educating men and boys in SRHR can result in: less use of physical, sexual and mental violence; increased contraceptive use; increased communication with partners; more equitable treatment of children; decreased rates of STIs; and an increased willingness to seek help about sexual and reproductive health.[78] Encouraging men to accompany their partners to antenatal care visits can also promote opportunities to provide men with further SRHR information and services, and give them greater interaction with health systems. Importantly, resources for programmes that work with men must not be provided at the expense of resources for programmes for women. Both approaches are vital in order to achieve success.

75 WHO (2007) 'Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions' World Health Organization, Geneva, Switzerland

76 SPC, UNFPA and Government of Samoa (2003) 'The Samoa Family Health and Safety Study' SPC, Noumea, New Caledonia, and; Republic of the Marshall Islands and SPC (2006) 'Marshall Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia, and; Tuvalu and SPC (2009) 'DRAFT - Tuvalu Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia

77 WHO (2007) 'Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions' World Health Organization, Geneva, Switzerland

78 Ibid.

Geography and a lack of quality transport can contribute significantly to preventing women from accessing skilled attendance at birth.

Chapter 7:
Skilled attendance at birth and emergency obstetric care

The safety of childbirth can be significantly increased by the presence of a skilled birth attendant and easy, rapid access to emergency obstetric care when needed. For this reason, increasing skilled birth attendance rates and improving obstetric facilities are highly effective interventions for preventing and lowering maternal death and injury, and neonatal death.

All PICTs need to agree on and use a common definition of skilled birth attendant at all levels of the health system. Skilled birth attendance rates in the Pacific are often above 90 percent, but these can be misleading as incorrect recording of skilled attendance occurs. For example, a 2005 family planning and emergency obstetric care study in Kiribati found that the reported 93 percent skilled birth attendance rate was likely closer to 63 percent. In part this was because many deliveries were carried out by 'informally' trained health workers who were misidentified as skilled birth attendants.[79]

The WHO defines a skilled birth attendant as "an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns".[80]

Many Pacific Island women continue to have no access to birthing assistance at all, or use relatives or Traditional Birth Attendants (TBAs). While many TBAs have received midwifery training, records do not always distinguish between a trained TBA and a non-trained TBA. In Samoa, which has some of the best obstetric facilities in the Pacific and a 90 percent skilled birth attendance rate, around eight percent of births are still attended by a TBA.[81] In contrast, around 29 percent of births in Papua New Guinea are assisted only by a female relative and up to 50 percent of all births may occur at home.[82]

Access to emergency obstetric facilities across the Pacific can be improved, particularly for women living in rural communities or on outer islands. Family planning and emergency obstetric care studies carried out in seven Pacific Island countries between 2005 and 2008 found variation in the availability of staff trained in obstetric care, and the facilities that could provide basic and comprehensive emergency obstetric care.[83] For example, the Federated States of Micronesia, Samoa, Vanuatu and the Solomon Islands met WHO criteria for the number of facilities needed. However, given the geographic challenges, large populations (significant portions of which are isolated) and transport challenges, women from the Solomon Islands and Vanuatu would benefit more if comprehensive emergency obstetric care facilities were spread more widely across these countries. Other countries such as Tonga and Kiribati did not have enough facilities providing comprehensive or even basic emergency obstetric care.

79 UNFPA (2008) 'Family Planning and Emergency Obstetric Care Facility Assessment in Seven Pacific Countries' Pacific Sub-regional Office, Suva, Fiji

80 WHO (2009) 'Skilled Birth Attendants' http://www.who.int/making_pregnancy_safer/topics/skilled_birth/en/index.html, visited on 15 July 2009

81 UNFPA (2008) 'Family Planning and Emergency Obstetric Care Facility Assessment in Seven Pacific Countries' Pacific Sub-regional Office, Suva, Fiji

82 National Statistics Office PNG (2009) 'Papua New Guinea Demographic and Health Survey 2006' National Statistics Office, Port Moresby

83 UNFPA (2008) 'Family Planning and Emergency Obstetric Care Facility Assessment in Seven Pacific Countries' United Nations Population Fund Pacific Sub-regional Office, Suva, Fiji

FOCUS 7:
Violence against women and girls

Violence against women and girls impacts on all aspects of their lives, including their sexual and reproductive health. At worst, violence can lead to the severe injury or death of women and girls, and miscarriage in pregnant women. Other impacts can include the contraction of STIs, including HIV, and unwanted pregnancy. Violence also leads to poor mental health and withdrawal, contributing to a feeling of isolation, loss of educational and economic opportunities, and a further inability to negotiate partner relations, including sex.[84]

In the Pacific, all forms of violence against women and girls tend to be under-reported. In large part this is because cultural taboos and notions of shame often prevent violence from being discussed openly – particularly in cases of extreme sexual violation such as rape and incest.[85] As such, it remains a highly sensitive subject and one that many PICT governments have yet to effectively address.

Nonetheless, it is widely known that violence against women and girls is very common across the region. Recent studies show that some PICTs have rates of violence against women that are amongst the worst of the world's national violence studies.[86] The region's low level of gender equality,[87] and PICT's often weak or discriminatory legislative frameworks that frequently do not enforce human rights, have been shown to be two major contributing factors to these high levels of violence against women and girls.[88]

In 2009, Pacific Island Leaders at the 40th Pacific Island Forum meeting in Cairns formally recognised the problem of sexual and gender-based violence, and announced that they were committed to addressing it at a regional level. SRHR advocates must hold these leaders accountable to this commitment.[89]

VIOLENCE AGAINST WOMEN STATISTICS FROM SELECTED PICTS

	Republic of the Marshall Islands	Samoa[a]	Solomon Islands	Tuvalu[b]	Kiribati
Experience of physical violence (ever)	28.3%	37.6%	46%	37.2%	60%
Experience of sexual violence (ever)	19.5%	19.6%	55%	21.2%	46%
Experience of physical and/or sexual violence (ever)		46.4%	64%		68%
Experience of violence during pregnancy	7%	23.8% (who had ever experienced physical abuse)	11% (6% said beating got worse during pregnancy)	7.8%	23% (10% said beating got worse during pregnancy)
Experience of force at sexual initiation	8%		38% (force or coercion)	13.4%	20% (force or coercion)

Source: (a) Registrar of the Marshall Islands and SPC (2009) 'Marshall Islands Demographic and Health Survey 2007' SPC, Noumea; (b) SPC (2007) 'Samoa Family Health and Safety Study' SPC, Noumea; (c) SPC (2009) 'DRAFT - Solomon Islands Family Health and Safety Study' SPC, Noumea; (d) Tuvalu and SPC (2009) 'DRAFT - Tuvalu Demographic and Health Survey 2007' SPC, Noumea; (e) SPC (2009) 'DRAFT - Kiribati Family Health and Safety Study' SPC, Noumea.

84 SPC, UNFPA and Government of Samoa (2003) 'The Samoa Family Health and Safety Study' SPC, Noumea, New Caledonia, pp. 2-3

85 Ibid. pp. 9-14

86 Amnesty International (2009) 'Pacific leaders must address high levels of violence against women' Media release, 06, August, 2009

87 SPC, UNFPA and Government of Samoa (2003) 'The Samoa Family Health and Safety Study' SPC, Noumea, New Caledonia, pp. 2-3, and; Keating A. (2007) 'Gender in Pacific Island States: Literature Review and Annotated Bibliography' http://www.sivanda.org/static/Keating_pacificlitm?am=0710andtag=CF, visited on 13 July 2009

88 Ali S. (2006) 'Violence against the girl child in the Pacific Island region' UNDAW and UNICEF, EDG/DVGC/2006/EP.14, Florence, Italy, and; Amnesty International (2009) 'Pacific leaders must address high levels of violence against women' Media release, 06 August 2009

89 Pacific Island Forum Secretariat (2009) 'Final Communique of 40th Pacific Island Forum, Cairns' http://www.forumsec.org.fj/pages.cfm/newsroom/press-statements/2009/final-communique-of-40th-pacific-islands-forum-cairns.html, visited on 12 August 2009

Chapter 8:
Unsafe abortion

Globally, 13 percent of all maternal mortality is the result of unsafe abortion.[90] Anecdotal evidence of 'back street' abortions in PICTs suggests unsafe abortion may be a significant maternal health problem in the Pacific too.[91] However, there is a severe paucity of reliable data on abortion in the Pacific. This is because most PICTs have outlawed abortion, so national statistics are limited whilst fear of legal action, religious beliefs and social stigma predominantly prevent Pacific Island people from openly discussing abortion. These limitations have prevented any in-depth regional analysis of the issue.

90 IPPF (2006) 'Death and Denial: Unsafe Abortion and Poverty' IPPF, London, UK, p. 4

91 Family Planning International and Asia Pacific Alliance (2008) 'Reproductive Health Supplies in the Pacific' Family Planning International, Wellington, NZ. Appendix 3

92 WHO in: IPPF (2006) 'Death and Denial Unsafe Abortion and Poverty' IPPF, London, UK, p. 4

93 PAI (2007) 'A Measure of Survival: Calculating Women's Sexual and Reproductive Risk' Population Action International, Washington DC, USA, pp. 24-25

94 IPPF (2006) 'Death and Denial: Unsafe Abortion and Poverty' IPPF, London, UK, pp. 3, 13

Unsafe abortion can have serious reproductive health consequences for women. Unsafe abortions are those conducted by "persons lacking the necessary skills or in an environment lacking the minimal medical standards or both".[92] Unsafe abortions or attempted abortions can cause women to die or become very sick from severe bleeding, internal infection, tearing of the uterus and septicaemia. Unsafe abortion can also cause infertility, chronic infections and increases the future risk of spontaneous abortions, ectopic pregnancy and premature delivery. A child born after an attempted unsafe abortion is also more likely to suffer from mental or physical disabilities.[93]

Making abortion safe and legal promotes the health of women and saves their lives. There are many reasons why a woman may make the difficult decision to have an abortion, regardless of its legal status. These include the stigma associated with being a young or unmarried pregnant woman, not having the financial resources to look after a child, already having many children, the fear of losing educational opportunities, the fear of losing employment and of being a single parent, or having become pregnant through rape or incest. Extensive research and experience show that laws do not stop abortion, and that often those countries with the most restrictive legislation have the highest rates of abortion.[94] Most importantly, it is countries with restrictive legislation where most women suffer injury and death through unsafe abortion.

People's religious and cultural beliefs must be respected but cannot be used as a justification for women dying or experiencing injury. Pacific societies, communities and families are often strongly influenced by conservative religious beliefs. Most therefore, do not condone abortion. Due to the legal, social and cultural restrictions, some women may obtain unsafe abortions and may not seek necessary medical help for any resulting complications. Alternatively, some Pacific cultures use traditional methods for inducing abortion – these often involve ingesting traditional medicines or undertaking extraordinary physical labour. Despite these practices being traditional, they can have serious health risks that may not be known or understood by those who both use and prescribe them.

More liberal laws on abortion must be fully implemented so that women can benefit from their provisions. Abortion laws vary across the Pacific though most are highly restrictive. For example, in Tonga, abortion is absolutely prohibited. Conversely, in Fiji the law is more liberal, allowing the procedure when it is deemed necessary to preserve both the physical and mental health of a woman, and when certain socio-economic factors are considered. Importantly, more liberal laws do not guarantee that the law will be fully implemented, that women who receive an abortion will be free of stigma, that abortion facilities will be well resourced or that the individual(s) performing the procedure will be well trained. This is particularly the case in rural and outlying areas where infrastructure is typically worse and it can be difficult to attract trained professionals.[95]

95 Imrana P. (2009) 'Gender Equity in Justice Systems of the Pacific Island Countries and Territories: Implications for Human Development' Technical background paper for the Asia-Pacific Human Development Report on Gender, 'Addressing Unequal Power and Voice', Fiji

96 IPPF (2006) 'Death and Denial: Unsafe Abortion and Poverty' IPPF, London, UK, pp. 1-2, 6

97 USAID (2001) 'Pop Briefs: Family Planning Prevents Abortion' Centre for Population Health and Nutrition USAID, Washington DC, USA

98 IPPF (2006) 'Death and Denial Unsafe Abortion and Poverty' IPPF, London, UK, pp. 1-2, and, PAI (2007) 'A Measure of Survival: Calculating Women's Sexual and Reproductive Risk' Population Action International, Washington DC, USA, pp. 24-25

Improving access to family planning and safe post-abortion care is critical to saving women's lives. Of the estimated 211 million annual pregnancies globally, 87 million will be unintentional – the leading cause of abortion.[96] The Pacific's level of poverty, high rates of risky sexual behaviour, violence against women and limited access to contraceptives mean Pacific Island women are at an elevated risk of unintended pregnancies. Improving Pacific Island women's access to family planning is one of the most effective means to reducing the number of unintended pregnancies and enabling women to choose when they have children.[97] Similarly, regardless of abortion's legal status, the provision of safe post-abortion care is the only way to ensure that unsafe abortions do not continue to lead to the unnecessary death of women.[98]

Globally, as much as 13 percent of maternal mortality is attributable to unsafe abortion, yet in the Pacific there is no reliable data on abortion.

FOCUS 8:
Pacific Island abortion research is urgently needed

Globally, evidence shows that unsafe abortion is a significant contributor to maternal mortality. Anecdotal reports suggest this correlation also exists in the Pacific. However, there is no data to substantiate these reports and the Pacific has high rates of adolescent fertility, suggesting that childbirth may be far more common than abortion. It is not known whether this is by choice or as a result of social pressure and legal restrictions on abortion.

Without accurate data on unsafe abortion, Pacific policy makers, health professionals and development organisations working to improve maternal health may be overlooking a major contributing factor to poor maternal health and death.

Chapter 9:
Child and maternal mortality

The majority of Pacific maternal and child mortality could be prevented through improved access to family planning, antenatal care, and emergency obstetric care. Yet these remain varied across the region and extremely weak in some PICTs. The result is that while some PICTs have successfully reduced mortality trends, greater reductions are urgently needed in others or they will likely fall short of meeting the Millennium Development Goal targets for reducing maternal mortality ratios and under five child mortality rates.[99]

Across the Pacific, approximately five women die a day due to complications of pregnancy and childbirth.[100] Most maternal deaths are linked to five direct causes. These are postpartum haemorrhage, pre-eclampsia, obstructed labour, puerperal sepsis and complications resulting from unsafe abortion. A range of indirect factors contribute to this, including the region's high rates of fertility as this increases a woman's cumulative lifetime risk to complications during pregnancy and childbirth.[101]

Greater work is needed to ensure that maternal deaths are reduced across the whole of the Pacific. Some countries such as Tokelau, Samoa and the Cook Islands report very low numbers of maternal deaths, if any, even over many years. However, others such as Papua New Guinea, the Solomon Islands, Kiribati and the Federated States of Micronesia have reported very high numbers of maternal deaths. In some instances, significant under-reporting of deaths likely means that figures may actually be higher.

Improving a pregnant woman's health and chances of survival, will save the lives of infants and children.[102] Most child deaths occur within 28 days of birth and are often the result of a woman's health being poor during pregnancy or following birth. Thus, a mother's health is critical to her child's survival.[103] In the Pacific, some of the conditions which commonly cause child death are pneumonia, diarrhoea, malnutrition, low birth weight, malaria and dengue fever.[104] All of these illnesses are preventable, particularly when women can use contraception to space their births, are well nourished and can get quality antenatal care, including education on infant care.

More appropriate and accurate ways of measuring maternal death need to be developed for PICTs and other small countries. In part this is because under-reporting of maternal deaths is common in developing countries. This is usually the result of authorities not being made aware of a death or incorrectly identifying a maternal death. However, in the Pacific, the standard MMR formula – the number of maternal deaths divided by the number of live births in a given time, multiplied by 100,000 – can lead to deceptively high MMRs in the many PICTs that have populations of around or under 100,000 people, and where the numbers of both deaths and births are very small. For example, if recent figures are used for Tuvalu, a country of approximately 1100 people, it would receive an MMR of around 500 which misleadingly puts it on a par with sub-Saharan African countries.[105] While there is currently no consensus on a single solution for overcoming this challenge, some development organisations and PICTs

99 Parke W. (2009) 'Achieving Results For Children' Presentation at the Institute of Policy Studies Symposium on Eliminating World Poverty. Wellington, New Zealand, 20-21, March, 2009, http://ips.ac.nz/events/downloads/2009/Will%20Parke%20MDGs%20Symposium%20Presentation.pdf, visited on 03 July 2009

100 PSRH (2009) 'Supporting Maternal Health in the Pacific: A Submission to the NZ Parliamentary Group on Population and Development (NZPPD)' Pacific Society for Reproductive Health and the Royal Australian and New Zealand College of Obstetricians and Gynecologists, 21 September 2009, Wellington, New Zealand, p.2

101 Robertson A. S. (2007) 'Current Status of Sexual and Reproductive Health: Prospects for Achieving the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals in the Pacific' Asia-Pacific Population Journal, Vol 22, Number 3, December 2007, p. 35

102 Ibid.

103 UNICEF (2008) 'The State of the World's Children 2009' UN, New York, USA, p. 2

104 UNICEF (2008) 'Child mortality rates a continuing challenge for Pacific States' Press Release, UNICEF, Suva, 26, August, 2008, http://www.unicef.org/pacificislands/media_9440.html visited on 03 July 2009 and; UNICEF (2008) 'The State of Asia-Pacific's Children 2008' Bangkok, Thailand pp. 44-46

105 Government of Tuvalu and UNDP (2006) 'Tuvalu Millennium Development Goals Report 2006' http://www.spc.int/prism/country/tv/stats/mdg/TV_mdgrpt.pdf, visited on 06 July 2009

have reported actual numbers of maternal deaths instead of using the MMR and others have used three or five year roving averages to consolidate the number of infrequent events.[106]

A number of PICTs used in this study have no MMR data. In order to overcome missing data, this study built proximate determinants of MMR by averaging the scores of indicators that have a strong correlation with MMR (see methodology).

Ensuring women have healthy pregnancies and safe deliveries saves their lives, and the lives of their children.

105 UNFPA (2007) 'Current Status of Sexual and Reproductive Health: Prospects for Achieving the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals in the Pacific' Asia-Pacific Population Journal, Vol. 22, Number. 3 December 2007, pp. 33-35

FOCUS 9:
Preventing Mother-to-Child Transmission of HIV

HIV is a virus transmitted through bodily fluids. This means that an HIV positive mother can pass the virus to her foetus during pregnancy, and to her baby during childbirth and breastfeeding. HIV is most easily passed on when a mother living with HIV has a high viral load. Drugs known as antiretrovirals (ARVs) are used to reduce viral load so that the risk of mother-to-child transmission (MTCT) can be as low as 2 percent.[107]

The United Nations agencies recommend a four-pronged approach to preventing mother-to-child transmission (PMTCT) of HIV:

1. Preventing primary HIV infection in women
2. Preventing unintended pregnancy among women living with HIV
3. Preventing transmission from HIV positive pregnant women to their infants
4. Providing care, treatment and support to HIV positive women.[108]

In the Pacific, preventing both primary infection and unintended pregnancy in women living with HIV can be effectively achieved through SRHR programmes that provide sexuality and relationships education and family planning information and services, including male and female condoms. Similarly, PMTCT and improving care, treatment and support requires improved surveillance, greater access to and use of VCCT, and innovative medicine supply chains that can overcome the geographical challenges of the Pacific region. Ensuring that these activities are integrated with SRHR information and services, and more broadly with health systems, will improve their effectiveness and sustainability.

Currently, the Global Fund to Fight AIDS, Tuberculosis and Malaria, in cooperation with the Secretariat of the Pacific Community (SPC), provide near universal access to ARV drugs in eleven PICTs. These include: the Cook Islands, the Federated States of Micronesia, Kiribati, the Marshall Islands, Nauru, Palau, Samoa, the Solomon Islands, Tonga, Tuvalu and Vanuatu. All other PICTs manage the supply of ARVs individually, except for Tokelau, Niue and Pitcairn Island where HIV has not yet been reported.

In Papua New Guinea, where the greatest need for ARV drugs exists, only around a third of people living with HIV have access to ARV drugs. Further, 2007 estimates show that only four percent of pregnant women living with HIV received ARVs for PMTCT, and that only three percent of infants born to mothers with HIV received ARVs within two months of birth.[109] While more Papua New Guineans are using ARVs now than ever before, it is critical that all four UN recommendations are stepped up so that the situation is significantly improved.

107 Positive Women Inc. (2007) 'HIV, pregnancy and women's health' http://www.positivewomen.org.nz/pdf/PW1343_Booklet_v9.pdf, visited on 01 September 2009

108 UNFPA (2008) 'The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children' http://www.unfpa.org/publications/detail.cfm?ID=192&filter1=&filterType=, visited on 11 September 2009

109 WHO, UNAIDS, UNICEF (2008) 'Epidemiological Fact Sheet on HIV and AIDS core data on epidemiology and response Papua New Guinea' http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_PG.pdf, visited on 31 August 2009

Chapter 10:
Sexual and reproductive health data in the Pacific

The core purpose of health data is to provide governments with accurate and up-to-date information about the health needs of their populations. This in turn allows them to develop informed, evidence-based health policies that can improve the current and future health of their citizens. While all PICTs record basic healthcare data at the service provision level, the quality of recording, and the capacity to collate, analyse and to report on the data at the national level, can vary widely. One result is that many PICTs have limited sexual and reproductive health policies in place.

Many PICTs need greater assistance in order to develop and maintain the necessary capacity to record, collate, analyse and report on national data – particularly that relating to SRHR. While some PICTs such as Tonga, Fiji and the Cook Islands have good health information systems, many PICTs do not have the capacity to operate comprehensive health information systems. Many also have only limited numbers of staff who are trained in statistics, demography, and data analysis and reporting. Other obstacles such as financial restraints, staff turnover and the difficulties associated with the regular collection of information in countries with isolated populations and challenging geography also present PICTs with considerable restraints.

The consequences of these challenges are broad. First, many PICTs have a limited ability to accurately and regularly collect even the most basic of data such as that for births and deaths, which are in themselves critical to measuring other key health indicators such as adolescent and total fertility, and child, infant, neo-natal and maternal mortality. Second, it is common for sexual and reproductive health data to be out-of-date or not reported on at all. Third, the lack of official data has led to many international organisations publishing their own SRHR data – resulting in a confusing mix of figures that range in accuracy. Fourth, it is now widely accepted that the lack of reliable data and capacity has been a major barrier to the development of effective SRHR policies and practices in PICTs.[110]

Technical assistance should focus on improving the ability of PICTs to effectively and regularly undertake three data collection, collation, analysis and reporting processes. These are population censuses, vital and civil registration systems, and specific population surveys. While each method has limitations, when used in conjunction with one another, they provide a wide range of valuable SRHR information.

Population censuses generally provide the key source of information on population characteristics such as age and sex, population distribution, and fertility and mortality. Nonetheless, Pacific censuses face three major limitations. First, a minority of Pacific censuses have included comprehensive questions on mortality. Second, the wording and definitions used in census questions may not always be the same between PICTs, making comparison between countries challenging. Third, Pacific censuses tend to occur on five or ten year cycles meaning data can be out of date by as many years. Other factors such as political unrest and the level of training census staff receive

110 Haberkorn G. (2005) 'Conceptual context for DHS in the Pacific, and for adopting a regional approach' unpublished discussion paper, Secretariat of the Pacific Community, Noumea, New Caledonia, and; Taniguchi K. (2005) 'Technical Assistance for the Demographic and Health Survey in Pacific Island Countries' http://www.adb.org/Documents/TARs/REG/tar-reg-39074.pdf, visited on 9 July 2005, and; Saketa S. (2004) 'Health Information Systems in the Pacific Island Countries (PICs). Issues, Challenge and Opportunities' Presentation at the WHO SEARO/WPRO Consultation on Strengthening Health Information Systems in Asia and the Pacific, Bangkok, 13-15 December 2004, http://www.searo.who.int/LinkFiles/Presentations_Day1-S1-presa4-Fiu.pdf, visited on 18 October 2009

There is an urgent need for more up-to-date and reliable sexual and reproductive health data.

111 Haberkorn G. (2005) 'Conceptual context for DHS in the Pacific, and for adopting a regional approach' unpublished discussion paper, Secretariat of the Pacific Community, Noumea, New Caledonia, p. 1

112 Ibid. p. 3, and; McMurray C. (2005) 'Birth registration in Vanuatu, Solomon Islands and Kiribati: A Situation Analysis' unpublished consultancy report prepared for UNICEF, in Haberkorn G. (2005) 'Conceptual context for DHS in the Pacific, and for adopting a regional approach' unpublished discussion paper, Secretariat of the Pacific Community, Noumea, New Caledonia, p. 4

113 Haberkorn G. (2005) 'Conceptual context for DHS in the Pacific, and for adopting a regional approach' unpublished discussion paper, Secretariat of the Pacific Community, Noumea, New Caledonia, pp. 2-4

114 SPC (2004) 'Information Action: Update on second generation HIV Surveillance' http://www.spc.int/ohs/english/publications/information/IA18/Second_generation_HIVsurveillance.pdf, visited on 8 July 2009, and; WHO (2006) 'Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries' World Health Organization, Geneva, Switzerland and; Republic of the Marshall Islands and SPC (2008) 'Marshall Islands Demographic and Health Survey 2007' Secretariat of the Pacific Community, Noumea, New Caledonia

can negatively affect census quality and timing.[111]

Vital and civil registration systems can often provide a more up-to-date source of data on births, mortality, and other important population and demographic issues. However, many Pacific Island vital and civil registration systems are subject to significant under-counting of births and deaths. Studies in both the mid-1990s and mid-2000s involving a number of PICTs have also found discrepancies between the data being reported by the different PICT government departments often involved with national registration, and reporting of vital and civil statistics.[112] In most instances such discrepancies are the result of PICTs not having the needed capacity to maintain effective, regular, consistent and up-to-date registration and reporting of vital and civil statistics data.[113]

Finally, specific population surveys provide a useful tool for the collection of health data – particularly relating to SRHR. In the Pacific there are two types of survey that are most useful. These are the Second Generation Surveillance surveys (SGS), and the Demographic and Health Surveys (DHS). The SGS surveys provide information on STIs including HIV, and knowledge and behaviours that put Pacific Island people at risk of contracting an STI. The DHS provide in-depth information on a range of issues that importantly include a number of indicators relevant to women's reproductive health such as fertility, contraceptive use, mortality, antenatal care, childbirth, postnatal care and women's empowerment. However, since the year 2000, only 13 PICTs have completed SGS surveys (not all using the same sample groups) and only five DHS have been completed. Also, surveys are subject to margins of error and while the data they produce is often widely used, the accompanying confidence intervals are often not, and it is these which provide evidence of statistical accuracy.[114]

Regional organisations and donors need to ensure they do not compound the data problem. Work undertaken by regional organisations and donors to improve the availability and usability of Pacific data must not undermine that data produced by PICTs. Regional organisations and donors must focus on building local capacity and avoid creating new data simply to serve donor needs.

TAKE ACTION NOW TO IMPROVE PACIFIC ISLAND WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH

There are only five years left for PICTs to achieve the objectives of the International Conference on Population and Development, and the Millennium Development Goals. With so much progress still to be made, it is imperative that steps are taken quickly to ensure all Pacific Island women can realise their full sexual and reproductive health and rights.

A Measure of the Future identifies a number of steps that individuals, communities and organisations can help PICT governments focus on achieving. While most PICTs have identified many of these steps in a variety of policies, and some have made important progress towards resourcing and implementing them, more must be done. Urgent, intensified action on resourcing and implementing these steps must be taken so that all Pacific Island women can enjoy the full range of choices and opportunities that they are entitled to.

Build, maintain and translate political support into action

Pacific Island leaders have made a wide range of regional and international commitments to improving the sexual and reproductive health of Pacific Island people. Individuals, civil society, policy makers and development organisations must advocate for, and become involved in, actions that help PICT governments to resource and implement these commitments so that SRHR are a reality for all Pacific Island women.

Stop harmful practices and discrimination

Gender discrimination, violence of all types, and very early marriage and childbirth must be ended. They violate women's rights and are harmful to women's sexual and reproductive health. Discriminatory legislation that enables or condones harmful practices must be amended, while protective legislation must be created and enforced. Human rights treaties must also be ratified, and these should guide all legislation and policies relating to the protection of women. Locally driven educational programmes can be utilized to build broad social support for new protective legislation and policy, and to create understanding of people's rights under the law.

Integrate SRHR and HIV activities at all levels

HIV activities must be integrated with SRHR activities, and vice versa. Research clearly shows that integration leads to better overall SRHR outcomes and stronger health systems. Political commitment to addressing HIV must be built on and expanded to ensure comprehensive, quality sexual and reproductive health information and services for all.

Expand and improve access to all SRHR services

Pacific Island people, no matter if they live in rural communities, on outer islands, or informal urban centres, must be able to access quality comprehensive SRHR services easily. This requires expanding these services and the infrastructure they need to function, such as electricity, water and clinics, and the infrastructure people rely on to access these services - roads, communication and public transport.

Educate people about their SRHR – especially youth

All Pacific Island people should have access to quality information and education on SRHR. In particular, information and education initiatives should make a specific effort to reach young people, both in and out of school. The provision of comprehensive, age-appropriate sexuality and relationships education should be integrated into school curricula, and teachers or external educators need to be supported to provide this education.

Ensure SRHR services reach youth

Priority must be given to providing confidential, non-judgemental, accurate SRHR information and services for young people. This can be achieved by integrating SRHR services more widely throughout healthcare systems, therefore normalising their presence and use, and also by providing information and services in settings where youth already congregate. Health professionals must be trained and supported to assist young people with the range of issues they experience in the modern world, including alcohol and substance use and abuse, STIs, unintended pregnancy, poor mental health, and coercion and violence.

Commit to family planning

The expansion of rights-based and voluntary family planning programmes must be an urgent priority for the Pacific. This will ensure that all Pacific Island women can realize their right to choose the timing, number and spacing of their children, and will reduce maternal mortality, the spread of STIs (including HIV) and unintended pregnancies.

Build a health workforce that works for women

Pacific Island women will have significantly safer pregnancies and childbirths if PICTs recruit, train and retain health professionals – particularly adequate numbers of nurses, midwives, doctors, obstetricians and gynecologists. Investing in a strong health workforce is one of the most effective methods for ensuring women have good sexual and reproductive health, and for preventing maternal mortality.

Trial the diagonal approach

The focus on health systems strengthening must ensure that efforts simultaneously improve health systems, and get health information and services to the people who need them. Trialing innovative new ideas such as the diagonal approach should occur as a contribution towards this effort.

Maintain and build efforts to improve supply systems

Ensure supplies reach all Pacific Island people. Fully implement the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities in all PICTs, and establish and utilise the national Reproductive Health Commodity Security Coordination Committees.

Research abortion in the Pacific and make it safe, accessible and legal

Research is urgently needed to determine the prevalence and consequences of unsafe abortion. Allowing safe, supportive, confidential and legal abortions is the only way to ensure women will not seek unsafe abortions that place them at risk of death or serious trauma. The risk of unsafe abortion and its consequences will be all but eradicated by decriminalising and destigmatising abortion, training medical personnel to perform appropriate abortions, and ensuring that quality abortion services, which include counseling and support, are accessible to all Pacific Island women. Regardless of abortion's legal status, ensuring that women who have undergone an unsafe abortion get quality healthcare will save them injury and death.

Involve men and boys

Educate, encourage and support men and boys to be more involved in efforts to improve sexual and reproductive health. This should not be at the expense of programmes specific to women – both are needed to achieve gender equality and good health.

Improve information and data collection processes

PICTs need assistance to scale-up their capacity to collect, analyse and report on national data. Support should be focussed on building PICTs' human and technical capacity, and improving their ability to effectively undertake and manage vital and civil registration systems, censuses and specific surveys such as the DHS and SGS. When accurate data and information is available on sexual and reproductive health, more effective policies and programmes can be developed.

Maintain committment to aid effectiveness

Development organisations and PICT governments must work to ensure that their commitments to the Paris Declaration, the Pacific Aid Effectiveness Principles and the Accra Agenda for Action are honoured, and individuals and civil society must hold them to these commitments.

Attend to the wider socio-economic determinants of health

PICT strategies for improving SRHR must take into account the wider social and economic determinants of health. Specific health issues can't be separated from the broader social and economic context within which they exist. By implementing polices that empower women and advance gender equality in all areas of life, the conditions for improved SRHR will also be created.

FRP – French Polynesia
GUA – Guam
NCL – New Caledonia
WLF – Wallis and Futuna
NMI – Northern Mariana Islands
CKI – Cook Islands
NIU – Niue
FIJ – Fiji
SAM – Samoa
PAL – Palau
ASA – American Samoa
TON – Tonga
FSM – Federated States of Micronesia
SOL – Solomon Islands
TUV – Tuvalu
MHL – Republic of the Marshall Islands
VAN – Vanuatu
NAU – Nauru
KIR – Kiribati
TOK – Tokelau
PNG – Papua New Guinea

Micronesia
Polynesia
Melanesia

The Reproductive Risk Index

	Chlamydia prevalence rate of women (15-44 years) (%)	Adolescent fertility rate Births per 1000 women aged 15-19 years	Median age at marriage of women (15-49 years)	Female secondary school enrolment (net) (%)	Antenatal care coverage - at least one visit (%)	Use of modern contraceptive methods women (15-49 years) (%)	Births attended by skilled health personnel (%)	Abortion policies	Maternal mortality ratio (MMR) Maternal deaths per 100,000 live births	Infant mortality rate (IMR) Infant deaths per 1000 live births	
	2004-2008	1996-2007	1990-2007	2003-2009	2000-2008	2000-2008	2002-2008	2007-2009	1994-2008	2000-2008	RRI
PNG	No data	65	22	40	58	24	53	III.	733	57	68
TOK*	No data	43	28	40	No data	No data	No data	I.	No data	31	57
KIR	13	39	22	32	100	18	65	I.	158	52	53
NAU	No data	69	22	52	95	25	97	III.	No data	46	49
VAN	25	59	23	50	67	37	74	III.	148	25	46
RMI	16	138	23	50	95	42	94	I.	74	21	45
TUV	18	42	21	59	99	22	98	I.	No data	17	45
SOL	11	67	23	44	97	27	86	I.	175	24	44
FSM	No data	48	25	51	80	49	92	I.	140	38	42
TON	13	24	26	49	99	23	98	I.	136	19	36
ASA	No data	54	26	50	70	33	100	III.	No data	11	36
PAL	11	29	26	51	100	23	100	I.	No data	20	34
SAM	27	38	24	52	100	45	100	III.	27	20	34
FJI	29	37	23	51	100	44	99	IV.	35	17	34
NIU	No data	28	26	47	100	22	100	III.	No data	8	30
CKI	20	68	31	50	100	40	98	III.	No data	15	29
NMI	No data	69	29	48	76	64	100	I.	No data	5	28
WLF	15	12	27	49	100	25	100	No data	96	5	24
NCL	24	20	32	51	No data	33	100	V.	48	6	24
GUA*	No data	57	27	No data	92	No data	99	III.	No data	12	23
FRP	No data	51	33	51	99	No data	100	V.	23	6	11

**For Guam and Tokelau, not enough data was available to calculate a meaningful rank within the index. Therefore their ranking should be ignored. They have been retained in the index because what data is available may still be useful for policy makers and advocates.*

Ordinal indicator: I. To save a woman's life or prohibited altogether; **II.** To preserve physical health (also I.); **III.** To preserve mental health (also I., II.); **IV.** Socio-economic grounds (also I., II., III.); **V.** Without restriction as to reason.

Data sources, methodology and limitations

GEOGRAPHIC AND DEMOGRAPHIC COVERAGE

A Measure of the Future ranks 21 of the 22 Pacific Island Countries and Territories and places each within one of four categories based on the level of reproductive risk that women face. To determine the level of reproductive risk, this study constructed a reproductive risk index based on ten health indicators that measure sexual and reproductive health services and outcomes. Because of inadequate data, Pitcairn Island was excluded from the study. The combined populations of the 21 PICTs in this study cover approximately 9.6 million people.

DATA SOURCES

A Measure of the Future utilises a range of data sources in order to build the most up-to-date and accurate reproductive risk index for the Pacific. Data was sourced from:

- The Secretariat of the Pacific Community, Pacific Regional Information SysteM (PRISM)
- The World Health Organization Country Health Information Profiles (CHIPS)
- Demographic and Health Surveys (DHS)
- Second Generation Surveillance surveys (SGS)
- UNICEF Multiple Indicator Cluster Survey (MICS)
- UNFPA Sub-Regional Office for the Pacific
- National Ministries of Health
- National Bureaus of Statistics
- National Vital and Civil registrations
- Census data.

CONCEPTUAL FRAMEWORK

This study is based on a conceptual life-cycle approach that was developed in a collaboration between PAI and experts in the field of population and reproductive health. Where this study has deviated from this approach, it has done so as a result of a lack of data, poor quality data, or because the scope of the index was deliberately enlarged so that it could better measure reproductive risk in the Pacific context.

METHODOLOGY

The indicators are selected based on their applicability to the lifecycle approach, on the availability of comparable national data and indicators, and on their international recognition. The ten indicators composing the RRI are:

- Chlamydia prevalence rate of women aged 15-44 years
- Adolescent fertility rate
- Median age at marriage of women aged 15-49 years
- Female secondary school enrolment (net) (%)
- Antenatal care coverage - at least one visit (%)
- Use of modern contraceptive methods in women aged 15-49 years (%)
- Births attended by skilled health personnel (%)
- Grounds on which abortion is permitted
- Maternal mortality ratio (MMR)
- Infant mortality rate (IMR).

A Measure of the Future uses the most recent, reliable and consistent data available at the time of publication. For MMR, nine countries had data missing. In these cases an estimation procedure has been used based on three indicators that function as *proximate determinants* of maternal mortality (the relative level of maternal mortality). The three indicators are:[d]

- Births attended by skilled health personnel (%)
- Infant mortality rate (IMR)
- Total fertility rate (TFR).

For each of the countries with missing MMR data, the proximate determinants of maternal mortality are calculated by averaging the scores of the three indicators mentioned above.

Calculation of the Reproductive Risk Index

All indicators are scored on a 100-point scale of 0 to 100, except the indicator *Grounds on which abortion is permitted.*

For seven of the other nine indicators *(Chlamydia prevalence rate, Secondary school enrolment, Adolescent fertility rate, Median age at marriage of women, Use of modern contraceptive methods, Maternal mortality ratio and Infant mortality rate)* the observed range is transformed so that it goes from 0 to 100. For each of these seven indicators, each country is located in the new range.

The remaining two quantitative indicators *(Antenatal care coverage and Births attended by skilled health personnel)* kept their actual values because they are already in the range from 0 to 100.

For the indicator *Grounds on which abortion is permitted* (an ordinal indicator), scores are assigned as follows:

Grounds	Score
To save the woman's life or prohibited altogether	95
To preserve physical health (also to save the woman's life)	70
To preserve mental health (also to save the woman's life and physical health)	40
Socioeconomic grounds (also to save the woman's life, physical health and mental health)	15
Without restriction as to reason	5

Finally, the ten indicators for each country are merged into a single composite index called the *Reproductive Risk Index (RRI)* by computing a simple average for all ten scores. Equal weight is given to all ten indicators.[e]

The RRI has a minimum value of 0 (desirable outcome) and a maximum value of 100 (non-desirable outcome). Countries are ranked from highest to lowest reproductive risk based on each country's RRI, and then grouped into four quartiles as follows: Very high Risk, High Risk, Moderate Risk, Low Risk.

LIMITATIONS

A Measure of the Future uses five indicators not used in the original PAI methodology. *Antenatal care coverage at least one visit* was used instead of antenatal care coverage four or more visits, because of a lack of data. *Use of modern contraceptives* was used instead of unmet need because of a lack of data. *Median age at marriage* was used instead of girls married

d For Tokelau information on the indicator 'Births attended by skilled health personnel' was not available and its proximate determinant of maternal mortality was calculated based on only the two remaining indicators.

e A test was carried out to add extra weights to indicators believed to affect the RRI more directly than others such as 'Maternal mortality ratio', 'Births attended by skilled health personnel' and 'Antenatal care coverage'. The subsequent weighted index did not differ significantly from the index using equal weights to all indicators.

before 18 years because data proved too difficult to obtain. *Chlamydia prevalence rate* was used instead of HIV prevalence rate because HIV data is poor, the rate is extremely low in most PICTs, and because chlamydia data is good and the rate is high in many PICTs. Finally, *female secondary school enrolment* was added because of the strong correlation between having a good education, and having better sexual and reproductive health.

Missing data

A Measure of the Future faced significant data challenges. Very few PICTs had quality data on all the indicators sought – 14 PICTs are missing data. It is important to note that missing data for a single indicator can change a country's ranking. This does not however diminish the value of the index in highlighting priority issues.

Out-of-date data

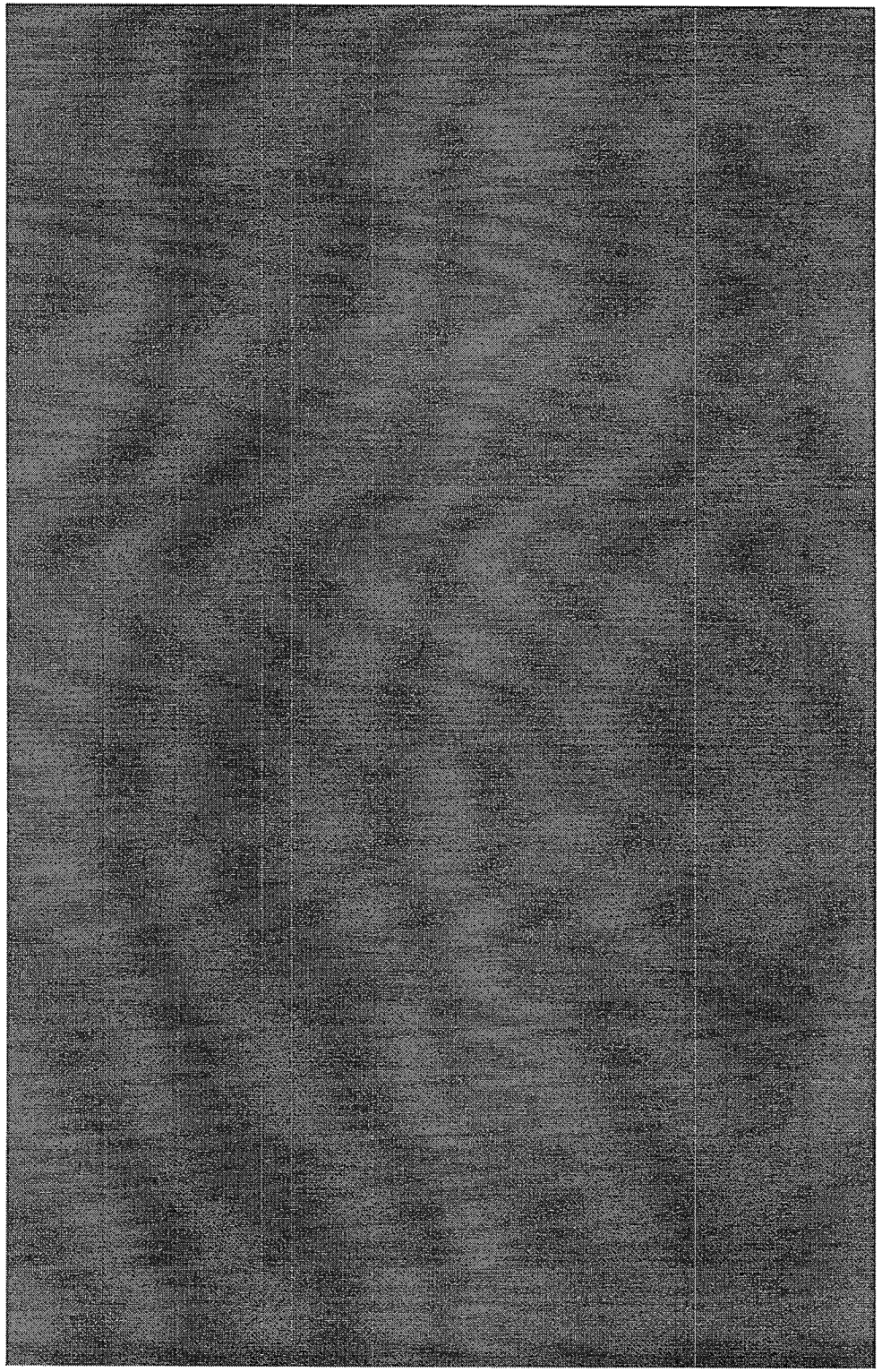
Where data has been found sometimes it is out of date by more than five years. The oldest data used in the index comes from the year 1990 whilst the newest data comes from the year 2009. Wherever possible, multi-year averages were used.

Definitions and sample groups

Definitions and sample groups across countries were not always the same. Ten of the 11 chlamydia data are from Second Generation Surveillance surveys of antenatal women, however, sample group size and age range varied. The single remaining chlamydia data was from routine surveillance. Similarly, in some PICTs censuses count de facto partnerships as 'marriage' and others do not. Also, the data on secondary school enrolment for American Samoa excludes private schools because a gender breakdown was not available.

USING THE INDEX

When using the index, it is important to note that while the data utilised in this study illuminates disparities in reproductive health between countries, it hides those disparities that exist within each individual PICT. Similarly, because of missing data and out-of-date data, the index ranking should be used with some caution. In particular, the rankings of both Guam and Tokelau should be ignored because more than three indicators are missing.



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All efforts were made to ensure that the information presented in *A Measure of the Future* was accurate at the time of publication. Family Planning International accepts no liability for errors.

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