ICPD AT 15

ACHIEVEMENTS, CHALLENGES AND PRIORITIES IN THE PACIFIC ISLANDS

Pacific Sub-Regional Review of ICPD POA Implementation

Geoffrey Hayes
Consultant Demographer

United Nations Population Fund Pacific Sub-Regional Office, Suva, Fiji
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United Nations Population Fund
Pacific Sub-Regional Office
Private Mail Bag
Suva, Fiji
Email: PacificSRO@unfpa.org
http://pacific.unfpa.org

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TABLES

ABBREVIATIONS

ADB	Asian Development Bank
AHD	Adolescent Health and Development
AIDS	Acquired Immunodeficiency Syndrome
APPC	Asia Pacific Population Conference
ASRH	Adolescent Sexual and Reproductive Health
BNP	Basic Needs Poverty
CCP	Comprehensive Condom Programming
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DHS	Demographic and Health Survey
ESCAP	Economic Commission for Asia and the Pacific
FBO	Faith Based Organizations
FAO	Food and Agriculture Organization
FLE	Family Life Education
FP	Family Planning
GF	Global Fund
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICOMP	International Council on Management of Population Programmes
ICPD	International Conference on Population and Development
ILO	International Labour Organization
IPCC	Intergovernmental Panel on Climate Change
IUD	Inter-Uterine Contraceptive Device
MDGS	Millennium Development Goals
MIPAA	Madrid International Plan of Action on Ageing
MMR	Maternal Mortality Ratio
MSM	Men who have sex with Men
NGO	Non-Governmental Organization
PPAPD	Pacific Parliamentarians Assembly on population and development
POA	Programme of Action (of ICPD)
PPD	Partners in Population and Development
PRSP	Poverty Reduction Strategy Paper
RHCS	Reproductive Health Commodity Security
RH	Reproductive Health
SBA	Skilled Birth Attendant
SDP	Service Delivery Points
SRH	Sexual and Reproductive Health
SPC	Secretariat of the Pacific Commission
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
TFR	Total Fertility Rate
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
WHO	World Health Organization

SUMMARY

There is much quantitative evidence that Pacific Island countries have made progress toward achieving the goals and objectives of the ICPD POA over the past 15 years, but the pace and extent of progress has varied greatly between countries. The countries that have reached or are on track to achieve the ICPD goals and MDGs relating to population are generally the smaller countries that retain a historical relationship with a former or current metropolitan power and/or have found opportunities to participate in overseas labour markets. For the most part these are the smaller countries of Polynesia and Micronesia, as well as Fiji.

In terms of the vast majority of the population of the Pacific Islands however, the situation is very different. The Western Melanesian countries of Papua New Guinea, Vanuatu and Solomon Islands, contain more than three-quarters of the region's population and have made much less progress. In these countries, the obstacles to broad-based development are so much greater than elsewhere in the region. These obstacles and challenges facing the region as a whole include the following:

Challenges

- How can the overall level of welfare ("development") be improved in a context of low per capita incomes and a slow pace of economic growth that has lasted for decades.
- Although the regional population growth rate, and the overall rate of natural increase, has declined in the past decade, the pace of decline has been too slow and too recent to significantly reduce annual increments to the regional population. At current rates, the total population will reach 10 million in 2011 and by 2050 another 8 million will be added to the population, given present trends.
- Annual population increments in Western Melanesia (Papua New Guinea, Solomon Islands and Vanuatu) remain high and will continue to place pressure on governments to expand public services such as health-care and education at the expense of higher quality.
- Stabilizing population in Western Melanesia would require a more rapid pace of fertility decline in order to reduce the rate of natural increase because emigration cannot play the role of offsetting natural increase that it has played in Polynesia, Micronesia, and Fiji.
- While infant and child mortality rates have declined, they remain high in some countries, especially at sub-national levels.
- Basic needs poverty has been increasing in some countries.
- Universal access to reproductive health is a long way from being achieved in the predominantly rural, village-based societies of Western Melanesia as well as parts of Polynesia and Micronesia. Even some of the better-off countries (e.g., Samoa and Tonga) remain more than three-quarters rural. Delivering services to dispersed, rural villages and islands is a major development challenge in the Pacific.
- The unmet need for family planning and especially contraception for young people remains significant in several countries; contraceptive prevalence remains below 50 percent in most countries. Approximately 650,000 women have an unmet need for family planning in the Pacific.
- Maternal mortality remains unacceptably high in Western Melanesia, especially Papua New Guinea.
- In spite of some reductions, adolescent fertility remains relatively high in several countries.

- The prevalence of sexually transmitted infections is high, especially among young people, and HIV and AIDS have become epidemic in Papua New Guinea.
- The vertical, fragmented and under-resourced nature of the various SRH and Primary Health Care services reduces the ability of service providers to address key SRH issues in a holistic and coordinated manner with significant gaps and lack of coverage for the population.
- Adolescents and young people in rural areas have limited access to information, counseling and services on reproductive and sexual health. Adolescent reproductive rights and sexuality remain culturally contested concepts in the Pacific.
- Gender-based violence is persistent and pervasive in the Pacific and unacceptably high in countries in which research has been conducted.
- Sexual minorities remain marginalized and stigmatized without widespread support or access to SRH services including for HIV/STIs.
- Population ageing is occurring in those countries that entered the demographic transition the earliest and the pace of ageing will accelerate in coming decades. The implications of changing age structures in the Pacific have been insufficiently studied.
- There are major gaps in the knowledge-base on population dynamics and processes in the Pacific. Much more research is required on, for example, the slow pace of fertility decline, the relationship between basic needs poverty and population dynamics, population patterns in outer islands, and the impact of emigration on the quality of life.
- The integration of population dynamics into development plans, poverty reduction strategies and sector plans has stalled. Little progress is evident in the past decade. Changing development frameworks, lack of technical support and waning donor interest are the main causes.
- Similarly, the development of national population policies has stalled, with the single exception of the Papua New Guinea National Population Policy 2000-2010. Several countries have out-dated policies but these have virtually no effect in terms of policy.

Priority Actions

The ICPD Programme of Action provides a framework for government action that acknowledges the fact that population and development are intricately linked. Successful implementation of the POA is a function of many variables, among which the availability of public resources and the quality and efficacy of public sector management play central roles. The challenge of accelerating the pace of GDP growth in Pacific Island economies is largely beyond the scope of the ICPD POA.[1] Identifying the correct strategies has proven elusive, although there is little doubt that the quality of governance is a fundamental starting point that applies to all countries in the Pacific regardless of their present level of development.

It is for this reason that a recent regional review (AusAID, 2009) has highlighted the need to achieve better development outcomes from development aid as well as domestic resources through the implementation of *The Pacific Aid Effectiveness Principles,* adopted in 2007, the *Paris Declaration* on aid effectiveness, and the Pacific Plan. The following list of strategies presupposes that the implementation of these approaches, possibly accompanied by increased domestic resources generated by economic growth, and improved financial management will benefit population programmes and support the further implementation of the ICPD POA.

1 Increasing per-capita GDP by reducing population growth is a static and simplistic approach that does not address the fundamental causes of slow growth in total GDP in the Pacific.

- Prepare multi-sector "third-generation"[2] national population policies in selected countries that raise the profile of population factors in socio-economic development while fully reflecting the human rights principles embodied in the ICPD POA and focused on the achievement of the MDGs.
- Take steps to further integrate population into sector plans, poverty reduction strategies, national development plans, and MDG reports. Technical assistance and training should be made available to support this process.
- Continue to support parliamentarian, faith based and traditional leadership and advocate for their increased awareness, understanding and acceptance of the need for rights based and equitable access to Sexual and Reproductive Health for all population groups. Encourage leadership champions to advocate for increased community tolerance and understanding of diversity and need within all Pacific communities.
- Continue to implement, but at a faster pace, comprehensive regional strategies in reproductive health and reproductive health commodity security with a stronger focus on the less-developed or poorer countries and the disadvantaged rural majority. Develop where they do not currently exist, national reproductive health strategies, encompassing and prioritizing adolescent reproductive health, RH commodity security, male involvement and associated issues.
- Raise the profile of family planning in reproductive health strategies and plans, by appropriate means, including additional finances and advocacy, and improve the quality of services, including greater promotion and acceptance of condoms as a low-impact contraception.
- In PNG, develop innovative strategies for both the measurement and the prevention of maternal mortality based on experience in comparable countries in other world regions.
- Implement the "PNG National HIV Prevention Strategy 2010-2015" and the "Pacific Regional Strategy on HIV and other STIs 2009-13" to reduce the rate of new HIV infections and to reduce the prevalence of other STIs, especially in young people and marginalized/vulnerable groups at high risk of infection.
- Increase student access to Family Life Education and lifeskills training to raise awareness, build skills and prepare young people for productive and healthy adult lives including healthy sexual behaviour and avoidance of SRH risk.
- Increase provision of youth and user-friendly ASRH, HIV/STI and counseling services for young people, including those at most risk, ensuring these services are non-judgmental, confidential, affordable and accessible
- Promote and facilitate the linkages and ultimate integration of safe-motherhood, family planning and HIV/STI prevention, treatment and care services.
- Build the population knowledge-base by undertaking secondary analysis and original research on key policy issues, including: (i) determinants of variations in fertility, including teenage fertility; (ii) reasons for the low-uptake of family planning; (iii) relationship between population dynamics and basic needs poverty; (iv) the impact of emigration and migrant remittances on social welfare, particularly in rural areas; (v) cultural values and attitudes associated with the denial of reproductive rights to unmarried adolescents and youth. In the process, build national capacity to undertake higher-level research.
- Promote the fuller utilization of census and survey data, while also ensuring that more countries conduct Demographic and Health surveys on a regular basis. Build national capacity to undertake such surveys.

2 The term "third generation" population policies refers to policies that focus on the joint achievement of the ICPD goals and the MDGs, building upon MDG reports and poverty reduction strategies. The terminology implies that population policies can be categorized as (1) "pre-ICPD"; (2) "post-ICPD" and (3) "post-MDGs".

- Address population ageing by forming national coordinating bodies to review the ageing situation at national levels and prepare plans and strategies to deal with the socio-economic implications. Strategic interventions include: promoting healthy ageing, reorienting health systems and services to meet the health needs of older persons, establishing and expanding old age social security, and supporting older persons to remain active.
- Advocate for the expansion of improved water and sanitation services.
- Develop new strategies to reduce gender based violence, including advocating for changes to national laws, policies and practices.
- Adopt and promote a pro-poor approach to planning and programming_for the service-delivery, including safe-motherhood and family planning, to make such services more accessible to disadvantaged and lower-income groups.
- Strengthen cooperation_among countries, and with NGOs, CSOs, the private sector, members of parliament, and other development partners for advocacy, building knowledge base and, as appropriate, for the delivery of services.

SECTION 1: INTRODUCTION

A. THE ICPD PROGRAMME OF ACTION

Background

The International Conference on Population and Development (ICPD), held at Cairo in 1994, adopted a comprehensive 20-year Programme of Action (POA) on population and development that subsequently produced a major reorientation of population policies and programmes worldwide. While building upon the Plans of Action adopted at earlier global population conferences held in Bucharest in 1974 and in Mexico City in 1984, the ICPD POA departed significantly from previous plans by placing human rights and gender equality at the centre of the population and development agenda. In contrast with earlier international plans that focused on demographic goals at country, regional and global levels, the ICPD POA stressed the needs and rights of individuals, couples and families. In a key departure from earlier approaches that had placed family planning in the context of fertility reduction, the ICPD POA placed the concepts of reproductive rights and reproductive health at the core of its recommended population-development strategies. These two concepts were further supported by the goals of gender equality and the empowerment of women.[3]

Furthermore, the ICPD POA encompassed a much wider range of subject areas and recommended actions than previous population and development action plans. The comprehensive nature of the ICPD POA derives in part from the fact that the POA incorporated many of the goals and objectives agreed to at related international conferences held in the early 1990s. These included, among others: the Declaration and the Plan of Action of the World Summit for Children, 1990; Agenda 21 adopted at the United Nations Conference on Environment and Development held at Rio de Janeiro in 1992; the Vienna Declaration and Programme of Action adopted by the 1993 World Conference on Human Rights (United Nations, 1994) and The Global Conference on the Sustainable Development of Small Island States held in Barbados in 1994. In another significant departure from the approaches adopted in previous population conferences, the ICPD POA placed population growth, distribution and structure in the context of environmental sustainability, rather than in the more narrowly defined concept of development as growth in per-capita income. As in previous conferences, however, the integration of population factors in development plans and strategies was a key recommendation to governments.

While the ICPD POA addresses its recommended goals, objectives and actions in the first instance to national governments, and respects the sovereign rights of governments to implement the POA in accordance with the cultural values and norms of national communities, it also stresses the importance of forging partnerships with NGOs, civil society and the private sector. Cooperation and partnership between national actors and the international community is another key strategy that should be employed to implement the POA.

The ICPD '94 and the POA that emerged from it subsequently influenced world conferences held the following year, particularly the Fourth World Conference on Women held in Beijing in 1995 and the World Summit for Social Development in Copenhagen in 1995. The ICPD POA, along with other international agreements, also provided a foundation for the Millennium Declaration adopted by 189 Heads of States and Governments in September 2000 and its eight related goals, known as the Millennium Development Goals (MDGs).

3 Eleven Pacific Island countries and three Pacific regional organizations (the SPC, Pacific Islands Development Program, and The South Pacific Forum Secretariat) attended the CPD '94 in Cairo. In 1993, representatives of Pacific governments met in Vanuatu and approved the "Port Vila Declaration on Population and Sustain able Development" (SPC, 1994). The Port Vila Declaration provided the basis for Pacific involvement in and contribution to the development of the ICPD POA.

The 1999 Review of the ICPD POA (ICPD+5)

The ICPD POA called for periodic reviews to be conducted on the implementation of the action plan. The first such review was conducted by UNFPA in 1998 and resulted in the re-affirmation of the continued relevance and validity of the goals and objectives of the ICPD POA. As a result of this review, further refinement of some goals, targets and indicators was carried out. The review also identified a number of issues and challenges that had arisen in the first five years of the POA and recommended revisions intended to strengthen the policy framework, improve implementation strategies, promote national capacity building and enhance resource mobilization (United Nations, APSS No.153, 1998). The document *Key Actions for the Further Implementation of the Programme of Action of the Programme of Action of the International Conference on Population and Development* was subsequently adopted during a Special Session of the United Nations General Assembly (GA) 30 June--2 July, 1999 (United Nations 1999), and is generally referred to as "ICPD+5".[4] Together with the original goals and objectives of the ICPD POA, the revisions introduced in 1999 contributed to the development of the MDGs in 2000.

Key objectives and goals: ICPD and ICPD+5

The ICPD POA and the ICPD+5 "Key Actions" recommended a number of interdependent objectives and goals to be realized by 2015, or earlier, and provided specific recommendations for government action to achieve them. Some of these objectives are expressed in terms of quantitative targets to be attained by specific dates, generally 2000, 2005 and 2015; other goals are stated in qualitative terms without any time reference other than the time-frame of the POA itself. It is noteworthy that neither the goals and objectives of the ICPD POA and the "Key Actions" developed in 1999 nor their respective targets are enumerated—as in the case of the MDGs. For this reason, the monitoring of the ICPD goals and objectives is more difficult because it is not possible to specify a definitive list.[5]

Table 1 (following page) shows the ICPD POA and ICPD+5 goals or objectives that are clearly quantitative in nature, along with their indicators and the target dates for their achievement.

Aside from the quantitative goals shown in Table 1, the ICPD POA urges national governments to take action in a range of policy areas with the overall goal of ensuring that population patterns and trends are consistent with "sustainable development and sustained economic growth". Below is a selected and condensed list of the main recommended actions and objectives that make up the core of the POA:

- Integrate population concerns into development strategies, plans and decision-making with the goal of improving the quality of life of present and future generations;
- Ensure that population, environment and poverty eradication factors are integrated in sustainable development policies, plans and programmes;
- Reduce both unsustainable consumption and production patterns as well as negative impacts of demographic factors on the environment in order to meet the needs of current generations without compromising the ability of future generations to meet their needs;
- Undertake research on the linkages among population, consumption and production, the environment and natural resources and human health as a guide to effective sustainable development policies;

4 Unless otherwise indicated future references to the ICPD POA in this document include the revisions contained in ICPD+5

5 In practice, many of the goals and objectives of the ICPD POA that derive originally from other international conferences and agreements are monitored in the context of those programmes rather than in the context of the ICPD POA.

Table 1: Quantitative goals, targets and indicators of ICPD and ICPD+5

(A) ICPD POA		
HEALTH, MORBIDITY AND MORTALITY		
Chapter and Paragraph of POA	Area and indicator	Base, target and target year
VIII (8.5)	A. Primary health care and health care. **Indicator:** Life expectancy at birth (E_0)	Reach E_0 greater than 70 by 2005 and =75 by 2015. Countries with highest level should aim to achieve E_0 greater than 65 by 2005 and greater than 70 by 2015.
VIII (8.16)	B. Child survival and health. **Indicators:** Infant Mortality Rate (IMR) and under 5 Mortality Rate (U5MR)	Target depends on level of mortality. Reduce by one third or to 50 and 70 per 1,000 live births, respectively, the IMR and U5MR, whichever is lower by the year 2000. "Intermediate" mortality countries: IMR below 50 and U5MR below 60 by 2005. By 2015, all countries should have IMR below 35 and U5MR below 45.
VIII (8.21)	C. Women's health and safe motherhood. **Indicator:** Maternal Mortality Ratio (MMR)	Reduce maternal mortality by 50 percent of 1990 levels by 2000 and a further 50 percent by 2015.

(B) ICPD+5 ("Key Actions")		
Paragraph	Area and indicator	Base, target and target year
EDUCATION AND LITERACY		
34	**Indicator:** Net primary enrolment ratio	Eliminate the gender gap by 2005
	Indicator: Net secondary enrolment ratio	Eliminate the gender gap by 2005
	Indicator: Net primary enrolment ratio	90 percent by 2010
35	**Indicator:** Illiteracy rate	Halve the rate for women and girls by 2005 relative to 1990.
REPRODUCTIVE HEALTH CARE AND UNMET NEED FOR CONTRACEPTION		
53	**Indicator:** Range of family planning, contraceptive methods, EOC, prevention and care of reproductive tract infections, etc.	By 2005 60 percent of primary healthcare and family planning clinics should be able to offer these services and by 2010 80 percent
58	**Indicator:** Gap between contraceptive use and proportion of individuals wishing to space or limit their families (unmet need).	Close (reduce) the gap by 50 percent by 2005, 75 percent by 2010 and 100 percent by 2050.
MATERNAL MORTALITY REDUCTION		
64	**Indicator:** percent of births assisted by skilled attendants	By 2005, 40 percent of births should be attended by skilled attendants, 50 percent by 2010 and 60 percent by 2015 (where mortality is high) All countries should strive so that globally 80 percent skilled attendants by 2005, 85 percent by 2010 and 90 percent by 2015
HIV/AIDS		
70	**Indicator:** Access to the information, education and services to develop skills to reduce vulnerability (services include condoms and VCT)	By 2005, 90 percent of pop 15-24 to have access and 95 percent by 2010
	Indicator: HIV infection rate in 15-24 year olds	Reduce by 25 percent in most affected countries by 2005 and reduced globally by 25 percent by 2010.

- Achieve gender equality and equity, empower women and eliminate violence against women;
- Eliminate all forms of discrimination against the girl child and improve the welfare of the girl child in regard to health, nutrition and education;
- Encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles;
- Develop policies and laws that better support the family, contribute to its stability and take account of its plurality of forms;
- Facilitate the demographic transition as soon as possible in countries where there is an imbalance between demographic rates and social, economic and environmental goals while fully respecting human rights;
- Enhance the self-reliance and quality of life of elderly people and develop systems of health care and social security that address the needs of an ageing population, paying particular attention to the needs of women;
- Ensure that comprehensive and factual information and a full range of reproductive health-care services, including family planning, are accessible, affordable, acceptable and convenient to all users.
- All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015;
- All countries should... assess and address the extent of national unmet need for good-quality family planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups;
- Prevent, reduce the incidence of, and provide treatment for, sexually transmitted infections (STIs), including HIV, and the complications of STIs such as infertility, with special attention to girls and women;
- Address adolescent sexual and reproductive health (SRH) issues, including unplanned pregnancy, unsafe abortion, and STIs, and provide appropriate services and counseling suitable for that age group;
- Substantially reduce all adolescent pregnancies;
- Foster a more balanced spatial distribution of population by promoting in an integrated manner the equitable and ecologically sustainable development of major sending and receiving areas; reduce the role of the various push factors as they relate to migration flows;
- Enhance the management of urban agglomerations through more participatory and resource-conscious planning and management;
- Address the root causes of international migration, particularly poverty and encourage more dialogue between countries of origin and countries of destination in order to maximize the benefits of migration... for the development of both sending and receiving countries;
- Strengthen national capacity to.... meet the need for basic data collection, analysis and dissemination, giving particular attention to information classified by age, sex, ethnicity and different geographical units...;
- Promote socio-cultural and economic research that assists in the design of programmes, activities and services to improve the quality of life and meet the needs of individuals, families and communities;
- Incorporate population concerns into all relevant national development strategies, plans, policies and programmes;

- Foster active involvement of elected representatives of people, particularly parliamentarians, concerned groups, especially at grass-roots level, and individuals, in formulating, implementing, monitoring and evaluating strategies, policies, plans and programmes in the field of population and development.

The ICPD POA and the Millennium Development Goals

With the advent of the Millennium Development Goals in 2000, the context in which the implementation of the ICPD POA is monitored has changed due to the fact that the MDGs have incorporated some of the objectives and targets contained in the POA.[6] Given the partial overlap between the ICPD POA and some of the MDGs, the implementation of the ICPD POA is ipso facto a contribution to achieving the MDGs. Furthermore, it is widely accepted in the development community that the implementation of the ICPD POA would also contribute to achieving the MDGs as a whole and not only those MDGs that overlap with the POA.

The MDGs are derived from the Millennium Declaration, a Resolution of the United Nations General Assembly passed on September 8 2000. The Millennium Declaration was a re-iteration and reinforcement of the values and principles of the United Nations and a call to intensify international efforts to eradicate extreme poverty and promote sustainable social and economic development. Since the eight MDGs were approved by the UN General Assembly in September 2001, MDGs have provided a universal framework for addressing poverty and underdevelopment at the national level. Many Pacific Island countries have adopted the MDGs as their own development goals and almost all countries have prepared at least one MDG Report describing their current level of achievement and their prospects for achieving the goals by the target date of 2015.

Although the MDGs did not originally contain an explicit reference to population or reproductive health as such, it was apparent at the outset that there was a close relationship between the MDGs and the ICPD POA. The MDG targets for maternal health, child health, and gender equality reflected similar, or identical, aims contained in the ICPD POA. On the other hand, the ICPD POA provides a wide range of recommended actions that governments could take that, in retrospect, would help to achieve the MDGs. As a simplified, goal-oriented, framework, the MDGs focus primarily on a limited number of development results (ends) rather than actions (means). In this respect, the ICPD POA is more strategic in nature than the MDGs, thus the two frameworks complement each other.

In 2005 the overlap between the MDGs and the ICPD POA was further increased by the incorporation of "universal access to reproductive health by 2015" as a target under MDG5: "Improve maternal health". Three of the four indicators to be used to measure progress toward this goal were derived from the ICPD POA.[7] (The full MDG framework is reproduced in Annex I).

In Table 2, some of the linkages between MDGs 1-7 and the ICPD POA goals and strategies are shown. Comparison of Tables 1 and 2 will show that the MDG framework has incorporated several ICPD objectives as well as their indicators and targets. However, in the process of incorporation some targets have been reformulated. For example, the ICPD POA called for maternal mortality to be reduced by one half of 1990 levels by the year 2000 and a further one half by 2015. The MDG target is to reduce maternal deaths by

6 Just as the ICPD POA incorporated objectives and targets from earlier international conferences.
7 These are the adolescent birth rate, antenatal care coverage (at least one visit and at least four visits) and the unmet need for family planning.

three-quarters between 1990 and 2015, a similar but more simply-stated target. It is also noteworthy that in some areas the ICPD POA targets are given for intermediate years (mainly 2000 and 2005) whereas the target date for achieving the MDG is universally 2015. A further distinction is that the ICPD POA specifies actual levels for some indicators (e.g., infant mortality and maternal mortality) and also sets different targets for countries with "high" as compared with "intermediate" mortality as of the base year of 1990.

Reviewing the implementation of the ICPD POA

The ICPD POA is both a set of strategies for addressing population and development at country levels and a set of goals with associated targets, indicators and deadlines against which achievement can be assessed. This implies that a review of implementation should focus on two questions: (1) have countries undertaken the specific actions recommended as part of the overall strategy; (2) have countries achieved the quantitative *targets* of the POA, as measured by their performance on the indicators specified in the POA. To date, most reviews have focused on the first of these questions. In recent years, however, more emphasis has been placed on measurable results.

The "results-based" approach is strongly emphasized by the MDGs, which are focused on ends rather than means. The present report attempts a balance between actions and results, or means and ends.

Table 2: MDGs and Targets and links to ICPD and ICPD+5 goals or strategies

MDGs and Targets	ICPD Goals or Strategies
Goal 1: Eradicate extreme poverty and hunger	**Universal access to voluntary reproductive health services, including family planning by 2015.** Achievement of this goal would reduce poverty by reducing fertility and average family size. This would in turn increase the labour force participation rates of women and raise average per capita family income. With lower fertility, the age composition of the population would be more conducive to economic growth and employment growth.
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.	
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	
Goal 2: Achieve Universal Primary Education	"Beyond the achievement of the goal of **universal primary education** in all countries before 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels as well as to vocational education and technical training..."
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education	
Goal 3: Promote Gender Equality and Empower Women	"Governments... should as quickly as possible, and in any case before 2015, meet the Conferences goal of achieving **universal access to primary education**; eliminate the gender gap in primary and secondary education by 2005; and strive to ensure that by 2010 the net primary school enrolment ratio for children of both sexes will be at least 90 percent compared with an estimated 85 percent in 2000". **Reduce the rate of illiteracy of women and men**, at least halving it for women and girls by 2005, compared with the rate in 1990.
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015	
Goal 4: Reduce child mortality	"By 2015, all countries should aim to **achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000**. Countries that have achieved these levels should strive to lower them further".
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	

Goal 5: Improve maternal health	"Countries should strive to effect significant reductions in maternal mortality by the year 2015: **a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births**... However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem." "All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible but no later than the year 2015" Governments should strive to ensure that by 2015 all primary healthcare and family planning facilities are able to provide, directly or through referral, **the widest achievable range of safe and effective family planning and contraceptive methods.; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases**, and barrier methods (such as male and female condoms and microbicides if available to prevent infection. By 2005, 60 percent of... facilities should be able to offer this range of services and by 2010, 80 percent of them should be able to offer such services".
Target 5.A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	
Target 5.B: Achieve, by 2015, universal access to reproductive health	
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases	Universal access to Reproductive Health services by 2015 would contribute to greater knowledge of the means of HIV transmission and methods of prevention. Treatment of other STIs would lower HIV transmission rates. The reduction of malaria would contribute to lower HIV prevalence rates. Effective treatment of TB would have a similar effect.
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	
Target 6.B: Achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it	
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	
Goal 7: Ensure Environmental Sustainability	Integrate demographic factors into environmental impact assessments and other planning and decision-making processes aimed at achieving sustainable development. Modify unsustainable consumption and consumption patterns through economic, legislative and administrative measures, as appropriate, aimed at fostering sustainable resource use and preventing environmental degradation
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 7.B; Reduce biodiversity loss, achieving , by 2010, a significant reduction in the rate of loss	
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	

Reviews of the ICPD POA in the Asia-Pacific region

Reviews of the implementation of ICPD POA have been conducted periodically at the national, regional and international levels, in accordance with the POA's recommendations. The first such review in the Asia-Pacific region was conducted by the Economic and Social Commission for Asia and the Pacific (ESCAP) in cooperation with the United Nations Population Fund (UNFPA). This review was undertaken jointly with a review of the Bali Declaration on Population and Sustainable Development during in March 1998 in Bangkok.

A second regional review took place in the context of the Fifth Asian and Pacific Population Conference (APPC), organized by ESCAP and UNFPA, and held in Bangkok in December 2002. During this Conference, some of the more controversial issues that had originally emerged in the ICPD in Cairo were again raised (particularly issues concerning reproductive health services for adolescents and unsafe abortion) and debated. After an unprecedented vote, the countries represented at the Conference[8] endorsed and reaffirmed the ICPD POA and adopted the "Asia-Pacific Plan of Action on Population and Poverty" (United Nations, 2003) with some reservations being expressed by one participating country. The Conference recommendations highlighted the increasing importance of ageing and international migration in the context of efforts to alleviate poverty in the Asia-Pacific region.

In the Pacific, a "Ministerial Meeting on Pacific Response to the ICPD Programme of Action" was held in Fiji in 1998. In the overview paper prepared by the UNFPA for this meeting (Chee, 1998), the population and development situation and the status of implementation of the ICPD POA in the Pacific was described in very similar terms to those contained in the present paper (see Section 2, below).

To mark the 10th anniversary of ICPD in 2004, a number of countries undertook national reviews of the implementation of ICPD POA. At the global level, the UNFPA conducted a "field inquiry" based on a comprehensive questionnaire to be completed by every country. Based on the results of the field inquiry and the country reports and background papers submitted to Fifth APPC, ESCAP, jointly with UNFPA, prepared a status report on the implementation of ICPD POA in Asia and the Pacific (United Nations, 2004). In the Pacific Islands sub-region, the results of the field inquiry and other documents were analyzed by the UNFPA Sub-regional Office for the Pacific and a report on the results was published (UNFPA Office for the Pacific, 2004).

In February 2009, ESCAP, with support from UNFPA, convened an Expert Group Meeting in Bangkok to take stock of progress in implementing the "Asia-Pacific Plan of Action on Population and Poverty", along with the objectives and goals of the ICPD POA. In September 2009, a regional review meeting was held in Bangkok during to mark ICPD@15 and to identify priorities for the final five-year period of the POA.

In addition to these UN-sponsored meetings, NGOs and other development partners have conducted their own reviews of the implementation of the ICPD POA over the past 15 years. Wherever applicable, the results of the above-mentioned reviews of the ICPD POA carried out since 1999 are reflected in the present report, as explained in Section C.

8 Including several Pacific Island countries.

B. THE PACIFIC ISLANDS: DEMOGRAPHIC AND ECONOMIC CONTEXT

The implementation of the ICPD POA over the past 15 years has obviously taken place within an evolving development context which has variously facilitated or constrained the implementation of the POA, while also, to some extent, being affected by the POA. The following sections describe some key aspects of this context.

Population size, growth and dynamics

The estimated population of the Pacific Islands sub-region[9] in 2009 is 9.7 million (Table 3), compared with 6.7 million around the time of the ICPD '94 (SPC 1994). Over the interim 15 years, 3 million people have been added to the population of the Pacific—an average increase of 200,000 per year. Most of this increase (92.5 percent in 2009) has occurred in the Melanesian sub-region. Papua New Guinea, Solomon Islands and Vanuatu account for 81 percent of annual growth in the Pacific. Current projections suggest that the population of the Pacific will reach 10 million in 2011 and just under 12 million in 2020 (Table 3)

9 In United Nations classification, the population of the Pacific Islands sub-region is the sum of Melanesia, Micronesia and Polynesia. Reference to the Pacific region "as a whole" is to this definition. The main focus of this report is on the 15 countries that are covered by the United Nations Multi-Country programmes administered from Suva and Apia plus Papua New Guinea, which has its own UN Programme of Assistance. The applicable countries are shown in Table 3.

Table 3: Basic demographic indicators Pacific Islands, ca 2009

Sub-region/ Country	Total population 2009	Projected population 2020	Current population growth rate (%)	Rate of natural increase (%)	Net migration rate (%)	Annual increment (number)	Percent of annual increment	Percent urban
Pacific Islands	**9,677,795**	**11,801,200**	**1.9**	**2.0**	**-0.1**	**183,688**	**100.0**	**23**
Melanesia	**8,478,155**	**10,465,00**	**2.0**	**2.1**	**-0.1**	**170,169**	**92.5**	**19**
Fiji	843,888	890,400	0.5	1.3	-0.8	4,219	2.3	51
New Caledonia	250,612	291,200	1.6	1.1	0.5	4,046	2.2	63
Papua New Guinea	6,609,745	8,267,400	2.2	2.2	0.0	142,876	77.8	13
Solomon Islands	535,007	703,500	2.7	2.7	0.0	14,587	7.9	16
Vanuatu	238,903	312,500	2.5	2.5	0.0	6,071	3.3	21
Micronesia	**539,440**	**624,200**	**1.4**	**1.7**	**-0.3**	**7,585**	**4.1**	**66**
FSM	110,899	116,500	0.4	1.9	-1.5	455	0.2	22
Guam	182,207	224,200	2.7	1.4	1.3	4,984	2.7	93
Kiribati	98,989	119,900	1.8	1.9	-0.1	1,805	1.0	44
Marshall Islands	54,065	59,500	0.3	2.6	-2.3	176	0.1	65
Nauru	9.771	12,000	2.1	2.1	0.0	203	0.1	100
Northern Mariana Is	63,112	70,300	0.0	1.6	-1.6	-18	0.0	90
Palau	20,397	21,800	0.6	0.6	0.0	119	0.1	77
Polynesia	**659,961**	**712,000**	**0.8**	**1.6**	**-0.8**	**5,086**	**2.8**	**37**
American Samoa	65,113	74,600	1.2	1.9	-0.7	781	0.4	50
Cook Islands	15,636	16,400	0.5	1.2	-0.7	72	0.0	72
French Polynesia	265,654	297,600	1.2	1.2	0.0	3,176	1.7	51
Niue	1,514	1,200	-2.3	0.6	-2.9	-36	0.0	36
Samoa	182,578	188,400	0.3	2.0	-1.7	615	0.3	21
Tonga	103,023	106,500	0.4	2.1	1.7	372	0.2	23
Tuvalu	11,093	11,800	0.5	1.4	-0.9	58	0.0	47
Wallis and Futuna	14,183	14,300	-0.3	1.1	--0.8	-43	0.0	0

Source: SPC, 2009 Population data sheet. Accessed at http://www.spc.int. And author's estimates.

The current annual growth rate for the region as a whole is 1.9 percent per annum compared with 2.3 percent per year in 1994 (SPC 1994; 2009). The growth rate has therefore dropped by about 17 percent over the 15 years of the ICPD POA or approximately 1.2 percentage points per year. It is significant that the population growth rate has dropped to below 2 percent because this is generally considered by demographers as the dividing line between "rapid" and "moderate" growth. By the standards of the 1970s and 1980s, the Pacific can no longer be classified as a region of "high" population growth. But despite the lower growth rate today compared with 1994, annual additions to the population are presently higher than in the 1990s (184,000 in 2009 compared with 154,000 in 1994) because of population "momentum", and this helps to account for the perception that the population is still growing rapidly. Annual increments to the population will begin to trend downwards over the next decade if the overall population growth rate continues to decline at the same rate as over the past 15 years, but annual additions will probably remain above 1990s levels for another 20 years.

It is impossible to prove that the decline in the rate of population growth can be attributed to the ICPD POA, but (as in the case of the global population) the trend is in the direction indicated in the POA. As is noted below, emigration from the Micronesian and Polynesian sub-regions as well as Fiji has played a role in reducing the overall growth rate in the Pacific Islands. The future of population growth depends on whether these emigration patterns continue and whether rates of natural increase will decline at a more rapid pace than in the past.

By comparison, the present rate of population growth in the Pacific Islands is almost double the current growth rate of the Asian region. The higher overall growth rate in the Pacific sub-region is a function of the fact that the countries with relatively higher growth rates (2 percent per year or over) are also those with the largest populations (Table 3). While only four countries have population growth above 2 percent per year, those countries make up 76 percent of the region's population and therefore have an overwhelming impact on the regional growth rate. The high growth countries are concentrated in Melanesia, with Solomon Islands having the highest rate (2.7 percent) followed by Vanuatu (2.5 percent) and Papua New Guinea (2.2 percent). Growth is 1.4 percent per year in the Micronesia sub-region and 0.8 percent in the Polynesia sub-region.

Population dynamics refers to the changing complex and variable interactions of fertility, mortality and migration rates. As alluded to in the ICPD POA, the most desirable direction of such dynamics is described as the "demographic transition", a process through which all countries have historically passed, or can be expected to pass, from high to low fertility and mortality. The main components of the demographic transition are the "mortality transition" (from high to low death rates) and the "fertility transition" (from high to low birth rates). The relative speed of these two transitions determines how long a country will remain in a state of "high" population growth.

The mortality transition has been underway in the Pacific for many decades, but the pace of change appears to have slowed in recent years. An accurate assessment is impaired by the lack of up to date life tables for several countries. In Solomon Islands, Marshall Islands and Vanuatu, published life expectancy figures are ten years old. Ten Pacific Island countries have achieved the ICPD target of life expectancy at birth above 70 years by 2005, and seven of these are in Polynesia (Table 4).

Three countries fall short of the 2005 ICPD target, most notably PNG, which had a life expectancy of only 54 years in 2000—the latest year for which data are available. Given the high prevalence of HIV infection in PNG—most recently estimated at 1.6 percent of the adult population (National AIDS Council Secretariat, 2007)—it is possible that life expectancy will remain under 60 years for many years to come (Hayes 2007) and it will therefore not reach the ICPD target for 2015. In Fiji, one of the more developed countries in the Pacific, male life expectancy reached a plateau of about 65 years in the mid-1980s and has remained at approximately that level ever since. The main reason for this is that while infant and child mortality have improved, adult mortality has increased due to the growing prevalence of such non-communicable diseases as diabetes, cancer, stroke and heart disease. The epidemiological transition, in which the causes of death shift from primarily infectious diseases to degenerative and non-communicable diseases, is well underway in Fiji as well as in most Polynesian countries.

The fertility transition has also been underway for several decades in some Micronesian and most Polynesian countries, as well as Fiji, and more recently in Western Melanesia. Like the mortality transition, the fertility transition has been slow. In most countries fertility decline still has quite some distance to go before it reaches "replacement" level (the point at which population growth due reproduction would cease, normally considered 2.2 children per woman on average).

Table 4: Selected ICPD and MDG indicators on mortality, water, sanitation and immunization

Sub-region/Country	Expectation of life at birth (both sexes)		Infant Mortality Rate (per 1000 live births)	Under five mortality Rate (per 1000 live births)	Maternal Mortality Ratio (per 100,000 live births)	Proportion of population using improved water source and sanitation (%)		Proportion of 1-year olds immunized against measles
	E_0	Ref year				Water	Sanitation	
Melanesia								
Fiji	67.5	2007	13.1	26.0	43	92.7	98.8	76 (2002)
New Caledonia	75.9	2007	6.1	--	--	--	--	--
Papua New Guinea	54.3	2000	57.0	77.0	--	40.0	45.0	82 (2006)
Solomon Islands	61.1	1999	66.0	--	103**	29.8	22.4	87 (2007)
Vanuatu	67.3	1999	25.0	30.0	148	75.3	95.2	66 (2003)
Micronesia								
FSM	67.7	2000	37.5	--	140*	94.0	44.0	84 (2001)
Guam	73.6	2000	11.7	--	--	--	--	
Kiribati	61.0	2003	52.0	69.0	284***	53.1	36.5	76 (2001)
Marshall Islands	65.6	1999	21.0	37.0	--	98.4	70.7	54 (2007)
Nauru	56.2	2006	38.0	--	--	81.7	96.9	--
Northern Mariana Is.	75.3	1999-01	7.3	--	--	--	--	--
Palau	69.2	2005	20.1	--	--	100.0	100.0	99 (2002)
Polynesia								
American Samoa	72.6	2000	11.7	--	--	--	--	--
Cook Islands	71.2	1996-02	15.3	--	--	95.1	99.3	98 (2001)
French Polynesia	74.1	2005-07	6.8	--	--	--	--	--
Niue	71.5	2001-06	7.8	29.0	--	99.0	100.0	99 (2002)
Samoa	72.9	2006	20.4	24.0	22	97.3	100.0	98 (2001)
Tonga	70.2	2004-5	19.0	25.0	136	98.0	99.0	96 (2002)
Tuvalu	63.3	1997-02	35.0	--	--	92.5	86.5	99 (2002)
Wallis and Futuna	74.9	1996-03	4.9	--	--	--	--	--

*--=not available *2007 . **2005-06. ***2004.*
Source: UNFPA Sub-regional Office for the Pacific database. SPC 2009 Population data sheet. Noumea. AusAID (2009). UNFPA (2008b).

In several countries across the Pacific, the average number of lifetime births per woman[10] is currently between 4 and 5, which by present world standards is considered high. While several countries have reached a TFR of around 3, only four countries have TFRs at or below replacement level (Palau, Northern Mariana Islands, New Caledonia and French Polynesia).

In spite of the incomplete fertility transition, some Micronesian and most Polynesian countries have low rates of population growth because of the impact of emigration. Eight of the nine Polynesian countries have a net migration outflow and four out of seven Micronesian countries (Table 3). In Melanesia only Fiji has net emigration. Natural increase (the difference between births and deaths) is 2.0 percent in the region as a whole but has dropped to 1.7 percent in Micronesia and 1.6 percent in Polynesia. But some countries within these sub-regions have higher rates of natural increase, notably Marshall Islands (2.6), Samoa (2.0) and Tonga (2.1). In some of these countries, net migration is sufficient to remove the equivalent of 80 percent or more of natural increase. Only a minority of countries in the Pacific have achieved low population growth by means of low rates of natural increase rather than emigration and with the exception of Palau these are dependent territories.

The ICPD POA urges governments to "complete the demographic transition", but most Pacific Island countries have some distance to go before achieving low mortality and low fertility. While the mortality transition has progressed quite far with life expectancy above 70 years in some countries, the fertility transition has lagged. It is possible that the availability of migration outlets has reduced the incentive at the family level to reduce fertility, particularly in Polynesia, although this relationship is complex and in the Fiji case the relationship may be the other way around—especially among the Indian minority. In spite of considerable progress over the past 15 years, completing the demographic transition remains a relevant policy challenge in the majority of Pacific Island countries.

10 Technically known as the Total Fertility Rate or TFR.

Table 5: Selected ICPD/MDG indicators of fertility, family planning and safe motherhood

Sub-region/ Country	Antenatal coverage – at least one visit and at least four visits		Births attended by trained health personnel (%)	Unmet need for family planning (%)	Number of women with unmet need (estimate, various years)	Contraceptive prevalence rate (%)	Teenage fertility rate (births per 1000 population 15-19 years)	Total fertility rate
	One	Four						
Total					649,140			
Melanesia								
Fiji	100.0	--	99	20	37,800	45	32	2.6
New Caledonia	--	--			--			2.2
Papua New Guinea	77.5	54.9	53	46	560,000	24	65	4.6
Solomon Islands	97.2	64.6	86	11	13,100	27	67	4.6
Vanuatu	67.0	--	74	--	9,600	38	--	4.4
Micronesia								
FSM	80.0	--	93	44	7,800	--	--	4.0
Guam	--	--						2.7
Kiribati	--	--	63	--	--	22	39	3.4
Marshall Islands	95.4	77.1	94	8	12,200	37	138	4.4
Nauru	94.5	--	97	--	--	25	69	3.4
Northern Mariana Is.	--	--			--			1.6
Palau	100.0	88.0	100	--	--	17	29	2.0
Polynesia								
Cook Islands	100.0	--	98	--	740	44	44	2.9
French Polynesia	--	--			--			2.2
Niue	--	--	100	--	--	23	28	2.6
Samoa	100.0	--	89	--	7,900	31	45	4.2
Tonga	--	--	95	--	--	28	24	4.2
Tuvalu	99.0	--	100	--	--	19	42	3.7
Wallis and Futuna	--	--	--	--	--	--	12	2.6

Source: SPC 2009 Population Data Sheet. UNFPA Sub-Regional Database. --=not available

Economic growth, development and poverty

In contrast to many Asian countries, particularly the "tiger" economies, economic growth in the Pacific Islands has been slow over recent decades (AusAID, 2009), in spite of significant economic reform. In several countries GDP growth has been lower than population growth, resulting in a decline in per capita GDP. Prior to the recent global recession, however, economic growth was on the increase in Papua New Guinea, Solomon Islands and in some of the Polynesian countries that have a significant tourist sector. In Fiji, one of the main tourist destinations in the Pacific, political instability combined with the global recession produced a 23 percent decline in tourist arrivals in 2009 relative to the previous year, contributing to increasing unemployment and probably exacerbating poverty. But Fiji's total economic output also dropped by 6.6 percent in 2007, before the global recession set in (AusAID 2009). It is important to note that tourism plays a much larger role in the economies of the Pacific Islands sub-region than is the case in most other developing regions, adding to economic vulnerability in a widespread economic downturn.

The very slow improvement in per capita GDP growth has no doubt constrained the ability of governments to increase their revenues and raise their contributions to health and population programmes.

Migrant remittances play a major role in the economies of several Pacific Island countries. As a percentage of GDP, remittances are significantly higher in the Pacific sub-region than in other countries of the Asia-Pacific region. In Tonga, for example, migrant remittances were equivalent to 42 percent of GDP in 2004 (World Bank 2006). Remittance income has also been increasing rapidly in Fiji and in 2006 an estimated $US127 million was received from migrants overseas (UN ESCAP Statistical Yearbook, 2008). In general, migrant remittances tend to improve the distribution of income and reduce poverty (World Bank, 2006) so the decline in migration opportunities caused by the current global economic crisis may worsen poverty at home.

Extreme poverty, hunger and destitution are nevertheless considered rare in the Pacific Islands due to the nearly universal access to land and other subsistence resources (Abbott, 2006). Figures on poverty using standard international monetary income definitions, such as the proportion of the population living on less than $US1.00, $US1.25, or $US2.00, have rarely been calculated in the region on the grounds that they are inappropriate in a culture and economy characterized by traditional forms of exchange and kin-group reciprocity. One exception is Papua New Guinea where it is reported that 35.8 percent of the population was living on less than $US1.25 per capita per day in 2004 (ADB, 2009). Earlier studies indicated that about 10 percent of Papua New Guinea's population was below the "food poverty line" in 1996. Food poverty was overwhelmingly a rural phenomenon.

In the context of MDG-based development planning in the Pacific Islands, extreme poverty has been replaced by the "basic needs" concept and "basic needs poverty lines" have been calculated for several countries (see Abbott, 2006). It is therefore not possible to compare poverty levels or trends in the Pacific with Asian countries. The basic needs concept is essentially a measure of relative rather than absolute poverty because it requires a judgment as to what needs are basic in any given society. It is possible for absolute poverty (as measured by dietary consumption and income) to be declining even as relative poverty is increasing).

The proportion of the population falling under the basic needs poverty line in Pacific developing countries ranges from 13 percent to 50 percent (AusAID 2009). Where time series are available, poverty has more often increased through time than declined and there is a strong impression in the data and anecdotal reports that relative poverty is worsening in the region. This is not proven generally but in Fiji poverty has increased between the last two household income and expenditure surveys (Abbott, 2006). Poverty is allegedly increasing in Papua New Guinea but the quality of the data used to make this judgment is far from robust.

An indirect measure of poverty can be obtained by the proportion of the population having access to improved water and sanitation. In most Pacific countries, over 90 percent of the population has such access, but in Kiribati, Papua New Guinea and Solomon Islands, access to an improved water source is only 30, 40 and 53 percent, respectively. Access to improved sanitation ranges from only 22 to 45 percent in these countries (Table 4).

Environment and climate change

Pacific Island countries are among the most vulnerable in the world to environmental calamities, including earthquakes, tsunamis, tropical cyclones, flash floods and droughts. Like other island regions (e.g., the Caribbean), the Pacific Islands experience much more rainfall volatility than other developing countries and are more likely to experience natural disasters or shocks (World Bank 2006). Environmental vulnerability has a particularly negative impact on food production, which in turn reduces food security. The impact of natural shocks is such that some Pacific Island Countries "...seem to be in a constant mode of recovery" (FAO 2006). These environmental conditions have always been present in the Pacific and are remembered in oral history.

The most fragile environments in the Pacific can be found in those countries that comprise mostly or completely low-lying atolls. Atolls lack rivers or lakes and have very little ground water reservoirs. Atolls also have very little organic soil for growing food and what little soil exists is easily inundated by salt water. Storm-driven salt spray can also damage plants and deter their growth. Traditionally, atoll populations consisted on a diet of fish, coconut, breadfruit, and, on some islands, taro. A delicate balance between the food supply and the population had to be maintained to ensure survival. With rising incomes, food and other products can be imported and higher population densities can be achieved; but atolls also have limited capacity to absorb the waste products of industrial production and lifestyle. Landfill is ruled out for lack of suitable sites and dumping in the sea threatens the fish supply. Many atolls have significant pollution problems affecting their ground water lens.

The spectre of rising sea levels caused by climate change is now haunting the Pacific Islands. This issue was originally raised during the Fourth Asian and Pacific Population Conference held in Bali in 1992. The "Bali Declaration on Population and Sustainable Development" adopted at the Conference (United Nations, 1992) noted that: "In many countries and areas, high rate of population growth and concentration have caused environmental problems, such as land degradation, deforestation, air and water pollution, threats to biological diversity from habitat destruction and rising sea level due to green-house effect."

The most recent "Synthesis Report" of the United Nations Intergovernmental Panel on Climate Change (UNIPCC, 2007) has projected that average global sea level could rise by between 0.18 and 0.59 metres by the decade 2090-99 relative to 1980-99. These projections are based on climate simulation computer models, which are subject to much uncertainty. Empirical measures of sea-level rise using tide gauges and satellite based imaging indicate that sea level has been rising at an average rate of between 1.8mm and 3.8mm per year over the period 1961-2003 (UNIPCC, 2007). According to the report, it is unclear whether the changes in surface temperature said to be responsible for rising sea level is short-term or signals long-term climate change. Given the vulnerability of the Pacific to a weather phenomenon known as the El Nino/ El Nina Southern Oscillation, which affects weather patterns—including sea temperature—on a cyclical basis, it is difficult to know whether recently-observed changes in weather patterns and sea temperatures are due to this factor or if global warming is to blame. Nevertheless, some regional experts (e.g., Nunn, 2009) are convinced that Pacific sea levels will rise by "more than one metre" by the end of the present century.

A sea level rise of between one half and one metre would have profound consequences for Pacific Island populations. Except for the highland and highland fringe areas of PNG, Fiji and Solomon Islands, most Pacific Island people live near the coasts. While some coastal locations may be less vulnerable, low-lying river deltas and coral atolls will be at risk of inundation and, in the worse-case scenario, become uninhabitable. While atolls and some "high" islands are protected by fringing coral reefs, increasing sea temperatures could place coral under "thermal stress" leading to death of the coral, thus increasing vulnerability to coastal erosion. But projected climate change would have an impact on all Pacific islands whether high or low due to the greater frequency of severe weather events such as heavy rain causing floods. While the frequency of cyclones may not necessarily increase, it is possible that those that do occur will be more intense. In so far as the oceans are absorbing greater quantities of carbon dioxide, there is also a danger that the oceans will become more acidic, with a potentially negative impact on sea-life an important source of food.

Given the importance of tourism to many Pacific Island economies, and the central role of pristine beaches in tourist expectations, the potential economic impact of climate change would be severe.

As Island countries do not produce significant quantities of the greenhouse gasses responsible for global warming it is impossible for them to mitigate the causes of climate change, other than urging the governments of the industrialized and industrializing countries to reduce their emissions. Island countries are therefore faced with the task of adapting to the anticipated changes. Given the very limited resilience and capacity for adaptation of atoll and river delta ecosystems, it is possible that population displacement will necessarily occur. The extreme case would be for atoll populations (such as those of Kiribati, Marshall Islands, Tokelau and Tuvalu) to be relocated to other countries as these countries do not have any "higher ground" to which populations can move (Nunn, 2009).

It is extremely important that Pacific Island countries have access to the widest possible range of scientific assessments of the likelihood of long-term climate change in the Pacific, and its potential consequences, before developing plans to abandon their countries.

Emergencies and conflicts

Quite aside from the effects of climate change, the Pacific Islands have also experienced a significant number of natural calamities within living memory such as volcanic eruptions, tsunamis, earthquakes and cyclones, some of which have displaced people, rendered many homeless and caused death and destruction. A recent example is the tsunami that struck the Samoa islands and Tonga in September 2009, causing the destruction of property and loss of life. An even more destructive tsunami struck the North coast of Papua New Guinea in 1999 destroying villages and causing significant loss of life and injury. Others islands have been struck by extreme weather events, including cyclones and tropical storms causing flooding and the destruction of food crops.

Some Pacific countries have also gone through civil and military conflicts which have either displaced large numbers of people or have made it difficult for them to have access to basic services. Examples include the civil war that erupted on Bougainville Island (PNG) in 1989 and lasted almost one decade, and the civil conflict that engulfed the Solomon Islands a decade later. The affected populations lacked significant health services, including reproductive health services and commodities for several years. Responding to the needs of people affected by such emergencies has stretched the limits--financial and human resources--of many countries, and therefore must remain a priority for international development assistance.

C. SCOPE, METHODOLOGY AND ORGANIZATION OF THE REPORT

This report presents the findings of a desk review of the Pacific experience in implementing the ICPD POA (including the revisions contained in the Key Actions adopted at ICPD+5). As previously noted, the ICPD POA can be assessed in terms of the extent to which countries have implemented the recommended actions as well as in terms of whether the quantitative targets of the POA have been achieved or are likely to be achieved by the specified target date—regardless of whether the recommended actions have been taken. By reviewing the performance of countries on quantitative targets, the report also constitutes a review of country performance on those MDGs that overlap with the ICPD POA targets

So far is the implementation of the recommended actions of the ICPD POA is concerned, this report is based primarily on the findings of prior reviews—in particular those carried out in preparation for the ICPD+5 and ICPD+10 global reviews. Country performance on quantitative targets is assessed on the basis of selected ICPD and MDG indicators. Recent data are shown in Tables 3-6. More details of trends on MDG indicators can be found in UNFPA Sub-Regional Office for the Pacific (2008).

The report is organized into three major sections. Following this introductory section which highlights the goals and objectives of ICPD and its link with the MDGs, Section 2 examines progress made by Pacific Island countries towards the achievement of the goals and objectives during the fifteen year period and is subdivided into four areas: population and development, reproductive health, gender equality and partnerships and resources. Section 3 highlights the progress made and the major challenges currently faced by countries, and recommends priority areas and strategies for the next five years and beyond.

SECTION 2: ASSESSMENT AND REVIEW OF PROGRESS SINCE ICPD

A. POPULATION, SUSTAINABLE DEVELOPMENT AND POVERTY

Population and poverty

While the ICPD POA does not include specific targets rates for population growth as such, Chapter I points out that:

> *Implementation of the goals and objectives contained in the present 20-year Programme of Action, which addresses many of the fundamental population, health, education, and development challenges facing the entire human community, would result in world population growth during this period and beyond at levels below the United Nations medium projections (p.7).*

It is quite clear that slower population growth at the global level is the preferred outcome of the ICPD. Current population estimates suggest that this objective has been achieved. The medium variant of the UN projection for the year 2015 was for the world population to reach 7.5 billion; the low variant was 7.1 billion. The actual estimated global population in 2009 was 6.8 billion and this is projected to reach 7.0 billion by 2011 (Population Reference Bureau, 2009). Given the present population increment of 83 million per year, the population in 2015 would reach 7.3 billion—about 200 million below the medium variant. On this score it can be said that the ICPD POA has achieved an important goal of reducing global population growth. To the extent that population growth contributes to increased poverty, the reduction in global growth can also be said to have reduced poverty. It is also likely that the decline in the population growth rate has produced environmental benefits as well.

Poverty is caused by a multitude of factors operating at micro- and macro-levels. At the micro-level of the household, high fertility translates into larger household size, higher dependency and lower per capita income. At the macro-level, a high rate of national population growth places pressure on social services, including health and education. These processes can be self-perpetuating unless the cycle can be broken through an economic breakthrough or political action. This is recognized in the ICPD POA: as it calls upon countries to "raise the quality of life through population and development policies and programmes aimed at achieving poverty reduction, sustained economic growth in the context of sustainable development" (para 3.5). The Fifth Asian and Pacific Population Conference (2002) concluded that the "countries that have been most successful in reducing poverty are also those that have done most in reducing high levels of population growth and balancing population and development dynamics as well as meeting reproductive health needs" (UN ESCAP, 2003).

While improving access to education and health services—including reproductive health and family planning services—is critical to poverty reduction, efforts to date in some countries of the Asia-Pacific region appear to be misdirected. It was argued at the recent Expert Group Meeting convened to review the implementation of the Asia-Pacific Plan of Action on Population and Poverty" that:

> *An objective assessment of the provision of public facilities for education and health in many countries of the ESCAP region would have to conclude that such provision not only does not serve to narrow the wide gaps between the welfare of the poor and that of other sections of the population, it actually serves to widen them. (Jones, 2009)*

A similar view was expressed by the Deputy Executive Director of UNFPA at the opening session of the Asia-Pacific High-Level Forum on ICPD held on 15 in September 2009:

> *People who have the most resources—whose needs for health care are often less—tend to consume most care, whereas those with the least means and the greatest health problems consume the least. Data shows that public spending on health services most often benefits the rich rather than the poor in high- and low income countries alike. (Mane, 2009)*

As emphasized by Ms Mane, the appropriate policy response would be to reduce existing inequalities in the provision of health-care. Hence, a pro-poor approach to the provision of basic services, including improving access to reproductive health and family planning services, should be a priority if poverty is to be alleviated and the quality of life improved.

In South-east Asia in particular, reductions in poverty have been closely associated with rapid economic growth. In turn, rapid economic growth has been associated with the demographic transition and slower overall population growth. Recent academic research on the relationship between population and economic growth has focused on the impact of changing age-structures on savings, investment and incomes at household and societal levels. The so-called "demographic dividend" that arises from a favorable ratio of dependents to workers is estimated to have contributed up to one third of the growth in per capita income of East-Asian and some South-east Asian economies in recent years. Although economic growth and development and the demographic transition are mutually reinforcing, the typical historical pattern is for the mortality transition to occur first with the fertility transition following after a lag that could last some decades. Thus public investment in health services that reduce mortality, especially infant and child mortality, and make family planning widely available are crucial to the fertility transition and indirectly contribute to economic growth.

Compared to South-east and East Asia, however, the Pacific Islands region has not experienced rapid or sustained economic growth in recent decades (AusAID, 2009). While some countries have achieved positive GDP per capita growth in some years, growth has frequently been a result of a short-term resources boom or a temporary increase in tourist arrivals. Where GDP growth has been achieved through mining, forestry and fishing either resource depletion or environmental damage has offset the monetary gains. These forms of primary resource extraction are also conducive to corruption, which diverts money into private hands and away from essential public investment. The type of rapid, sustained and egalitarian GDP growth that has occurred in many Asian countries as a result of a development strategy focused on "export-driven" manufacturing has not occurred in the Pacific Islands. In spite of significant economic

reforms, the expected benefits of broad-based development accompanied by growth in wage employment have failed to occur, and poverty has increased. In the meantime, Pacific Islanders have continued to exploit the employment opportunities provided by overseas labour markets. There is little doubt that migrant remittances have helped to reduce poverty and to maintain incomes in the face of limited employment opportunities at home (World Bank, 2006).

Until recently, poverty reduction has not been a major feature of development planning in the Pacific Islands. MDG 1 highlights "extreme poverty", a concept that is broadly believed not to apply in the Pacific Islands setting.[11] For the MDGs to become accepted at the country level as a framework for development planning, the concept of poverty had to be re-cast as "basic needs poverty", "poverty of opportunity" or "poverty of access" to basic social services, education and employment (Abbott and Pollard, 2004; Abbott, 2006). In theory, the relationship between basic needs poverty (BNP) and population dynamics is clear. Any list of basic needs would have to include access to basic primary health services (including reproductive health and family planning), along with clean water and sanitation, primary education, and the opportunity for employment. All these aspects of development can be linked to population change. The MDG framework emphasizes the interrelationships between all the MDGs, and this argument finds some empirical support in the Pacific from an analysis of several MDG indicators conducted by the UNFPA (UNFPA 2008) which finds strong correlations between maternal health, access to improved water and sanitation, and the proportion of women in paid employment.

Although the relationship between poverty and population growth is clear in theory, the empirical data at the national level suggest that the relationship is more complex and depends to some extent on the economic context. In Fiji, for example, population growth has dropped to half of 1 percent per year (Table 3), yet the proportion of the population in basic needs poverty has increased (AusAID, 2009). Conversely, the proportion of the population of Vanuatu in basic needs poverty has declined, but the population growth rate remains one of the highest in the Pacific. Samoa has much lower population growth than Vanuatu, as well as a high inflow of remittances from migrants abroad, yet the proportion of the population in basic needs poverty has also increased in recent years (AusAID, 2009).

Observations such as these suggest that more detailed research is needed on the interrelationships between population change and poverty, especially in a contact of high levels of international migration. For example, if emigrants are mainly drawn from higher skilled occupations, a process of "de-skilling" may occur, contributing to a lower quality labour force, leading in turn to a reduction in capital investment, higher levels of unemployment or underemployment and increasing poverty.

Infant and child mortality

Improved child health is an important goal of the ICPD POA and also one of the MDGs. As shown in Table 1, the ICPD POA set quantitative targets for infant and child mortality for the years 2000, 2005 and 2015 in the following terms:

> *Countries should strive to reduce their infant and under-5 mortality rates by one third, or to 50 and 70 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50*

11 Up until the 1990s, Pacific countries were perceived by many planners to be in state of "subsistence affluence".

deaths per 1,000 and an under-5 mortality rate below 60 per 1,000 births. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000 (para 8.16).

While the IMR is also included in the MDG framework as an indicator for monitoring progress in reducing infant and child mortality, neither a level nor a rate of change is specified. Instead, the MDG target indicator is the under-5 mortality rate (U5MR) and the target is to reduce this rate by two-thirds between 1990 and 2015.

Clear evidence of progress in reducing infant and child mortality is evident in the Pacific. The infant mortality rate has been on a downward trend in all Pacific Island countries since the 1990s, although the pace of decline has varied between countries. The ICPD target of 50 per 1,000 in 2000 was achieved in all but two countries (Table 4), but very few countries achieved the more ambitious target of a one third reduction between 1990 and 2000, partly because infant and child mortality rates were already quite low and reducing them further would require more costly interventions. Only three countries—Papua New Guinea, Solomon Islands and Kiribati—fell short of the 2005 target and these are also the only countries that may have difficulty achieving the 2015 target. All other Pacific Island countries have already achieved the ICPD goal of an IMR below 35 by 2015 (Table 4). These trends should be seen as an important achievement in the Pacific, but even in countries in which much progress has been achieved (e.g., Samoa and Tonga) infant mortality is still three to four times the rates found in New Zealand or Australia.

The ICPD POA targets for the under-5 mortality rate (U5MR) by 2000 and 2005 were also achieved in most Pacific countries by 2005 or earlier. Attaining the MDG target of reducing the U5MR by *two-thirds* between 1990 and 2015 is more difficult because the normal pattern in the mortality and morbidity transition is for the pace of decline to slow down as the U5MR reaches lower levels, and several Pacific countries already had low levels by year 2000. Nevertheless, several countries—including Vanuatu, Marshall Islands and most of Polynesia--are on track to achieve this target. The larger Melanesian countries of Papua New Guinea, Solomon Islands, and the more developed country of Fiji may not be able to achieve the necessary rate of reduction. Only two countries (Kiribati and Papua New Guinea) are not presently on track to achieve the ICPD goal for under-5 mortality by 2015.

One of the key factors that explain country performance on the U5MR in the Pacific is immunization coverage. Where the U5MR remains high or is improving at a slow rate, the proportion of 1-year old children immunized against measles is well below the average for countries in which under-five mortality is already low or falling more rapidly. It is also notable that the countries making the least progress in reducing the under 5 mortality rate are those that have the worst access to an improved water supply and sanitation. Thus, these basic health determinants remain important in such countries. An improvement in access to improved water and sanitation will require broad-based, pro-poor development and is therefore likely to be slow.

It is also important to note the constraints under which health systems operate in the Pacific. While health expenditure as a percentage of GDP is low in some countries (4.4 percent in PNG and 3.8 percent in Vanuatu) in others it compares with more developed neighbours such as New Zealand and Australia (7-9 percent). However, such comparisons can be misleading because this expenditure does not necessarily buy a comparable level of services—particularly personnel—given that per capita GDP remains low in most countries. Papua New Guinea, for example, has one physician and 10 nurses for every 20,000 people compared with 42 and 164, respectively, in New Zealand (WHO, 2009). Again, only broad-based economic development and growth that benefits lower income and disadvantaged groups is likely to improve this situation.

Age structure and the demographic "window of opportunity"

Most Polynesian and several Micronesian countries have already reached, or are about to reach, the so-called demographic "window of opportunity" (Rallu and Robertson, 2007) provided by an age structure in which the population in the working age range (15-64) is proportionally larger than the population of dependants (0-14 + 65 and over). This window of opportunity provides an economic advantage to these countries in that the costs of dependent children or the elderly are as low as they are ever likely to be for the current generation of working age persons. This phenomenon should contribute to increased savings and investment as well as providing the funds for human resources development, thus leading to more rapid economic growth than would otherwise occur. Under the conditions of fertility decline and increasing life expectancy, the window will be open for a short time, possibly a decade or two, after which population ageing will increase the overall dependency ratio again and the window will close.

Few Pacific countries are aware of the implications of the so-called "demographic bonus" (Ogawa, Chawla and Matsukura, 2009) for economic development and public policies to promote economic growth. As already mentioned, and discussed further below, Polynesians and Micronesians have reacted to the window of opportunity by seeking opportunities in external labour markets because opportunities for paid work at home are limited—especially in outer islands and remote areas. This situation also applies to Fiji (particularly, but not exclusively to Indo-Fijians) and it is highly likely that political instability will delay the potential benefits of the demographic bonus emerging in that country.

Population ageing

An inevitable consequence of the demographic transition to lower mortality and fertility is an age-structure transformation. Population ageing is reflected in increasing proportions of the population reaching 60 years and over—a process caused by increasing life expectancy and reduced fertility. In the Asia-Pacific region as a whole, it is estimated that older persons will constitute about 15 percent of the population by 2025 and 25 percent by 2050. Furthermore, an increasing number of countries will enter this stage and population ageing, which was until recently limited to the more economically developed countries, will become more rapid and an important feature of population dynamics of all countries in the not too distant future.

Anticipating this issue, the ICPD POA called on countries to "develop systems of health care, as well as systems of economic and social security in old age, where appropriate, paying special attention to the needs of women." The POA also calls on countries "to enhance the self-reliance of elderly people to facilitate their continued participation in society" (para 6.18 and 6.19). International efforts to respond to

the challenges posed by population ageing culminated in the adoption of "The Madrid International Plan of Action on Ageing" (MIPAA) at the Second World Assembly on Ageing in 2002 which has since become the basis for action on population ageing.

Up until the 1970s, most Pacific Island countries had youthful populations with a median age of around 17-19 years. The proportion of youth in these populations has remained relatively high due to population "momentum", but as in Asia, the mortality and fertility transitions have begun to have an impact on age structures and several countries now have ageing populations.[12] The proportion of the population aged 60 years and over has been increasing steadily over the past two decades. The growth rate in this age group currently exceeds the total growth rate by a considerable margin in several countries. Between 2000 and 2050, the elderly population of the Pacific Islands is projected to grow from 376,000 to 2.25 million, and the "oldest old" (80 years and over) is projected to grow from 18,900 to 266,400 over the same period (UNFPA Pacific Sub-regional Office, 2009). By the year 2050, the populations of some Pacific Island countries will have a median age of almost 40 years. Because female life expectancy is generally higher than male, the majority of the elderly population is already female but this trend will likely accelerate in the future.

Ageing is currently most advanced in the Micronesian and Polynesian countries and in Fiji. The double impact of the demographic transition and emigration is particularly evident on outer islands and remote areas where the population of labour force age is shrinking while the elderly population is growing and becoming more feminine. In Western Melanesia, the mortality and fertility transitions started later and have proceeded more slowly—hence these populations are still youthful and will not start ageing for another decade or more.

12 The "Port Vila Declaration" of 1993 anticipated this development.

Where ageing is occurring, Pacific governments have yet to examine in detail the implications for health care and social welfare. As in Asia, most elderly are cared for in a family setting, but this arrangement will come under increasing strain in the coming years as higher proportions of the elderly population reach 80 years of age and over and suffer from disability, infirmity, chronic illness and a shortage of care-givers due to the impact of emigration. In countries (such as Samoa) that have introduced a universal old-age benefit and free health care, the budgetary implications of rapid population ageing are serious.

The following list summarizes the main features of ageing in Asia and also has applicability to those Pacific countries with ageing populations:

- Population ageing is already occurring in most Asian and many Pacific Island countries; the effects of ageing will begin to be felt within the next decade.
- Ageing will occur more rapidly than in developed countries and the time required to adjust welfare and social security systems to meet the challenge of ageing is limited;
- Ageing is occurring at much lower levels of development and incomes than ever before;
- Social security systems are underdeveloped and cover only a small proportion of the population in most countries;
- Health systems are not prepared to meet the emerging epidemiological transition to degenerative and non-communicable diseases, and with the persistence of poverty, the elderly poor will suffer most;
- Women significantly outnumber men among older persons and particularly in the "oldest old" age group;
- Older women will be disadvantaged, a situation aggravated by the cultural norms that discriminate against women in many countries;
- The extended family remains the foundation for economic and social support for older persons, but it is undergoing change and with increasing education, migration and smaller family size the role of the family in caring for older persons is likely to diminish;
- Women are the major care givers for older persons at home. Nurses in hospitals and other institutions are mainly women in all Asian and Pacific countries. While ageing would increase the demand for nursing and create employment opportunities for women, increasing female employment in formal sector occupations will limit their ability to care for older persons at home;
- Public financing for health care and social security will be under stress;
- The knowledge base and policies to accumulate wealth from the "demographic dividend" that would cushion the impact of ageing are still unclear and not available to policymakers.

Actions to address the issue of population ageing will depend upon the particular demographic, socio-economic, and cultural circumstances of particular countries. In broad terms, the following list indentifies priority actions that should be considered by Asian and Pacific countries in preparing for an ageing society:

- Expand the coverage of social security systems to include those not covered by formal system; assess the sustainability of current systems and make necessary changes that would ensure their sustainability;
- Reorganize health systems and service delivery infrastructure to meet the emerging needs of older persons, including the special needs of older women;
- Establish and support mechanisms for self reliance of older persons through community involvement; provide appropriate support to families for care of the elderly;

- Encourage and facilitate the participation of older persons in productive activity through continuous learning and, where possible by increasing the age limit for retirement;
- Encourage healthy life styles among the young through appropriate health education;
- Promote the participation of the private sector and NGOs in old age care, including health care and in setting up community based self help schemes;
- Support research and knowledge base development, particularly for benefitting from the potentials of demographic dividend and the accumulation of wealth;
- Disseminate knowledge including national experiences widely to planners and policy makers through appropriate modalities;
- Incorporate population ageing into all sector plans and strategies or consider the formulation of a broad-based population policy that focuses on the implications of changing age structures for social and economic welfare.

International migration

The ICPD POA recognized the emergence of international migration, in particular labour migration, as an important component of population dynamics and the significant impact it has on development, poverty reduction and the empowerment of women. The POA identified the diverse forms of international population movements, classifying them as documented, undocumented, refugees and asylum seekers.

The objectives of ICPD POA in addressing the multi-faceted issue of international migration are to: derive maximum benefit for both sending and receiving countries from these movements; to promote the rights of migrants and their families, provide protection and eliminate discrimination; to ensure that those in vulnerable situations, particularly women and girls, are protected from abuse and have access to basic needs and services.

A review of the international migration patterns from and within the Asian and Pacific countries was undertaken at Fifth Asian and Pacific Population (2002) and dealt with its impact on such issues as development and poverty, family and remittances. The review highlighted the increase in the number of women among international migrants during recent years. The Plan of Action adopted at Fifth APPC affirmed the actions recommended in the ICPD POA, but called for the regularization of desirable migration (unauthorized migration that is tacitly accepted by destination countries), better utilization of remittances, and the promotion of regional cooperation to manage the migration flows.

International migration plays a significant role in both the population dynamics and economies of many Pacific Island countries—mostly in the Micronesian and Polynesian sub-regions. All the Polynesian developing countries have net outward migration as do four out of five Micronesian countries. Fiji has also emerged in recent years as an important sending country for migrants to Australia, New Zealand, USA and further abroad—including the Middle-East. Most emigrants are in skilled occupations, including doctors, nurses, teachers, accountants and IT personnel, but security guards and bus drivers are also joining the emigration stream.

As already indicated, international migration plays a significant role in reducing overall population growth, given relatively high rates of natural increase in many countries, as well as alleviating unemployment and underemployment. Migration streams to and from the Pacific are many and varied as to their country of origin, destinations, skill composition, degree of permanence, and gender balance. Some countries have open access to New Zealand or the United States and some Island citizens can move without restriction. In others, migration is controlled by the receiving countries (mostly Australia, New Zealand and the United States). Generally, Melanesian countries do not have easy access to international migration by virtue of historical ties (as is the case in Samoa and the Polynesian countries associated with New Zealand) and migration plays a negligible role either in their population dynamics or their economies. Fiji is a partial exception due to the eligibility of Fijians to join the British army and their recent practice of joining private security firms operating in the Middle-East and elsewhere. The emigration of ethnic Indians from Fiji has been long-standing and has contributed to reducing the overall rate of population growth in Fiji.

International migration from Pacific Island countries is vulnerable to the global economic recession, particular in countries providing semiskilled or unskilled workers on temporary labour contracts. Seafarers and temporary agricultural workers are two of the occupations likely to be affected in the next few years. Global shipping has declined significantly in the past year due to the recession. A slowdown in recruitment of these occupations is likely to increase hardship in the Pacific—especially in the more remote islands with few other opportunities for wage work. If world economic growth returns to previous levels, the downturn in migration may prove to be temporary. Efforts to design bi-lateral agreements on unskilled labour mobility between Pacific countries and Australia and New Zealand that would enhance economic growth in Island economies are still in early stages (World Bank, 2006), although New Zealand has already implemented a seasonal temporary employment scheme to provide unskilled labour to the horticulture industry. Kiribati, Tuvalu and Vanuatu presently participate in this scheme.

Development partners, including the United Nations, have a major role to play in building a knowledge base on international migration, including its impact on development, and to promote dialogue among sending and receiving countries. In this context the over-riding challenge is to ensure that international migration contributes to the development of both sending and receiving areas.

Integration of population in planning and poverty reduction strategies

The ICPD POA reiterated calls to "integrate population issues into the formulation, implementation, monitoring and evaluation of policies and programmes relating to sustainable development" (para 3.16) in line with the World Population Plan of Action adopted at earlier conferences. The POA recognized that "efforts to slow down population growth, to reduce poverty, to achieve economic progress, to improve environmental protection, and to reduce unsustainable consumption and production patterns are mutually reinforcing" (para 3.14); thus, population factors should be integrated into all development strategies and sector plans.

In a report prepared to assist Pacific Island countries to participate in the ICPD in 1994, the following relevant comment was made:

> *Given the magnitude of population developments just outlined, and their social, economic and political implications, it appears that the joint consideration of population and development will have to become the single most urgent area of public policy reform for Pacific island government. (SPC, 1994)*

It is fair to say that over the 15 years that have elapsed since ICPD most Pacific Island governments have not treated the issue of population and development interactions with the urgency it was said in 1994 to deserve. The population policies that normally provide the context within which governments can address their particular population and development situation have, with some exceptions, languished in an incomplete state and with uncertain prospects for completion. Similarly, the integration of population into sector plans has not advanced much since the pre-ICPD period.

This situation is not unique to the Pacific. In Asia, the 10-year review of ICPD implementation showed that the degree of integration of population in development strategies varied widely between countries in scope and depth. Changing national contexts and planning systems adopted during recent decades by many Asian countries have added another dimension of variation (UN ESCAP and UNFPA, 2004), but generally the integration of population into development planning was much less than might have been expected after ICPD.

The 2003 Field Survey on ICPD implementation conducted by UNFPA included a number of questions designed to determine what steps countries had taken to integrate population concerns into their development strategies, as called for in the POA. In the Pacific, two-thirds of the countries that responded to the survey said that they had taken "strong" action to integrate population into development strategies, but in many cases the question was interpreted as referring to the integration of reproductive health into health plans (UNFPA Office for the Pacific, 2004). At the time of the Field Survey, poverty reduction did not feature strongly in national development strategies in the Pacific and that is reflected in the high proportion of non-responses to the question on population and poverty. Only one country (PNG) had incorporated its national population policy goals into its poverty reduction strategy.
A key dimension of integrated population and development planning is the use of population projections to assess future demands for health services and personnel, infrastructure, employment as well as future environmental impact. The 2003 review indicated that only one country in the Pacific appeared to be making use of population projections for planning purposes. A later review of a number of health plans and strategies (UNFPA Pacific Sub-Regional Office, 2008) found no evident use of population projections to forecast future demand for health services, for example.

It appears that in the Pacific Islands, the paradigm shift to reproductive health and rights in the ICPD POA was interpreted by many development planners in the Pacific Islands to mean that population policies were neither necessary nor useful. Only one country in the sub-region completed and ratified a national population policy after ICPD '94. Several other countries commenced the process of policy formulation but development stalled when technical support ran out. At this point in time possibly six national population policies remain incomplete, in draft, awaiting approval, or have been abandoned.

It is important to note that from the early 1990s, the nature of development planning in the Pacific, as in other developing regions, changed radically as development policy moved away from centralized planning and 5-year development plans to a free market system in which the role of government in the economy was to be minimized. The promotion of a more *laissez-faire* economic system included the privatization of government assets, the deregulation of communications, transport and labour markets, the reduction of various trade barriers, and the promotion of private sector development. Given these institutional arrangements there was very little room for population dynamics to be incorporated into macroeconomic development plans. Most governments adopted short-term (2-3 year) development strategies, which made little or no reference to population trends. With the arrival of MDG-based development planning in 2000-01, population policy formulation was further downplayed.

In PNG, however, the multi-sector, ICPD POA-inspired National Population Policy (NPP) 2000-2010 has played an important and useful role in the development of the country's poverty reduction strategy as well as in the preparation of MDG reports. This is especially true at the sub-national level, as almost all provinces have used the NPP to formulate their provincial development plans. Population policies still have a useful role to play in the region and the ICPD POA provides an appropriate framework to guide their formulation—fully consistent with human rights. MDG-based planning can benefit from a more comprehensive approach to population that a multi-sector population policy can provide, and renewed efforts to develop such policies is required.

In the Pacific, as in Asia, few countries have conducted a systematic review of the current status of the integration of population, reproductive health and gender issues into national development plans and poverty reduction strategies. However, there is evidence that increased efforts are being made in many countries, including Nauru in the Pacific. These include, inter alia, the preparation of position papers, organizing national policy dialogues, and taking active part in discussions leading up to the formulation of national development plans and poverty reduction strategies. These initiatives have been reinforced by the progress made during recent years in the collection of data and the development of indicators to monitor progress toward the MDGs, as well as ICPD Goals.

Although the initiatives undertaken in some countries are encouraging, it is unclear whether they have contributed to an increased allocation of resources to improve reproductive health, including family planning, and sexual health services, especially as regards to impoverished or underserved groups. Budgetary short falls are perhaps reflected in the indicators of maternal and child mortality and unmet need for family planning. These indicators are generally higher among people with the lowest incomes and in the poorest countries.

Increased efforts are needed to improve national capacity to collect and analyze population and socio-economic data that reflect the inequitable distribution of services as well as measure the impact of unequal access to services on health and educational outcomes. There is also a need to improve communication skills so that the findings of research and analysis are effectively communicated to high level planners and policy makers. Effort is also required to convince planners and policy makers to translate their commitments into action by increasing investment in human capital formation—especially in health and education. It must also be highlighted that investments in education and health will not only contribute towards ensuring that basic needs and rights are met, but given the current demographic scenario of many countries, would add significantly to the growth of GDP, by optimizing the benefits of the "demographic dividend".

Data and Research

The ICPD POA called on Governments to strengthen their national capacity to carry out sustained and comprehensive programmes on the collection, analysis, dissemination and utilization of population and development data. The POA called upon countries to pay particular attention to the monitoring of population trends and the preparation of demographic projections and to the monitoring of progress towards the attainment of health, education, gender, and social security goals, and of service accessibility and quality of care. The POA also calls for socio-cultural and economic research as well as policy research on a diverse set of issues to be built into population and development programmes and strategies (Chapter XII).

The majority of countries in the Asia-Pacific region have adequately monitored their population trends by means of population censuses and demographic surveys, although not always at frequent intervals; the principle shortcomings have been in the further analysis of demographic data and especially the analysis of linkages between demographic factors and indicators of health, gender, education, poverty and employment status.

In the Pacific, all countries have conducted modern population censuses—at least since the 1960s—and Fiji participated in the World Fertility Survey in the 1970s. Pacific countries have carried out censuses in every census round to date—either at 5-year, 10-year, or intermittent intervals. Building national capacity in census-taking has been an important priority for countries and donors alike over the past two decades, and a significant quantity of resources has been committed to this goal—much of it prior to ICPD. Similarly, capacity-building in the teaching of demography and demographic research has been supported by UNFPA and AusAID, among others

In spite of these efforts, dissatisfaction continues to be expressed by development partners regarding the infrequency, poor quality or limited range of statistical indicators in general—including many population-related indicators—available in the Pacific (AusAID 2009). It has also been argued that the quality of the 2000 round of censuses in the Pacific declined relative to the 1990 round (Hayes 2006). UNFPA, among other agencies, is increasing its support for the 2010 census round in an effort to improve census quality and promote more extensive analysis of census data.

Demands for statistical data have increased significantly since ICPD but, paradoxically, the post-ICPD period also coincided with a decrease in donor support for censuses and surveys. Many of the indicators required to measure the implementation and results of the ICPD POA were not available for the base year of 1990 and many are still not available. The measurement of "unmet need" for family planning, for example, has been erratic and only one country in the Pacific sub-region has data for two points in time. The advent of the MDGs has highlighted the deficiencies in data collection in the Pacific and new efforts are underway by several agencies (including AusAID, SPC, NZAID, UNESCAP, UNFPA, IMF) to improve statistical capacity in the sub-region. Particularly urgent is the building of local capacity to analyze census and survey data to make the data more relevant for public policy formulation. A major advance in data collection occurred when Demographic and Health Surveys (DHS) were conducted in five Pacific Island countries over the period 2006-2008, but more analysis of the results and expansion of the DHS to other countries is needed to support population and development planning.

Demographic training and research in the Pacific sub-region at university level was heavily supported by UNFPA in the 1980s but this support declined in the 1990s and thereafter. The study of Pacific Island populations at Pacific-rim universities in Hawaii, Australia and New Zealand also reached a peak in the 1990s and has been in decline since. The Pacific Islands still lack sufficient local expertise in census and survey operations, demographic estimation and projections, as well as analysis and interpretation. There remains no dedicated research institution on population subjects in the Pacific sub-region.

It is important to acknowledge, however, that the knowledge base in such areas as teenage fertility, adolescent reproductive health, and reproductive health commodity security has improved significantly in recent years through national studies conducted by local staff with the support of the UNFPA and the SPC. Useful research experience has been gained through these studies as well as practical suggestions for revising policies and programmes focusing on adolescents. Earlier, UNFPA-sponsored studies by university-based researchers within this broad area of adolescent reproductive health and teenage pregnancy (Seniloli, 2002a; 2002b) also provided significant insights into the determinants of teenage fertility and the use of services by adolescents. Without further comparative analysis of the findings of these studies, the higher-level generalizations that are required to assist and guide policy formulation remain lacking.

Efforts to strengthen national capacity in data collection, analysis and research should, therefore, continue to be given high priority in national development strategies and in the agendas of development partners—as called for in the ICPD POA. Training in multi-variate analysis that goes beyond the typical bi-variate descriptive analysis that is commonly found in census reports is needed, along with other forms of causal analysis. The further analysis of DHS data to investigate interrelationships between key policy variables such as unmet need for family planning provides a context in which such training could be done. Given that several countries have now completed a DHS, the scope for policy-oriented comparative studies is considerably enlarged.

B. REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

Reproductive Health and Rights in ICPD and ICPD+5

While emphasizing the mutually reinforcing linkages between population and development, the ICPD POA departed significantly from previous World Population Conferences in 1974 and 1984. The 1994 conference called on countries to re-orient population policies and programmes away from a narrow concern for population numbers, toward a broader focus on human welfare. Strong emphasis was placed on improving the lives of individuals and families while also ensuring that their human rights were protected.

Based on the rights and freedoms set forth in the Universal Declaration of Human Rights, Principle 3 of the ICPD POA states that

> *"...While development facilitates the enjoyment of all human rights, the lack of development may not be invoked to justify the abridgement of internationally recognized human rights...".*

Furthermore, Principle 8 asserts that:

> *States should take appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.*

In Chapter VII, "Reproductive Rights and reproductive Health", the POA also states that

> *"...The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning" (para 7.3).*

The "Key Actions" of the ICPD+5 review called upon governments to "ensure that policies, strategic plans and all aspects of the implementation of reproductive and sexual health services respect all human rights..." (para 5.2b).

The ICPD POA also calls upon countries to "strive to make accessible through primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015". It defines reproductive health care in the context of primary health care to include, inter alia: "family planning counseling, information, education, communication and services; education and services for prenatal care, safe delivery and post natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as defined in paragraph 2.5 including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counseling on human sexuality, reproductive health and responsible parenthood...".

The Asia-Pacific review conducted at ICPD+10 indicated that most countries in the region have taken one or more steps to promote reproductive rights. The measures taken include formulation of policies and/or enactment of laws on reproductive rights, setting up institutional mechanisms and strengthening advocacy for the promotion of these rights. The review also highlighted policy and programme related developments in many countries that are contributing to a more conducive environment in which women can exercise their reproductive rights.

But the review also noted that "....even in a favourable policy and programme environment, countries in which educational levels of and employment opportunities for women are low and where socio-cultural and religious factors play a pivotal role, progress towards ensuring the reproductive rights of women remains slow" (UNFPA 2004), a statement that remains true today. The report also highlights such factors as provider bias, and their lack of knowledge, understanding and skills as hindering progress towards achieving the delivery of reproductive health, including services that meet the informed and voluntarily-determined needs of clients.

The 15 year Asia-Pacific review meeting held in Bangkok in September 2009 also took stock of the progress made in implementing the ICPD POA from a "rights perspective" and confirmed that there are many factors that limit access to the full range of reproductive health services among the countries of the region. The relative importance of these factors is determined by the level of economic and social development, cultural milieu, policy environment as well as access to and quality of services in the different countries. Available evidence indicates that rights are more often denied to the poor, the marginalized and vulnerable groups such as sex workers and men who have sex with men. Similarly, women, adolescents, and unmarried young adults in many countries are unable to exercise their rights, including reproductive rights, despite the significant efforts made during the past fifteen years.

The ICPD+10 Field Survey (2004 UNFPA Office for the Pacific) in the Pacific provided information on the steps that governments have taken to advance reproductive rights, such as free and informed consent, contraceptive choice, the abolition of family planning quotas or incentives. Out of 13 responding countries, ten indicated that they had taken some steps to advance reproductive rights (UNFPA, *2004*). Several countries responded that reproductive rights were stated in their population policies, while four countries had incorporated a rights perspective in their health or reproductive health plans and strategies. The provision of free family planning and reproductive health services is seen by several countries as a concrete expression of a reproductive rights perspective. It can also be argued that a rights perspective is at work in those countries that have dropped the long-standing requirement that a husband's signature must be obtained before a clinic can dispense contraceptives to a married woman.

On the other hand, the reproductive rights of unmarried adults and adolescents are clearly not fully accepted or protected in some Pacific countries; surveys have revealed that adolescents may be asked for their parent's permission before being provided with contraceptives (Havea, 2007), or denied such services on the grounds of their young age (Albert, *nd*).

Safe motherhood and maternal health

As indicated earlier, reducing maternal mortality rates to half the 1990 levels by the year 2000 and by half again by 2015 is one of the objectives of the ICPD POA. Improving maternal health is also an important MDG and related targets include:

i) the proportion of births attended by skilled personnel and
ii) the Maternal Mortality Ratio (MMR).

In several Pacific Island countries, the proportion of births attended by skilled birth attendants (SBAs) reached 100 percent some years ago and all but two countries have already achieved the ICPD POA target of 90 percent of births assisted by SBAs by 2015 (Table 3). Papua New Guinea is the country least likely to achieve this target. Kiribati currently falls short but with effort could achieve the 2015 target. The report of a recent technical meeting on reproductive health in the Pacific (UNFPA 2009) noted that participants believed that 100 percent coverage by SBAs was possible in all countries by the deadline of 2015; but PNG could only achieve this with the help of a major training programme to increase the number of SBAs and to place them in the rural locations where they are needed. In many Pacific countries, traditional birth attendants (TBAs) continue to provide assistance in child-birth, especially in rural villages.

Data on access to and utilization of prenatal care are shown in Table 5. Information on the number of women who attend four or more times during pregnancy is collected but not always reported in the Pacific. Where data are publicly available, the range is from 55 to 88 percent. Not surprisingly, the lowest figures are found in countries with the highest Maternal Mortality Ratios.

The ICPD POA goal of reducing the MMR by three-quarters between 1990 and 2015 has in affect been achieved by most Polynesian and Micronesian countries, as well as in Fiji. Some Polynesian countries have not recorded a single maternal death in recent years.[13] In Papua New Guinea, Solomon Islands, Federated States of Micronesia, and Kiribati, however, the situation is quite different.

In Papua New Guinea, the MMR trend since 1990 cannot be determined due to the absence of reliable, time-series data on maternal deaths. Although maternal deaths are recorded in the Health Information System, reporting is biased towards locations at which there is a hospital. Analysis of HIS data indicates that maternal mortality is highest where health services are best, an unlikely scenario. Survey based estimates, with their attendant shortcomings, are the only potentially reliable means of estimating the national MMR in Papua New Guinea. The most recent estimate, obtained from the 2006 DHS, is based on an estimation method that provides a figure for 12 years prior to the survey (in this case 1994). The resulting estimate of 733 maternal deaths per 100,000 live births is by far the highest in the Pacific and the second highest in the Asia-Pacific region after Afghanistan. The 1994 estimate is now being used as the 1990 baseline for the MDGs and ICPD goals (Bakker, 2009), a much more appropriate approach than treating this figure as a current estimate.[14] Health authorities and experts believe that this ratio has not improved over the past decade, although there are no reliable data to confirm this. Nevertheless, it is extremely unlikely that the ICPD/MDG target of a 75 percent decline in MMR by 2015 could be achieved in Papua New Guinea. The Solomon Islands has possibly made more progress; its MMR was estimated at 103 in the 2005-06 period—a decline of 70 percent since the 1990-94 period when it was reported to be 345.[15]

It is estimated that worldwide more than 500,000 women die each year for reasons of pregnancy, in giving birth or in its aftermath, of which 44 percent occur in the Asia and Pacific region. In the Pacific the vast majority of maternal deaths occur in Papua New Guinea, where, assuming that the estimated (1994) MMR remains around 700, approximately 1,500 maternal deaths can be expected every year. The major causes of maternal deaths in Asia and the Pacific include hemorrhage, eclampsia, obstructed labour, sepsis and abortion. Indirect causes include anemia (often malaria-related), jaundice, and heart problems. Violence against women also contributes to maternal deaths (Mathai, 2009). In the Pacific, anecdotal evidence suggests significant number of women seek abortion services; however, there is little statistical data to substantiate this.

Most maternal deaths are preventable through proven and cost-effective interventions. Recent literature highlights three primary factors that contribute to maternal mortality. These are known as the "three delays": (i) delay in making the decision to seek medical help for an obstetric emergency (due to cost), (ii) delay in reaching a facility (due to distance); and (iii) delay in receiving adequate care due to shortage of skilled staff or essential equipment (such as blood transfusion).

Shortages of skilled staff, difficulty of access to emergency obstetric care and cost considerations retard progress in reducing MMR and improving maternal health. High maternal mortality in a number of Asian and some Pacific countries is also influenced by high unmet need for family planning, unplanned pregnancies and recourse to unsafe abortions, particularly among adolescents and young women, also contributes to high maternal mortality in a number of Asian and some Pacific countries. The 10 year review of ICPD noted that of the countries worldwide that had reported taking a number of steps to reduce MMR, only

13 A more pessimistic assessment of progress can be found in a recent report (AusAID, 2009), which suggests that only Samoa, Solomon Islands and Tuvalu are on track to achieve the MDG target on maternal mortality. But this assessment does not take into account stochastic variation in MMRs in smaller countries.
14 Claims that the MMR in PNG doubled between 2000 and 2006 (AusAID, 2009) are incorrect and based on a misunderstanding of the estimation method. A correct analysis of these estimates can be found in (Bakker, 2009).
15 The MMR was estimated for one year only and may be subject to statistical fluctuations. See: UNFPA (2008b).

15 percent reported establishing RH and FP clinics as a strategy and in Asia only 7 out of 44 countries reported doing so (United Nations, 2004), a situation that is unlikely to have changed since. This reflects a lack of or even a declining importance given by planners and policy makers in many countries of the region to family planning, as it is seen mainly as a means of fertility reduction and not as a cost-effective strategy to improve maternal and child health.

It is also reported that efforts to get pregnant women at risk to hospitals during emergencies, through incentives and support, does not always prevent maternal deaths. Women may be discharged soon after delivery due to lack of facilities at the hospital, and die soon after due to complications that could have been prevented if appropriate services had been available.

In the Global Survey conducted for ICPD+10, all Pacific Island countries that responded cited steps they had taken to reduce maternal mortality and morbidity. These ranged from improvements in prenatal and postnatal services, training of health providers, improved transportation for emergency obstetric care, and better data collection and record-keeping (UNFPA Office for the Pacific, 2004). Most countries have developed strategies for reducing maternal mortality and morbidity, but the implementation of these strategies is constrained by the shortage of resources and the formidable barriers of geography. However, some small island countries (Cook Islands, Niue, Palau, Tokelau, Tuvalu) have been able to reduce maternal mortality to the point where it has "ceased to be a public health problem", as called for in the ICPD POA. This is in spite of their isolation and dispersed distribution of their populations, suggesting that it is possible to overcome some of the barriers that may be present in other countries.

However, the limitations of financial resources for public health is a major factor holding back progress in those Asia-Pacific countries that continue to have high MMRs. Public health expenditure as a percent of GDP tends to be low in such countries. Shortfalls in donor support for maternal health and family planning and inefficiencies in the utilization of available resources continue to compound the problem.

Improving maternal health and reducing maternal mortality will, therefore, remain one of the most daunting challenges in the Asia-Pacific region. The following generic actions and strategies have been suggested:

1. Improve access to basic health services, safe water and improved sanitation;
2. Expand access to and improve choice of family planning methods, and make abortion safe where it is legal;
3. Expand prenatal care coverage and identify high risk pregnancies;
4. Train skilled birth attendants and improve infrastructure for emergency obstetric care;
5. Reduce the three delays: delay in decision to seek care, delay in transport and delay in providing appropriate care during and after delivery;
6. Target programmes to benefit the poor, socially excluded, marginalized and the vulnerable;
7. Address gender inequality and advocate for the rights of women to safe motherhood and family planning; and
8. Advocate for increased allocation of resources for health and its efficient utilization.

In the Pacific, several countries have prepared reproductive health policies to implement strategies such as these and other countries are in the process of doing so. A "Pacific Policy Framework for RH Services and Commodity Security" (PPF) has been developed and approved by Pacific Health Ministers to guide the

formulation of such policies. A technical meeting has been held to assist health planners to identify key issues at country level and to implement the recommendations of the PPF. Proposed actions include:

- Reducing maternal *morbidity* in countries with low MMR;
- Establishing routine auditing of maternal deaths and "near misses";
- Phase out TBAs ("Traditional Birth Attendants" and replace them with SBAs ("Skilled Birth Attendants");
- Increase the number of antenatal visits to 4 or more.
- Improve RH commodity Security to prevent shortages and stock-outs
- Expand family planning choices, especially in rural and remote areas;
- Improve Health Information Systems;

It is acknowledged that in the Pacific Islands the cost, unreliability and infrequency of transport to remote rural areas and outer islands is a significant barrier to reducing maternal mortality where it is high. This impediment is beyond the control of the health-care system to change. Only broad-based economic growth and development that could facilitate major investment in infrastructure, can improve this situation. Similarly, the shortage of skilled medical staff can only be relieved when GDP per capita rises significantly and/or new, more cost-effective approaches to training can be developed.[16]

Family Planning

One of the objectives of the ICPD POA is *"To help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being, and respects the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children" (para 7.14a)*. In this regard the POA calls on countries to *"...take steps to meet the family planning needs of their populations as soon as possible, and should in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and related reproductive health services which are not against the law" (para 7.16).*

These calls marked an important shift away from a "target centered" approach to a "needs-based, client-centered" approach that recognizes the rights of couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. It also explicitly stated that "demographic goals should not be imposed on family planning providers in the form of targets and quotas for the recruitment of clients", a practice that was previously followed in several Asian countries.

The 10 year Asia-Pacific review reported that "since ICPD in 1994, all the countries that had pursued policies involving the setting of targets or quotas and incentives to meet fertility goals have abandoned them in spite of the reservations expressed by some that this, together with the integration of family planning with broader reproductive health care, might have a negative impact on the acceptance of family planning and on the contraceptive prevalence rate" (CPR) (United Nations, 2004). A review conducted as part of the Fifth APPC (2002) has also shown that "The integration of family planning into reproductive health programmes that provide men and women with choice in planning their reproductive lives, while still incomplete, has not led to reversals in fertility decline" (Guest, cited in United Nations, 2004).

Evidence from more recent surveys indicates that although fertility decline has not gone into reverse, the pace of decline has slowed down or stalled. Moreover, even as contraceptive prevalence rates have

16 In 2007, Gross National Income per capita (GNI) in Cook Islands, arguably the country with the best health standards in the Pacific outside the dependent territories, was over 13 times the GNI of Solomon Islands and 12 times that of Papua New Guinea (ADB, 2009).

increased in some countries, the unmet need for family planning remains high. Unmet need is around 20 percent or more in Afghanistan, Cambodia, Laos PDR, Malaysia, Nepal, Pakistan, and Papua New Guinea. In a few Asian and Pacific countries the desired number of children remains high while in others there is a wide gap between the desired and actual number of children, as measured by the TFR. Moreover, CPRs vary widely between and within countries as does the availability and use of modern methods.

In the Pacific Islands, contraceptive prevalence generally remains well below the average for developing regions (which was 56 percent in 2007), and in some countries the CPR has hardly changed in the past 25 years (data for the 1970s is reported in Lucas and Ware, 1981). Although the reported data by country in Table 5 do not refer to the same exact year, the range is from a low of 17 percent in Palau to a high of 45 percent in Fiji.[17] While Fiji's CPR is presently the highest in the Pacific, it should be borne in mind that the CPR in Fiji was estimated at 29 percent in 1979—three decades ago (Lucas and Ware, 1981; Robertson, 2006). A government-sponsored family planning programme has been in existence in Fiji since 1962. In Kiribati, the CPR was estimated at 22 percent in 1977, exactly the rate reported at present. In Tonga, "current users" of family planning comprised 36 percent of eligible women around 1979 whereas the present CPR is only 28 percent (Table 5). While there are doubts about the accuracy of earlier figures on contraceptive use, the slow increase, or even negative trends (taking the data at face value) over several decades is difficult to explain given that fertility has declined over the same period. Only in Samoa does there appear to be some consistency between the trends in CPR and fertility.

The current situation appears to be not unlike that described by a number of demographers in the 1980s and 1990s. In a report published just before the ICPD POA in 1994, one informed observer wrote:

> *That efforts towards fertility reduction have met, even in the most effective cases, with much less than complete success is no secret among those interested in population matters in the Pacific. Apparently, even among the women of Tuvalu and Fiji Indians, the "acceptor rate" has never exceeded 40 percent of all those eligible. Plateaus or even declines seem to be as characteristic of acceptor statistics as are rapid increases. Negative reactions are a frequent feature of the appraisals by the public in many Pacific Island communities. Undesirable side-effects associated with several methods, particularly the hormonals and IUD, seemed to be more prevalent in the Pacific than in other regions of the world, or at least more of an obstacle. Horror stories of severe problems with IUDs or hormonals, given without adequate medical supervision or follow-up, circulate throughout the region. In the case of hormonals the dosages are now better regulated than was the case in the early days and side-effects have been reduced, but in many cases the public relations damage has already been done (Pirie, 1994).*

Since the ICPD, it is likely that the quality of family planning services in the Pacific has improved significantly, but the generally low CPRs and their fluctuations through time remain in evidence.

The persistence of high levels of unmet need and the leveling-off in fertility decline in several countries in the Asia-Pacific region have caused concern in various national and international contexts. If unmet need persists, population growth rates will remain high, or decrease more slowly from current levels. This could be an obstacle to poverty reduction while also contributing to the deterioration of the environment. Moreover, it could also hinder efforts to achieve other reproductive health goals, including reduction in maternal and child mortality as well as constraining the spread of HIV, as discussed in the following section.

17 Reported CPRs tend to fluctuate widely in any given country, probably due to inconsistency and inaccuracy in data collection methods.

Therefore, there has been a growing chorus of calls to reposition and revitalize family planning as part of the development agenda in the coming years.

This call has been echoed in the Pacific Islands (Robertson, 2006). In spite of major efforts by countries, with significant support from international partners, family planning is not reaching the groups who need it. Teenage fertility, although generally declining, remains high by developed country standards; unmet need among older women is also high and lifetime fertility remains above 4 children per woman in several countries. Family planning programmes require renewed political support and innovative strategies to meet the needs of disadvantaged groups such as the urban and rural poor and women with the highest unmet need (Robertson, 2006). It is also important to conduct more socio-cultural research on the factors inhibiting the use of family planning. DHS and other data suggest that even after several decades of government family planning programmes, including IEC campaigns to improve knowledge and awareness of family planning methods, women continue to report lack of knowledge and fear of side effects (PNG Statistics Office, 1997) as reasons for not using family planning when they wish to stop or delay childbearing.

The need to reposition family planning on the development agenda has been recognized in several international meetings, including Asia-Pacific ICPD 15-year review meeting held in Bangkok in September 2009. The "Declaration" approved at the meeting called for an enhanced "political commitment to reposition and revitalize family planning as a development agenda for achieving reproductive health outcomes as well as broader poverty reduction goals". Similarly, the Declaration adopted by the International Forum on ICPD@15 organized by PPD in Kampala in November, 2008, called on Governments "to emphasize the importance of family planning to the attainment of the MDGs and increase support for family planning in national development budgets and donor supported programmes" (PPD, 2007).

Also, the 2009 MDG report notes that "Funding gaps are conspicuous for programmes needed to meet MDG 5 [reduce maternal mortality], the goal towards which least progress been made" (United Nations, 2009). The report concludes that "the strengthening and expansion of family planning programmes can make a major contribution to improvements in maternal and child health, but requires adequate funding and reliable access to supplies. Yet, since the mid 1990's, most developing countries have experienced a

major reduction of donor funding for family planning on a per woman basis." A possible explanation for this is that HIV prevention programmes have diverted funds that might otherwise have gone to family planning programmes (UNFPA, 2007; UNFPA, 2009). Increased linkages between SRH and HIV/STI services would facilitate and encourage higher barrier contraceptive use and reduce unplanned pregnancy rates.

The repositioning of family planning in reproductive health programmes and development strategies is a high priority for the remaining five years of the ICPD POA. This will require adequate resources for ensuring the supply and availability of family planning commodities and making it accessible to and affordable for those groups whose access is presently severely limited.

HIV and other STIs

HIV[18]

One of the objectives of the ICPD POA is to *"prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women." (para 7.29)*. The Key Actions adopted at the five year review called on Governments to *"...ensure that the prevention of and services for sexually transmitted diseases and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary health care level" (Key Actions, para 68).*

The Millennium Declaration called on Governments to halt by 2015 and begin to reverse the incidence of HIV/AIDS.

At the regional level, the Fifth Asian and Pacific Population Conference, held in Bangkok in 2002 reviewed the HIV/AIDS situation in Asia and the Pacific, and called on Governments and all development partners to establish:

a) national prevention programmes, recognizing and addressing the factors leading to the spread of the epidemic, reducing HIV incidence for those identifiable populations with high or increasing HIV infection or indicated through public health information as at the highest risk of infection,
b) information and education programmes aimed at risk-taking behavior and encouraging responsible sexual behavior and expanded access to essential commodities (United Nations, 2003).

In the Pacific Islands, HIV surveillance remains insufficient to determine the precise scale and pattern of HIV infection in all countries. It is clear, however, that Papua New Guinea is the most affected country with HIV prevalence estimated at 1.6 percent of the adult population in 2007 (National AIDS Council Secretariat, 2007; Government of Papua New Guinea, 2009). Elsewhere in the Pacific HIV prevalence in the adult population remains low. Although the annual rate of HIV reporting shows an upward trend from

18 The ICPD POA and the ICPD+5 revision, as well as most documents on the subject up until early 2009 employ the term "HIV/AIDS" to refer jointly to the infection and its consequences. With advances in treatment, the consequences of an HIV infection do not necessarily include AIDS. For this reason, the terms are now separated. In this paper, however, the term HIV/AIDS is employed if it is a direct quotation from an original source. The topic of AIDS is not discussed.

the mid-1980s, the number of reported cases per year in Polynesia has remained relatively constant since 1996. In Micronesia, reported cases peaked in 1999 and have leveled-off since (SPC 2008). As of 2007, 99 percent of new notifications of HIV infection in the Pacific Islands originated from Papua New Guinea. However, continued vigilance and prevention programmes are essential throughout the region in order to limit the further spread of the epidemic and to roll it back.
To accomplish this it is important to know the main modes of transmission in each country. In the Pacific Islands as a whole, the predominant mode of HIV transmission is sexual, comprising — heterosexual contact (50 percent), male-to-male sex (32 percent) and mother to child transmission (5 percent), the latter being a direct result of sexual contact. Injection of drugs has previously been rare in the Pacific; the 6% of reported cases via this mode of transmission probably occurred outside the region. However there are some signs of increasing injecting — the latest SGS survey in Vanuatu found 7.3% of young people reporting injecting in the last 12 months. Injecting behaviour is also seen in some dependent territories such as Guam and CNMI.

Risk factors for HIV vary from country to country. In Tuvalu, Kiribati and other PICs, some commercial seafarers are known to have brought the infection home and infected their partners and subsequently their offspring. In Papua New Guinea, the infection has been carried from the north coast to the Highland interior by long-distance truck drivers who buy sex along the highway, as well as by other routes. HIV is highly associated with mobility in the Pacific region. The primary age-group for contracting HIV is sexually active adults (25-44 years), with rates increasing in young people (15-24 years). Men who have sex with men, including transgender individuals, are a second major group at risk (Sladden 2005). The UNAIDS Progress Report on HIV and AIDS in Asia and the Pacific (UNAIDS, 2009) cited reports of surveys indicating that more than one in ten young men said that they had sex with men and condom use was reported to be rare.

In the broader population, rates of condom use are also generally low, especially in young people – as evidenced by high rates of STIs (see below) and teenage pregnancies. Greater distribution, marketing and promotion of condoms is required to reduce STIs and unplanned pregnancies. Initial steps have occurred to implement comprehensive condom programming (CCP) in some Pacific Island Countries (see RHCS below). In all Pacific Island Countries, high risk behaviours such as unprotected sex – both commercial and casual, male to male sex (including of transgendered individuals), and mother to child transmission remain priorities for prevention efforts. Further linkages between mainstream SRH services, such as FP, ANC, Maternity and MCH programmes, with HIV/STI services would increase coverage of HIV/STI prevention, detection and management. Community leaders – parliamentarian, faith based and traditional chiefs, can play a stronger role in advocating for reduced stigma of people living with HIV/STIs and those at most risk of infection. Leaders could also remove some cultural perceptions and barriers that limit condom acceptance and uptake by sexually active adults.

Family planning programmes can be an effective way to reach out to persons at risk of HIV infection with information and services, including counseling, on HIV transmission and prevention. The call for providing integrated reproductive health services, including family planning, in the context of primary health care made at ICPD is important because, among other things, it would protect the confidentiality of women seeking information and services on HIV, AIDS and STIs, and avoid their stigmatization. It would also reduce the risk of mother to child transmission of HIV. Linking HIV/STIs and safe motherhood/family planning services would provide synergy and contribute to the attainment of ICPD goals and MDGs.

The Report of the Commission on AIDS in Asia recommends that "Reproductive health services should be used as an entry point to increase women's access to HIV prevention, testing and referral services." Family planning is a central component of reproductive health and family planning programs have reached these women successfully in all countries of Asia. Therefore, efforts to integrate the provision of HIV/STIs and family planning services should be a priority strategy, as it would give married women a chance to reduce their risk of contracting HIV.

This is in line with suggestions made elsewhere. For example, a joint IPPF, UNFPA, WHO, and UNAIDS project in 2005 has produced a framework for such priority linkages as a guide for countries to effectively link and integrate SRH and HIV. The review showed that linking SRH and HIV is beneficial and feasible, especially in family planning and HIV testing centres. Cost-effective studies suggested net savings when HIV and STI prevention are integrated into maternal and child health services (See Raj Karim, 2009).

Other STIs

An underlying condition that is conducive to the heterosexual transmission of HIV in the Pacific is the high prevalence rates of other STIs. Some STIs are ulcerative, allowing direct entry of HIV, whilst non-ulcerative STIs also increase genital inflammation and receptivity to HIV. Recent epidemiological surveys (WHO et al 2006) found high rates of Chlamydia (up to 41 percent) and gonorrhea (up to 1.7 percent) in women under 25 years of age. Syphilis also continues to circulate in Pacific populations with congenital syphilis cases also observed. Marshall islands and other Micronesian countries experience sustained transmission of syphilis. Such STI rates are significantly higher than in neighbouring Australia (see: NSW Minister of Health, 2007). There is little sign of improvement in these prevalence rates and in some cases they are increasing, especially in young people (SPC, 2009 – Vanuatu SGS survey). As mentioned above, low levels of condom use and poor access to treatment—especially for adolescents are the main reason. Although condom use has been increasing, the use of condoms in "high risk" sex remains below 20 percent in the countries surveyed. For condoms to effectively reduce transmission, use has to be around 80% or higher. Adolescents also find it difficult to obtain non-judgmental ASRH services in the Island countries where health services are mostly provided by governments. In some countries NGOs have had more success in reaching young people.

Efforts are underway to improve comprehensive STI case management, including reducing risk behaviours, and increasing partner management and uptake of condoms. Some trials have also been conducted of presumptive treatment for Chlamydia and increased screening and diagnosis for better treatment control. However some of the underlying barriers to reducing STIs and risk of HIV lie in the widespread cultural sensitivities to:

- sex education for young people,
- promotion of condom use by sexually active adults, and
- the denial and stigmatization of groups at high risk such as sex workers and men who have sex with men.

When left without access to services, these groups act as bridging populations for STI and HIV risk in the broader community. If SRH services can be provided to high risk groups, this lowers transmissions both to themselves and their sexual contacts – be these commercial, casual or long term partners. Stigma, discrimination and law enforcement approaches to sex work and male to male sex are ineffective and merely serve to drive individuals engaging in these behaviours further from preventive services, thus increasing the risk to the whole community.

Adolescent Reproductive Health

The ICPD POA is perhaps the first international agreement to explicitly address the reproductive health needs of adolescents. Despite an ever increasing number of adolescents in developing countries and changing behavioural patterns among them, including in matters to relate to sex, the issue was never before placed on an international agenda. The main objective, as stated in the ICPD POA, is "to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence, and the provision of appropriate services and counseling specifically suited for that age group" (ICPD POA para 7.44a).

The ICPD POA called on Governments "to meet the needs of adolescents and to establish appropriate programmes to respond to those needs." The Key Actions adopted during the five year review further called on Governments "to protect and promote the rights of adolescents to the enjoyment of highest attainable standards of health" and to "provide appropriate, specific, user-friendly and accessible services to address effectively their sexual and reproductive health needs...".

Accordingly, the Fifth APPC Plan of Action called on Governments to "Provide adequate access to youth-friendly, age appropriate, evidence-based sexual and reproductive health information, education and counseling, and services on the sexual and reproductive health of adolescents; provide appropriate life-skills training for adolescents to promote female empowerment and male responsibility in reproductive health;..."

The 10 year review undertaken in 2004 (UN ESCAP and UNFPA, 2004) indicated that countries have taken a number of measures that include, among others, (i) introduction of out-of-school youth programmes, (ii) training of teachers on adolescent health issues, (iii) peer education. It was clear during the review that while progress was made in a number of countries it was limited to the formulation of policies/strategies and/or the provision of education, information and counseling. RH services were not available in most countries to adolescents and unmarried young people. In countries with very low age at marriage, social factors limited access to RH/FP services to adolescents and young people, even if they were married. The important role played by NGOs in a number of countries in Asia in initiating innovative interventions to meet the needs of adolescents was also highlighted during the review.

In the Pacific, access to youth-friendly "Adolescent Health and Development" (AHD) services has been significantly improved over the past decade. NGO-based clinics have been established in at least 12 countries, seven countries have established school-based clinics, and youth centres have been built in the

main towns of many countries. In addition, Adolescent Sexual and Reproductive Health services have been integrated into government health services in most countries and specialized training provided to nurses. Peer education programmes have also been located in universities. As yet, these service delivery points for adolescents and youth are mainly located in urban areas and access is difficult for rural, village-based youth. At least one NGO is operating mobile clinics in rural villages but this mode of service-delivery is not widespread.

The ICPD POA also stresses the need to "substantially reduce all adolescent pregnancies" (para 7.45). The teenage fertility rate (births per 1,000 women aged 15-19) is normally used to measure adolescent fertility.

In traditional Pacific societies, the age of menarche was high (due to poorer nutrition) and there was a range of social practices that delayed marriage and deterred childbearing.[19] With improved diets, younger age at menarche, and the erosion of traditional culture (partly associated with urbanization), teenage fertility increased along with fertility in general and in recent decades rose well above the rates found in more developed countries. In the past decade, teenage fertility rates have declined in some countries by 20 to 40 percent. In Polynesia and Fiji, teenage fertility is now below the average for the South-Eastern Asia region, but some Micronesian and Melanesian have had persistently high rates in the range of 67-95 births per 1,000. In the Marshall Islands, the 2007 DHS found that over one quarter of girls aged 15-19 were either pregnant or had already given birth (Republic of Marshall Islands, 2009). Unlike the situation in Asia, where most teenage pregnancy occurs within marriage, adolescent pregnancy in the Pacific occurs mainly among unmarried women. The main consequence is disrupted schooling and reduced life prospects, although unsafe abortion and maternal death can also result.

A significant effort has been made by UNFPA and its partners, including national departments of health and NGOs, over the past 15 years to address adolescent reproductive health and, in particular, teenage pregnancy. Several national studies of the factors underlying high teenage pregnancy have been conducted as well as assessments of adolescent reproductive health knowledge and access to services. While a comparative analysis of these studies has yet to be conducted, some common themes are apparent. These include:

- Poor understanding among adolescents of the physiological aspects of sexuality and conception, including the significance of menarche, menstruation, fertile and non-fertile periods, etc.
- Limited and poor understanding and access to contraception methods and the risks of sexually-transmitted infections;
- Sex education improves understanding but less than might be expected; There is also a lack of teaching life skills including empowerment and negotiation skills
- The right of unmarried adolescents and youth to be sexually active is a contested area within the moral order of Pacific societies; it is far from being universally accepted. However more young people today are ignoring or rejecting the cultural norms and values of earlier generations. Young people are also exposed to sexual imagery through music, film and advertising, which appear to legitimate early sexual activity.
- Marital status, not age, confers full adult status in the Pacific, carrying with it the right to receive reproductive health services, including contraceptives; prior to marriage that right is contested.
- Some service providers find it difficult to provide services (such as contraceptives) to young people to whom they may be related;

19 Throughout Melanesia, the time required to accumulate "bride price" could be long. Then the couple would need to establish a garden before considering the possibility of having children. The couple would also have to take into account the obligation of the father to make gifts to the mother's father and brothers.

- Sexually active, unmarried youth may be asked for parental permission before being provided with contraceptives;
- The moral ambiguity surrounding pre-marital sexuality makes it difficult for adolescents and youth to approach service providers, even where the services are available;
- In some Pacific cultures, teenage pregnancy is formally disapproved of but does not bring significant social sanctions that might cause shame or punishment; family support is usually available for unmarried mothers.
- Teenage pregnancy arises from a combination of factors that vary by country and urban/rural settings; coming of age in the Pacific is fraught with tension, confusion, ignorance and internal conflict;
- A significant proportion of adolescent girls who have become sexually active report that their first sexual experience was associated with force or coercion.
- There is insufficient promotion and access to condoms for young people who choose to be sexually active

Thus, although there have been major national and regional efforts by governments, NGOs and other development partners during the past 15 years to improve adolescents' access to reproductive health services, these efforts have been only partially successful. In predominantly rural societies, such as Solomon Islands, Papua New Guinea, or Federated States of Micronesia, a large proportion of the youth population does not have direct access to services. While knowledge can be improved through the media (especially radio), the services required to back up advances in knowledge are few and far between. Significant hurdles for meeting the reproductive health needs of adolescents and young people remain. These include: social and cultural norms that work against reproductive rights, gender inequality and gender-based violence, negative attitudes of parents, teachers and service providers to unmarried sexuality, and the remaining gender-gap at secondary and tertiary levels. Pacific countries have come a long way in addressing these issues over the past 15 years, but much more progress can and should be made. Greater provision of youth/user-friendly SRH services, including access to condoms and other contraceptives, is required in order to enable young people to protect themselves from unplanned pregnancies and HIV/STIs. The biggest single attribute for "youth-friendliness" is non-judgmental service providers who provide SRH services to young people without moralistic or conservative views. Further efforts are also required to increase delivery of "family life education" (FLE) and similar lifeskills training in schools, including education on sex, sexuality, fertility and HIV/STIs.

Access, quality and integration of services

Access to reproductive health care: The ICPD POA calls upon all countries to *" strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible but no later than the year 2015". (para 7.6)* Key Actions adopted during the Five year review in 1999 put it more specifically, calling on Governments to *"strive to ensure that by 2015 all primary health-care and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases; and barrier methods such as male and female condoms and microbicides if available, to prevent infection. By 2005, 60 per cent of such facilities should be able to offer this range of services and by 2010, 80 per cent of them should be able to offer such services" (para 53).*

The inadequacies of Health Information Systems in Asia and the Pacific make it difficult to assess the extent to which primary health-care and family planning facilities across the region are able to provide the range of reproductive health, including family planning, services envisioned by the ICPD POA and ICPD+5. However, realization of this goal is contingent upon the attainment of the goal of universal access to basic health services through a primary health care approach, as called for in the Declaration of Alma Ata adopted at the International Conference on Primary Health care in 1978, in Alamaty. While a majority of Asian and Pacific countries have achieved this goal there are a number of countries in Asia and the Pacific (e.g., Afghanistan, Cambodia, India, Indonesia, Laos PDR, Pakistan, the Philippines, Papua New Guinea and other Pacific Island countries) where large segments of the population do not have access to basic health services. Lack of access to basic health services, therefore, is a major bottleneck in these countries to improved access to the full range of reproductive health services at the primary health care level or through referrals to higher levels of care.

Available information indicates that more than 95 percent of the service delivery points (SDP) in most countries of Asia and the Pacific provide three or more contraceptives. Afghanistan (83), Bangladesh (70), India (90+), Pakistan (70), and Sri Lanka (50+) Kiribati (68) and Samoa (78) are countries in which a significant proportion of SDPs do not provide three or more contraceptives. (UNFPA, 2008) Though information on the specific type of contraceptive available in an SDP is not available, it is likely that the three methods dispensed at most SDPs will include pills, male condoms and injectables (Depo Provera). Availability of other methods (e.g., IUD, norplant, and sterilization that require a skilled staff to provide it) will be limited to secondary and tertiary level facilities, and may be accessed through referral. Emergency contraception and female condoms are unlikely to be available in most SDPs, and this would limit choice.

Access to supplies and services in the Pacific is determined by the proximity of the service delivery point to the population, which in many countries is widely dispersed on small islands or in highland valleys, and the likelihood that the SDP will have the required commodity in stock and staff on hand qualified and willing to dispense it. In many rural areas access in this sense remains poor. Secondly, the prospective client must be seen as eligible to receive the service in the view of the service provider. Most if not all Pacific countries have now dropped the requirement that a husband's signature is required before a married woman can be provided with contraceptives. But as already noted, impediments remain in the case of young unmarried people.

In the Pacific, only general hospitals (located in the national capital or larger cities), or district hospitals in the larger countries, would be able to deliver the full range of reproductive health, including family planning, services. But even in these locations, services may not necessarily include the female condom, which has only recently been introduced in the region. Recent studies suggest that it is not uncommon for hospital-based RH clinics to offer four alternative methods of contraception (pills, injectibles, condoms, IUDs) as well as male and female sterilization, but all health centres and primary health facilities in rural areas are unlikely to be able to offer such choices or not consistently. Further promotion and implementation of comprehensive condom programming, including of both male and female condoms is necessary to reduce both STI and unplanned pregnancies in the region, especially in young people. Comprehensive approaches to condom promotion includes marketing, strengthening stock control and supply chain management, increasing community demand and facilitating access to condoms in community settings.

Quality of reproductive health care: If information on access to reproductive health care is limited, as noted in the preceding section, it is less likely that information on quality of care and its various elements is collected, even using sampling methods, in most countries. Key elements of quality of care include: client choice of methods, information for and counseling of users, the technical competence of service providers, interpersonal relations between providers and clients, mechanism for follow-up and continuity of care and an appropriate constellation of services.

Based on the information collected through a field inquiry, country reports presented at the Fifth APPC, and ICPD at 10 reports for Asia and the Pacific, it must be concluded that factors such as inadequate skills of service delivery personnel, lack of client orientation in the delivery of services, insufficient mechanisms for follow-up and supervision and the limited choice available to clients impede progress towards high quality reproductive health care. The reports also noted that progress is being made and cited specific examples of the steps taken by countries to improve quality of care which include, among others, capacity development through training of service providers, establishment of standards of care and protocols, adoption of guidelines for "gender sensitive" care, and strengthening of logistics to ensure supply and availability of RH commodities, including a mix of contraceptives.

In all likelihood these efforts and other interventions to improve service quality have continued at the national level. However, in most countries and at the regional level insufficient importance is given to the collection and analysis of information on quality of care, and this makes it difficult to draw any definitive conclusions on the rate of progress in improving the quality of reproductive health care. Monitoring progress in quality of care is particularly important to assess whether reproductive health, including family planning, information, counseling and services, that are provided in the Asian and Pacific countries respects the rights of individuals and couples, as called for in the ICPD POA.

Integration of reproductive health services: As noted earlier, the ICPD POA calls upon countries to "...strive to make accessible through primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015." The POA has also identified the major components of reproductive health care. Specifically, the Key Actions adopted at the 5 year review has called upon countries to ensure that 60 percent of primary health care and family planning facilities offer a wide range of services by 2005, including family planning, obstetric care, and prevention and treatment of RTIs including STIs and that 80 percent of Service Delivery Points will do so by 2010.

The ICPD@10 report for Asia and the Pacific noted that countries in the Asia-Pacific region have made efforts to integrate the various components of reproductive health, including family planning and HIV/STIs, by identifying essential services package of reproductive health services in the respective national contexts. The review report also noted that countries with well developed health infrastructure and in which family planning services formed part of the health services are moving closer towards fuller integration of services. However, in countries that had vertical programmes for family planning, the move towards integration is proving to be difficult due to a number of factors, and this remains true even today (United Nations, 2004).

Full integration of services requires management arrangements to facilitate an integrated system of service delivery, including logistics and information support, and the development of human resources. Constraints or obstacles to the integration of the different components of services, which have obvious benefits, are both country- and donor-driven. At the country level they include weak infrastructure, vertical planning, limited community involvement and lack of focus on integration during in-service and pre-service training. Constraints that emerge from donors include misalignment between country and donor priorities, donor competition, and poor harmonization (PPD, 2008).

Given that integration of major components of RH, safe-motherhood, family planning and HIV/STIs, is cost-effective and has proven benefits to improve health outcomes--including reduced maternal and child mortality and constraining the spread of HIV--efforts to integrate these services should be pursued as a priority through active advocacy at the highest echelons of Government and in the context of health sector reforms.

Reproductive Health Commodity Security (RHCS)

ICPD POA and the Key Actions of ICPD+5 stressed the need to ensure reliable and adequate supply of a range of reproductive health commodities, including contraceptives. Increased demand arising from increases in the population of reproductive age in most Asian and Pacific countries is stretching the ability of countries to meet the rising demand, a situation which is aggravated by the economic and financial crises that hit the countries of the region in 1997 and again in 2008.

Ensuring commodity security has multiple dimensions. These include:

i) the ability to forecast and respond to demand when the need arises;
ii) improvements in procurement and logistics management including supply chain management to ensure supply at SDPs and, for condoms, in community settings;
iii) ensuring availability, ease of access and affordability for the poor, marginalized and the vulnerable;
iv) marketing and increasing community demand; and
v) ensuring adequate finance for reproductive health commodities, including contraceptives.
vi) evaluation and quality assurance mechanisms.

It also important that a sufficient range of contraceptive methods is available so that clients are able to exercise choice.

The ICPD at 10 review report for Asia and the Pacific noted that most countries in Asia and the Pacific have taken actions to improve RHCS. These efforts include: promotion of partnerships with NGOs and the private sector in improving access to reproductive health commodities, including contraceptives; making improvements in the procurement and distribution of reproductive health commodities and supplies and strengthening logistics management and information systems, as well as obtaining technical and financial support from international agencies, including donor agencies.

However, the capacity of countries to plan and manage an efficient logistics management information system, and to procure, store and distribute the reproductive health commodities to SDPs in time, and to ensure access to contraceptives for the poor and vulnerable vary among the countries of Asia and the Pacific. Religious and other factors play a role in determining policies on the method mix made available to the clients in some countries. A shortfall in resources, as discussed below, is another concern for a number of countries in the region.

Assessments of Reproductive Health Commodity Security (RHCS) have been conducted in most Pacific Island countries in recent years, and while some improvements are evident significant impediments to RHCS remain—even in the more developed countries. A Pacific Plan of Action for Reproductive Health Commodity Security was formulated in 2003, but by 2008 many of the recommendations had not been fully implemented.

Nevertheless, several Pacific countries have developed strategies to improve RHCS—often within the context of a broader reproductive health strategy or policy. But few countries have made specific allocations for RH commodities in their national budgets, in spite of ministerial-level commitments to do so. All developing Pacific countries remain totally or predominantly dependent on UNFPA and/or other donors to provide RH supplies. UNFPA has recently up-graded its purchasing and distribution system at the regional level, so the countries are well-served, but many countries have not complemented this support by improving warehousing and distribution systems at the national level. Despite some progress and high-level political commitment, much remains to be done to ensure that RH commodities are physically available when and where required.

Challenges facing Pacific islands include: maintaining supply under difficult geographic conditions, building the capacity of countries to manage the logistics of medical supplies of all types including RH commodities, and developing skills of estimating and projecting demand, ordering stock, and maintaining inventories. Maintaining the quality of supplies is a further challenge due to a combination of climatic conditions and an insecure supply-chain that exposes goods to deterioration.

C. GENDER EQUALITY AND EMPOWERMENT OF WOMEN

Education:

The ICPD POA called upon countries to go beyond the achievement of the goal of universal primary education by 2015 and ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational and technical training (para 4.18).

The Key Actions adopted at ICPD+5 urged all countries to eliminate the gender gap in primary and secondary school attendance by 2005 and to raise primary enrolment to 90 percent by 2010 (Key Actions, para 34). Similarly, the MDG target is to "eliminate the gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015".

Regional reviews undertaken during the Fifth APPC, and as part of the 10 year review of ICPD implementation, have shown marked improvements in enrolment in primary and secondary education and in bridging the gender gap. (United Nations, 2004) The review highlighted specific measures that have been taken by Governments to ensure universal primary education and to bridge the gender gap.

In the Pacific gross enrolment date show that the gender gap in primary and secondary education is now generally small although there are notable exceptions (Table 6). At primary level, the gap ranges from 0 to 13 percent, while at secondary the range is wider—from 1 to 24 percent (in some countries more girls than boys are enrolled in school). The gender gap at secondary level is greatest in the less-developed Melanesian countries of Papua New Guinea and Solomon Islands and smallest in Micronesia and Polynesia. Net primary enrolment is near or above 90 percent in most Polynesian and Micronesian countries but falls well short of this level in Papua New Guinea and the Solomon Islands.

Gender equality in education is close to being achieved at the primary level across the Pacific sub-region but there is some distance to go before the gap is closed at the secondary level. Because much tertiary education takes place outside the region, it is difficult to estimate the gender gap at the tertiary level; however, most governments and international scholarship providers do strive to maintain a gender balance in the provision of tertiary scholarships.

The key indicator used for monitoring progress toward gender equality and the empowerment of women in the MDG framework is the proportion of women employed in paid, non-agricultural work. Available evidence indicates gradual increases in women's participation in paid employment outside agriculture in most countries of Asia, though the situation varies considerably across countries. A recent review has indicated that women constitute less than half of the paid workers in the non-agricultural sector in all Asian countries and their share is very low in a number of countries (Osteria, 2009). In the Pacific the female proportion of the paid labour force outside the agricultural sector ranges from only 5 percent in Papua New Guinea to a maximum of 45 percent in the Cook Islands (Table 6). Access to paid employment, therefore, is far from balanced by gender in Asia and the Pacific.

Employment

The ICPD POA urged all countries to adopt *"appropriate measures to improve women's ability to earn income beyond traditional occupations, achieve self reliance, and ensure women's equal access to the labour market and social security systems" (para 4.4d).*

Table 6: ICPD/MDG indicators on education and gender, 2005-09

	Education		Gender		
	Ratio of girls to boys in education (girls per 100 boys in school)*		Proportion of seats held by women in national parliament (%)	Share of women in non-agricultural paid employment	Percent of women aged 15-49 ever experiencing physical or sexual partner violence**
	Primary	Secondary			
Melanesia					
Fiji	98	107	8.7	38.1 (1996)	--
Papua New Guinea	86	67	0.9	5.0 (2000)	--
Solomon Islands	86	70	0.0	29.6 (1999)	64
Vanuatu	91	93	3.8	40.0 (1999)	--
Micronesia					
FSM	93	104	7.1	33.6 (2000)	--
Kiribati	93	114	5.6	39.5 (2005)	68
Marshall Islands	83	104	3.0	36.0 (1999)	28
Nauru	115	84	6.0	--	--
Palau	97	100	3.7	40.1 (2000)	--
Polynesia					
Cook Islands	89	94	8.0	44.6 (2001)	--
Niue	86	83	10.0	42.8 (2001)	--
Samoa	93	104	6.1	43.0 (2001)	46
Tonga	90	99	1.0	35.6 (1996)	--
Tuvalu	93	87	0.0	44.1 (2002)	--

Source: UNFPA Sub-regional Office for the Pacific database. Secretariat for the Pacific Community (SPC), 2009 Population data sheet. Noumea. AusAID (2009). RMI (2009). WHO (2005; 2006).
**Not adjusted for sex ratio in population. **Method of measurement in Marshall Islands may not be the same as in other countries.*

Whilst some men are engaged in sex work in the Pacific, the majority of sex workers are women, including young girls who maybe coerced into providing sexual services. Both local and migrant women are involved. Apart from the risk of HIV/STIs and pregnancy, the illegal nature of sex work in most PICs brings extra risk in terms of stigma, violence and rejection from communities. Despite this, law enforcement approaches do little to reduce sex work, with demand driven services continuing to be provided.

Political participation

The Key Actions adopted at ICPD+5 reaffirmed the call made at ICPD to *" establish mechanism to accelerate women's participation and equitable representation at all levels of the political process and public life in each community and society.... and ensure the full and equal participation of women in decision making processes in all spheres of life." (para 43)*

The 10 year review noted that countries have taken a number of measures, including affirmative action and constitutional provisions, to promote the participation of women in political and decision making levels at all levels. As a result, and with improved education, women's role in political processes and decision

making is gradually improving in a number of countries in Asia. However, a recent regional review has noted that the percentage of women in ministerial level positions and in the national parliaments is lower than 20 percent in most Asian countries (Osteria, 2009).

In the Pacific, political participation has shown little improvement over the past decade and the proportion of seats in parliament presently held by women remains below 10 percent in most countries. Papua New Guinea, with 109 seats in Parliament has only one woman member, and this has been the case for the last two parliaments. In spite of efforts to appoint women directly to parliament, an option provided for in the Constitution, no such appointments have been made to date.

Gender based violence (GBV)

The ICPD POA urged countries to "eliminate violence against women" (para 4.4e) and to "...take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children". (para 4.2) and to foster "zero tolerance" towards violence against girls and women. The urgent need to address GBV is also highlighted in the Fifth AAPC plan of Action (United Nations, 2004, para E.3)

Gender-based violence is recognized as a major human rights issue in many international development agendas, including the ICPD POA and the Beijing Platform for Action. It includes a wide range of violations of human rights, including trafficking in women and girls, rape, spousal abuse, sexual abuse of children, and harmful practices that irreparably damage the reproductive and sexual health of girls and women (UNFPA, 2004).

Domestic violence is a common phenomenon in most countries and is often considered as "normal". Many women who are victims of domestic violence do not report such abuse for fear of persecution from the family and the community and further abuse from authorities—even those who are expected and obliged to provide protection. There are also reported cases of sexual harassment and gender-based violence in the work place in many countries. As discussed in the preceding sections, gender-based violence is detrimental to women's reproductive health and is a factor in maternal death and the transmission of HIV.

In the Pacific, the ICPD+10 review of the implementation of ICPD shows that most Pacific Island countries have taken some steps to address gender-based violence; but recent research implies that these steps have been insufficient. There has also been some regression as one Pacific government has recently refused to ratify CEDAW on the grounds that it is against its "culture".[20]

Representative studies of GBV have now been conducted in each of the three sub-regions of the Pacific using standardized methodology developed by WHO. In the countries studied, the incidence of "physical partner violence" among ever-partnered women aged 15-49 ranged from 41 percent in Samoa to 46 percent in Solomon Islands and 60 percent in Kiribati (Table 6). In Solomon Islands and Kiribati, 64 and 68 percent of women, respectively, had experienced physical and/or sexual partner violence. These rates are among the highest reported in the world by WHO. (WHO 2005) Somewhat lower, but still high rates of violence against women were found in the recent Marshall Islands DHS: 28 percent of women aged 15 and over reported having experienced violence and 72 percent of these women indicated that their husband or partner was the perpetrator (Republic of Marshall Islands, 2009). Although most men and many women believe that physical violence on women by men is approved or permitted by "culture", the incidence of violence is higher in urban areas than in the more "traditional" rural villages. Factors conducive to violence include unemployment and access to alcohol. Some evidence suggests that more educated women are less likely to experience sexual violence than less educated women. Nevertheless, there is little doubt that violence against women remains a serious social issue in the Pacific across all social groups.

A range of sexual minorities and varying gender identities are found in the Pacific. Various festive occasions celebrate transexuality and transsexual individuals often find an accepted role in society often in some form of service industry or household duties. Transgendered individuals are found throughout the Pacific region, although more hidden in many Melanesian countries. Stigma and discriminatory attitudes including violence are common to these and other sexual minorities such as men who have sex with men and transsexuals. The SRH rights of these individuals need to be strengthened, including access to condoms and HIV/STI testing, treatment and care. The current growth of the Pacific Sexual Diversity Network (PSDN), is an illustration of how sexual minority groups are growing in organization and coordination, with such networks providing empowerment, information and support for these marginalized and vulnerable individuals. Further efforts are needed to support and provide services to the various sexual minorities present in the region.

D. PARTNERSHIPS AND RESOURCES

Partnerships

The ICPD POA stressed that the achievement of population and development goals would require enhanced partnerships at various levels. The importance and effectiveness of international cooperation between donor and recipient countries, and the role of non-governmental and private sector organizations were acknowledged and encouraged. The comparative advantages of NGOs in addressing culturally-sensitive issues and in reaching constituencies that may be poorly served by government agencies was highlighted. The POA also stressed the importance of coordination of the activities and programmes of all development partners to avoid unnecessary duplication and to ensure congruency between programmes (ICPD POA, Chap. 14).

20 It is likely that the inheritance of land is the key impediment in this case given that the land-holding group is patrilineal. It should be noted that even where inheritance follows matrilineal principles, women are not necessarily protected from violence.

Similarly, the Key Actions adopted at ICPD+5 stressed the need for enhanced collaboration and cooperation between governments, multilateral donors, non-governmental organizations, civil society, community based organizations, etc. to advance the ICPD POA. (paras 76-86) The important role that parliamentarians and national legislatures can potentially play in advocating for the implementation of the POA was also highlighted. Similarly, the Fifth Asian and Pacific Population Conference reiterated the on-going importance of greater cooperation and partnerships between governments, NGO, the private sector and community-based organizations. The further involvement of parliamentarians in advocacy for and awareness-raising of ICPD and the need for more South-South cooperation were again stressed. (ESCAP, 2003)

The MDGs has as one of its Goals: "Develop a global partnership for development" across a range of substantive areas—including the international trading system, addressing the special needs of Land-locked and Small Island Developing States, debt relief, affordable drugs, and information and communication; and has set of targets to be achieved.

Regional reviews undertaken as part of ICPD+5 and ICPD+10 have shown that NGOs and Civil Society Organizations have played a pioneering role in highlighting issues that are culturally sensitive or that national Governments are reluctant or slow to address. For example, as noted earlier, NGOs are actively involved in improving access to reproductive health services for adolescents, sex workers and sexual minorities in many Asian and Pacific countries. The review also found that since ICPD, direct donor support to NGOs-with the concurrence of the Governments- for population and reproductive health programmes has increased. It was estimated that for the Asia-Pacific region as a whole one third of the total expenditure for population activities was channeled through NGOs.

At the regional level, NGOs have mobilized themselves periodically (e.g., during the Fifth APPC and the 15-year regional reviews) to take stock of progress in meeting ICPD Goals and propose strategies for moving the agenda forward. NGOs take active part in the Asia-Pacific Conference on Reproductive and Sexual Health (APCRSH) which provides a forum for sharing of experiences in promoting reproductive rights and in improving access to reproductive health services among the countries and participants from the region.

Many countries, including Fiji, included NGO representatives in their national delegations to the Fifth APPC. At the national level, however, the role and importance of NGOs in population and reproductive health programmes varies considerably. In a few Asian countries NGOs are given voice in the planning and policy processes while in others their role is limited to implementing small scale projects or programmes. There are also example of countries in Asia earmarking funds in the national budgets for NGO programmes and activities.

A number of Asian countries have sought cooperation from religious leaders and other influential groups at the community level to promote reproductive rights and reproductive health and to improve access to information, counseling and services for adolescents and young people. Efforts have also been made in the Pacific Island countries to involve the churches and national church bodies in population programmes, including those addressed to adolescents.

However, the view was expressed during the Asia-Pacific NGO consultations to mark ICPD@15 that the role played by NGOs has diminished and needs to be strengthened. Hence the Asia-Pacific NGO Forum "urged Governments to recognize NGOs as equal partners and create inclusive mechanism for meaningful NGO and civil society participation." The stipulation under the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), for country coordinating mechanisms in countries receiving GF grants to include both Government and significant non-government representation, is a good example of ensuring NGO and community involvement.

Parliamentarians have played an important role in population programmes in Asia for well over three decades. The Asian Forum of Parliamentarians on Population and Development (AFPPD) and the affiliated national committees of members of parliaments in 24 Asian countries have become active in promoting the Cairo Agenda at the global, regional and national level. In a number of countries they have played important role in promoting legislation in support for reproductive health rights and programmes and for promoting gender equality and equity.

The other influential and widespread leadership in the Pacific region are the faith based organizations (FBOs). As discussed earlier, some specific FBOs find the SRH agendas and issues, challenging and sensitive to address and encompass within their guiding principles for their constituencies. UNFPA can play a stronger role in consulting, informing, encouraging and negotiating with various FBOs to strengthen their support for a rights based approach to increasing access to SRH services for the local populations. PRSPs, SWAps, UNDAF and the efforts to advance MDGs have provided added opportunity for improving civil society participation in setting the agenda for development and for their implementation in a number of Asian and Pacific countries.

In the Pacific Islands, the scale and intensity of collaboration and cooperation between national governments, multilateral agencies, donor countries, NGOs, Civil Society and community based organizations has increased substantially in recent years. This is exemplified by the institutional arrangements put in place to address HIV and other STIs. The "Pacific Regional Strategy on HIV and other STIs 2009-13", along with its implementation plan and technical working groups has provided an effective umbrella framework for cooperation and collaboration between national governments, donors, NGOs, and multilateral organizations that was previously lacking. A similar regional approach has been developed in the area of reproductive health services and commodities. The "Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008-2015" agreed to by Pacific Ministers of Health provides a framework for collaboration—especially between governments, international agencies (UNFPA, WHO and UNICEF in particular) and NGO service providers. NGOs have already played a significant role in providing reproductive health services to adolescents and youth, but mostly at national level and on a small scale. The recently-approved Pacific Policy Framework should enhance the opportunities for NGOs involvement in providing services to youth. In some, but not all countries, NGOs have been more successful in reaching and serving young people than government-run clinics.

Some progress has also been made in introducing the "sector wide approach" (SWAp) to health policies. Three countries (Papua New Guinea, Solomon Islands and Samoa) have adopted the SWAp in their health sector, bringing together a wide range of organizations to address the common purpose of improving the delivery of health services.

An important milestone in the creation or fostering of partnership in support of the ICPD POA in the Pacific was the re-establishment of the Pacific Parliamentarians Assembly on Population and Development (PPAPD) in 2002. The PPAPD has provided an effective forum for policy dialogue within which legislators have improved their understanding and knowledge of population issues and the goals of the ICPD POA.

Examples of south-south cooperation in the Pacific Islands can be found but this modality of cooperation remains underutilized.

Partnership, collaboration and coordination in the Pacific have undoubtedly increased in scale and importance at the national and regional level since the advent of the UNDAF modality closely followed by the MDG framework. The inclusion of the target of "universal access to reproductive health" under MDG 5 has provided an entry-point for population issues in strategies to achieve the MDGs. All international agencies and the major donor countries firmly support the MDGs and have achieved a significant level of cooperation in doing so.

Resources: Domestic and International

One of the objectives included in the ICPD POA is to *"achieve an adequate level of resource mobilization and allocation, at the community, national and international levels, for population programmes and for other related programmes, all of which seek to promote and accelerate social and economic development, improve the quality of life for all, foster equity and full respect for individual rights, and by doing so contribute to sustainable development" (para 13.21).*

It was estimated at the time that the implementation of the costed package which includes family planning services; basic reproductive health services; STI and HIV prevention activities; and basic research, data and population and development policy analysis would cost US$ 17.0 billion in the year 2000 and increase to 21.7 billion by the year 2015. It was also noted that two-thirds of the projected costs should be mobilized from domestic sources and the remaining one third should be borne by international donor community. It should also be noted that the costed packages of services does not include broader population and development objectives included in Cairo Agenda and there has been no attempt to estimate the resources required for meeting these broad development objectives. Resource requirements using more robust estimates of demand and the rising costs of commodities and equipment are currently being undertaken, which when available, will provide a more accurate picture of the situation.

Monitoring of resource flows indicates that by 2000 international population assistance totaled $2.6 billion, which was only 46 percent of the goal of $5.7 billion and represented considerable shortfall in resources at that time. Since 2002, however, international assistance has steadily increased to 7.4 billion in 2006, which surpasses the goal set at the ICPD.

A recent UNFPA report notes that "although the total financial target has been surpassed, the increase has not been evenly distributed over the costed population categories." Moreover, it is noted that "significant amount of resource flows goes to other population-related activities that address broader population and development objectives of the Cairo agenda, but that have not been costed out and are not part of the agreed target..." The report notes that funding for family planning is well below target, according to the

estimates. Domestic expenditure, though more difficult to track and estimate, is reported to be US$11.1 billion in 2007, which is slightly lower than the goal set at ICPD.
The Asia-Pacific region was the second largest recipient of population assistance and final expenditure figures indicate an increase from $365.1 million in 1997 to $885.5 million in 2007. Nearly half of these funds are channeled through NGOs while the remainder is channeled through bi-lateral (19 percent) and multi-lateral (34 percent) support. India ($149.9 million), Bangladesh ($92.0 million) and Indonesia ($76.3 million) are the three major recipient countries.

With increasing demand and rising costs, and with the inclusion of the components that were not costed in 1994, it is very likely that the presently available resources will be considerably below what is needed. In this regard, it should be highlighted that public expenditure on health as percent of GDP, as indicated earlier, is low in most Asian and many Pacific Island countries.

Available statistics for the Pacific Islands suggest that total international resources increased from $7.8 million in 1997 to $41.7 million in 2007—a five-fold increase (UNFPA, 2008). But 79 percent of this increase was in Papua New Guinea and presumably can be explained by increased funding for HIV and AIDS programmes. In 2007, three-quarters of all international population assistance in the Pacific sub-region went to Papua New Guinea. When Papua New Guinea is excluded, international resources in the remaining countries increased from $2.7 million to $8.9 million over the 1997-2007 period. While this is a considerable increase, it is highly likely that some of it can also be attributed to increased allocations for HIV prevention in other Pacific countries. More detailed analysis of the data would need to be conducted to confirm this.

It is also probable that family planning programmes in Papua New Guinea have not received a proportional increase in funding over the decade as a result of the flows of resources to HIV prevention. In general, support for family planning in the Pacific sub-region has been falling, as in other regions (Robertson 2007a, 2007b). The lack of resources may partially account for the low level of contraceptive prevalence and high unmet need in the Pacific sub-region. While HIV prevention remains a high priority—especially in Papua New Guinea—ensuring that family planning programmes receive an increasing share of aid flows is also crucial if unmet need is to be reduced across the sub-region. Stronger linkages between RH and HIV/STI programmes and services and developing more integrated and holistic SRH services would also assist increase coverage of both RH and HIV/STI services in Pacific populations.

When Papua New Guinea is excluded, the Pacific Island countries receiving the largest shares of international financial assistance over the past decade were Solomon Islands (21.3%), Fiji (21.2%), Federated State of Micronesia (12.0%) and Tonga (8.4%). On a per capita basis, however, the smaller Island countries of Niue, Tuvalu, Cook Islands, Palau and Marshall islands were the largest recipients.

It is imperative that Governments in the Asia-Pacific region should increase their budgetary allocation to population and development programmes and to use their resources more efficiently in order to reduce the shortfall in resources. It is particularly important that adequate funding should be provided to expand access to family planning services in order to reduce the unmet demand which is still high in many countries.

SECTION 3: PROGRESS, CHALLENGES AND STRATEGIC PRIORITIES

Progress and achievements

Periodic reviews undertaken in Asia and the Pacific have shown that progress has been made in implementing the ICPD POA in nearly all the countries of the region. In the Pacific Islands sub-region, the following achievements can be highlighted:

- The regional population growth rate has declined from 2.3 percent per annum to 1.9 percent—a drop of 17 percent. Although emigration has contributed to slowing growth, the rate of natural increase has also declined by 20 percent over the same period. Although the pace of change has been slow, the demographic transition has continued to advance in the expected and desired direction. The projected population in 2025 based on the rate of growth around the time of ICPD in 1994 was 13.6 million. The projected population in 2025 based on current growth rates and recent trends is 12.8 million. The difference of around 800,000 should be taken as a measure of progress.
- Rising life expectancy is evidence that overall standards of health have improved since 1994. The life expectancy goals of the ICPD POA have been achieved in most countries, but not in all.
- The ICPD POA targets for infant and under-5 mortality have been achieved in all but a few countries and this has obviously contributed to improved life expectancy figures.
- Maternal mortality has declined in several smaller countries and ceased to be a "significant public health problem" in some of them.
- Reproductive health services have been integrated into primary health services in most countries and the quality of service has improved through better trained, informed, and culturally sensitive health personnel. Although impossible to prove, it is highly likely that the insensitivities observed among some family planning workers prior to ICPD are much less in evidence today.
- Services targeting adolescents through NGOs, schools, youth centres and specialized government clinics have greatly expanded. Along with other contributing factors this has reduced adolescent fertility in some countries.
- Most countries have achieved universal primary education for both boys and girls and others are well on their way in achieving it.
- The gender gap is virtually eliminated at primary level and progress has been made on eliminating the gender gap at secondary and tertiary levels.
- The knowledge base on a range of reproductive health issues has improved significantly, following studies of teenage fertility, access and use of adolescent services, and reproductive health commodity security. Demographic and Health Surveys have been conducted providing a significant advance in knowledge of unmet need, contraceptive prevalence, access to antenatal and other reproductive health services, gender-based violence and a range of health issues.
- A regional definition of poverty has been conceptualized and legitimated in the context of MDG-based development planning that provides a basis for further analysis and explication of the linkages between population dynamics and poverty trends in the Pacific Islands.
- Specialized studies of gender-based violence have highlighted the prevalence and pervasiveness of violence against women in the region and its socio-cultural and economic determinants. This research has provided a stronger platform on which to mount remedial strategies.

- Region-wide strategies have been developed and are being implemented on reproductive health commodity security, reproductive health policies, and family planning. A programme and policy base has been established to achieve universal access to reproductive health by 2015 in most countries.
- Male involvement in reproductive health issues has been advanced through pilot programmes within work and other predominantly male settings (sports, police and military)
- Although the HIV virus is present in all countries, HIV and AIDS have not reached epidemic proportions in most of them. The rate of new infections has remained stable in Micronesia and Polynesia.
- New and stronger partnerships have been developed between international agencies, donors, NGOs and civil society to advance the ICPD POA. The establishment of the Pacific Parliamentarians Association for Population and Development (PPAPD) is a singularly important achievement.
- The international resources available for population programmes in the Pacific have increased five-fold between 1997 and 2007, but the bulk of the increase has been allocated to one country (Papua New Guinea) and mainly for the purpose of HIV prevention.

In summary, There is evidence that progress has been achieved in the Pacific on achieving the quantitative goals of the ICPD POA in terms of the "number of countries" in the sub-region that have reached or are on track to reach the ICPD goals and MDGs relating to population. The countries that have made the most progress are generally those that are either in a historical relationship with a former or current metropolitan power or have opportunities to participate in overseas labour markets.

In terms of the vast majority of the population of the Pacific Islands sub-region, however, the situation is very different. The Western Melanesian countries of PNG, Vanuatu and Solomon Islands, contain more than three-quarters of the region's population and have made much less progress, mainly because the obstacles to broad-based development are so much greater. Some of these obstacles and challenges are noted in the following section.

Challenges

- The fundamental challenge facing Pacific Island governments, societies and communities is how to improve the overall level of welfare ("development") in a context of low per capita incomes and a slow pace of economic growth. The countries that are doing best are those that have been able to exploit overseas labour markets and avoid the build-up of "surplus labour" at home, but these strategies are not available to the larger countries.
- While the decline in the regional population growth rate, and the overall rate of natural increase, over the past decade are encouraging, the pace of decline has been too slow and too recent to significantly reduce annual increments to the regional population. At current rates, the total population will reach 10 million in 2011 and by 2050 another 8 million will be added to the population.
- Annual population increments in Western Melanesia (Papua New Guinea, Solomon Islands and Vanuatu) remain high and will continue to place pressure on governments to expand public services such as health-care and education at the expense of higher quality.
- Stabilizing population in Western Melanesia would require a more rapid pace of fertility decline in order to reduce the rate of natural increase because emigration cannot play the role of offsetting natural increase that it has played in Polynesia, Micronesia, and Fiji.
- Basic needs poverty has been increasing in some countries.

- While infant and child mortality rates have declined, they remain high in some countries, especially at sub-national levels.
- Universal access to reproductive health is a long way from being achieved in the predominantly rural, village-based societies of Western Melanesia as well as parts of Polynesia and Micronesia. Countries in which the population remains more than 75 percent rural include: Papua New Guinea (85%), Solomon Islands (84%), Samoa (79%), The Federated States of Micronesia (78%), Vanuatu (77%) and Tonga (77%). Delivering services to dispersed, rural villages and islands is a major development challenge in the Pacific.
- The unmet need for family planning and especially contraception for young people remains significant in several countries; contraceptive prevalence remains below 50 percent in most countries. About 650,000 women have an unmet need for family planning. Cultural and religious sensitivities preclude widespread access and acceptance of barrier contraception – the only realistic method for preventing HIV, other STIs and unplanned pregnancies in young people and other marginalized and vulnerable groups.
- Maternal mortality remains unacceptably high in Western Melanesia, especially Papua New Guinea.
- In spite of some reductions, adolescent fertility remains relatively high in several countries.
- The prevalence of sexually transmitted infections is high, especially among young people, and HIV and AIDS have become epidemic in Papua New Guinea.
- The vertical, fragmented and under-resourced nature of the various SRH and Primary Health Care services reduces the ability of service providers to address key SRH issues in a holistic and coordinated manner with significant gaps and lack of coverage for the population.
- Adolescents and young people in rural areas have limited access to information, counseling and services on reproductive and sexual health. Adolescent reproductive rights and sexuality remain culturally contested concepts in the Pacific.
- Gender-based violence is persistent and pervasive in the Pacific and unacceptably high in countries in which research has been conducted.
- Sexual minorities remain marginalized and stigmatized without widespread support or access to SRH services including for HIV/STIs.
- Sex workers, mostly women, are similarly rejected from communities and remain at high risk of HIV, STIs and other SRH problems, in turn increasing risk for the broader Pacific communities from which sex workers' clients and partners come.
- Population ageing is occurring in those countries that entered the demographic transition the earliest and the pace of ageing will accelerate in coming decades. The implications of changing age structures in the Pacific have been insufficiently studied.
- There are major gaps in the knowledge-base on population dynamics and processes in the Pacific. Much more research is required on, for example, the slow pace of fertility decline, the relationship between basic needs poverty and population dynamics, population patterns in outer islands, the impact of emigration on the quality of life. Population data-sets (census, surveys and HIS) remain under-analyzed.
- The integration of population dynamics into development plans, poverty reduction strategies and sector plans has stalled. Little progress is evident in the past decade. Changing development frameworks, lack of technical support and waning donor interest are the main causes.
- Similarly, the development of national population policies has stalled, with the single exception of the Papua New Guinea National Population Policy 2000-2010. Several countries have out-dated policies but these have virtually no effect in terms of policy.

Priority Actions

Population dynamics and trends are determined by a complex interplay of economic, social, geographical, cultural causes. Socio-economic systems are also affected by population factors and strive either to adapt to or modify them. The interplay of these two systems varies from country to country and through time. The ICPD Programme of Action provides a framework for government action that acknowledges the fact that population and development are intricately linked. Successful implementation of the POA is a function of many variables, among which the availability of public resources and the quality and efficacy of public sector management play central roles. The challenge of accelerating the pace of GDP growth in Pacific Island economies is largely beyond the scope of the ICPD POA.[21] Identifying the correct strategies has proven elusive, although there is little doubt that the quality of governance is a fundamental starting point that applies to all countries in the Pacific regardless of their present level of development.

That island economies comprise a special category of socio-economic system made up of unique elements and special challenges is reflected in the "Programme of Action for Sustainable Development of Small Island Developing States". The implementation of this Programme is one of the targets of MDG 8 "Develop a Global Partnership for Development", one of the indicators of which is "ODA received in small island developing states as a proportion of their gross national income", a recognition that Official Development Assistance plays a highly significant role in fostering development in such countries.

It is for this reason that a recent regional review (AusAID, 2009) has highlighted the need to achieve better development outcomes from development aid as well as domestic resources through the implementation of *The Pacific Aid Effectiveness Principles*, adopted in 2007, the *Paris Declaration* on aid effectiveness, and the Pacific Plan. The following list of strategies presupposes that the implementation of these approaches, possibly accompanied by increased domestic resources generated by economic growth, and improved financial management will benefit population programmes and support the further implementation of the ICPD POA.

- Prepare multi-sector "third-generation"[22] national population policies in selected countries that raise the profile of population factors in socio-economic development while fully reflecting the human rights principles embodied in the ICPD POA and focused on the achievement of the MDGs.
- Where circumstances are not favourable for the development of a multi-sector national population policy, take steps to further integrate population into sector plans, poverty reduction strategies, national development plans, and MDG reports. Technical assistance and training should be made available to support this process.
- Continue to support parliamentarian, faith based and traditional leadership and advocate for their increased awareness, understanding and acceptance of the need for rights based and equitable access to SRH for all population groups. Encourage leadership champions to advocate for increased community tolerance and understanding of diversity and need within all Pacific communities.
- Continue to implement, but at a faster pace, comprehensive regional strategies in reproductive health and reproductive health commodity security with a stronger focus on the less-developed or poorer countries and the disadvantaged rural majority. Develop where they do not currently exist, national reproductive health strategies, encompassing and prioritizing adolescent reproductive health, RH commodity security, male involvement and associated issues.
- Raise the profile of family planning in reproductive health strategies and plans, by appropriate

21 Increasing per-capita GDP by reducing population growth is a static and simplistic approach that does not address the fundamental causes of slow growth in total GDP in the Pacific.

22 The term "third generation" population policies refer to policies that focus on the joint achievement of the ICPD goals and the MDGs, building upon MDG reports and poverty reduction strategies. The terminology implies that population policies can be categorized as (1) "pre-ICPD"; (2) "post-ICPD" and (3) "post-MDGs".

means, including additional finances and advocacy, and improve the quality of services, including greater promotion and acceptance of condoms as a low-impact contraception.

- In PNG, develop innovative strategies for both the measurement and the prevention of maternal mortality based on experience in comparable countries in other world regions.
- Implement the "PNG National HIV Prevention Strategy 2010-2015" and the "Pacific Regional Strategy on HIV and other STIs 2009-13" to reduce the rate of new HIV infections and to reduce the prevalence of other STIs, especially in young people and marginalized/vulnerable groups at high risk of infection.
- Increase student access to Family Life Education and lifeskills training to raise awareness, build skills and prepare young people for productive and healthy adult lives including healthy sexual behaviour and avoidance of SRH risk.
- Increase provision of youth and user-friendly ASRH, HIV/STI and counseling services for young people, including those at most risk, ensuring these services are non-judgmental, confidential, affordable and accessible
- Promote and facilitate the linkages and ultimate integration of safe-motherhood, family planning and HIV/STI prevention, treatment and care services.
- Build the population knowledge-base by undertaking secondary analysis and original research on key policy issues, including: (i) determinants of variations in fertility, including teenage fertility; (ii) reasons for the low-uptake of family planning; (iii) relationship between population dynamics and basic needs poverty; (iv) the impact of emigration and migrant remittances on social welfare, particularly in rural areas; (v) cultural values and attitudes associated with the denial of reproductive rights to unmarried adolescents and youth. In the process, build national capacity to undertake higher-level research.
- Promote the fuller utilization of census and survey data, while also ensuring that more countries conduct Demographic and Health surveys on a regular basis. Build national capacity to undertake such surveys.
- Address population ageing by forming national coordinating bodies to review the ageing situation at national levels and prepare plans and strategies to deal with the socio-economic implications. Strategic interventions include: promoting healthy ageing, reorienting health systems and services to meet the health needs of older persons, establishing and expanding old age social security, and supporting older persons to remain active.
- Advocate for the expansion of improved water and sanitation services.
- Develop new strategies to reduce gender based violence, including advocating for changes to national laws, policies and practices.
- Identify and strengthen support for mobile and migrant communities within PICs, ensuring SRH services are tailored for migrant needs.
- Adopt and promote a pro-poor approach to planning and programming_for the service-delivery, including safe-motherhood and family planning, to make such services more accessible to disadvantaged and lower-income groups.
- Strengthen cooperation_among countries, and with NGOs, CSOs, the private sector, members of parliament, and other development partners for advocacy, building knowledge base and, as appropriate, for the delivery of services.

Conclusion

Possibly the most striking conclusion arising from this review is that in many respects the current population-development situation in the Pacific Islands, is not radically different from what was observed in the early 1990s immediately prior to the ICPD (Pirie, 1994, 1995; SPC, 1994) and observed again when the implementation of the ICPD POA in the Pacific was reviewed in 1998 (Chee, 1998). The same themes of slow economic growth, high rates of natural increase, high teenage pregnancy, low but fluctuating contraceptive prevalence rates, high STIs, low government spending on health, international and rural-urban migration arising from rural underdevelopment, growing urbanization accompanied by the growth of informal settlements, early signs of ageing and increasing relative poverty are common in each of these reviews. There is little doubt that progress has been achieved over the 15 years of the ICPD POA, but it is probably also fair to say that it has been slower than might have been expected, or hoped for.

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ANNEXES

Annex I: Millennium Development Goals, Targets and Indicators, 2008 Revision

Goals and Targets	Indicators for Monitoring Progress
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.	1.1 Proportion of population below $1 (PPP) per day 1.2 Poverty gap ratio [incidence x depth of poverty] 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment to population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under 5 years of age 1.9 Proportion of the population below minimum level of dietary energy consumption
Goal 2: Achieve Universal Primary Education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education	2.1. Net enrolment in primary education 2.2. Proportion of pupils starting grade 1 who reach grade 5 2.3. Literacy rate of 15-24 year olds
Goal 3: Promote Gender Equality and Empower Women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015	3.1 Ratio of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunized against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

Goal 6: Combat HIV/AIDS, Malaria and other diseases	
Target 6.A. Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of the population aged 25-24 with comprehensive correct knowledge of HIV/AIDS 6.4. Ratio of school attendance of orphans to attendance of non-orphans aged 10-14
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of the population with advanced HIV infection with access to antiretroviral drugs
Target 6.C. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of the population under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence prevalence and death rates associated with tuberculosis 6.10. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
Goal 7: Ensure Environmental Sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per $1 GDP (PPP). 7.3 consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction.
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of the population using an improved water source 7.9 Proportion of population using an improved sanitation facility
Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums
Goal 8: Develop a Global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes a commitment to good governance, development and poverty reduction – both nationally and internationally.	**Official development assistance:** 8.1. Net ODA, total and to the least developed countries, as a percentage of OECD/DAC donors' gross national income 8.2. Proportion of total bilateral, sector-allocable ODA of OECD/DAC to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3. Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4. ODA received in landlocked countries as a proportion of their gross national income 8.5. ODA received in Small Island Developing States as a proportion of their gross national income

	Market access: 8.6. Proportion of total developed country imports (by value and excluding arms) from the developing countries and from the least developed countries, admitted free of duty 8.7. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8. Agricultural support estimate for OECD countries as a percentage of their gross domestic product 9.9. Proportion of ODA provided to help build trade capacity **Debt sustainability:** 8.10. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11. Debt relief committed under HIPC initiative 8.12 Debt service as a percentage of exports of goods and services
Target 8.B: Address the special needs of the least developed countries. Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	
Target 8.C: Address the special needs of landlocked countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communication	8.14. Telephone lines and cellular subscribers per 100 population 8.15. Personal computers in use per 100 population and internet users per 100 population 8.16. Internet users per 100 population