



ICPD +10

Progress in the Pacific



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The present volume has been consolidated and edited in accordance with UNFPA practice and requirements.

FOREWORD

It is my privilege and honour to present, on behalf of the United Nations Population Fund (UNFPA) a compilation of the official outcomes of the ten-year review of the International Conference of Population and Development (ICPD) as reported by thirteen Pacific Island Countries.

The thirteen Pacific Island Countries that responded to the Global Survey (Cook Islands, Federated States of Micronesia (FSM), Fiji, Kiribati, Marshall Islands, Niue, Palau, Papua New Guinea (PNG), Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu) were among the 179 States that participated in the International Conference on Population and Development held in September 1994 and that took part in the negotiations to finalise a Programme of Action (PoA) on population and development for the next 20 years. In preparation for the five-year review of the ICPD in the Hague, the Netherlands in February 1999, the same thirteen countries and Tokelau attended a Ministerial Meeting in November 1998 organised by UNFPA in collaboration with the Government of Fiji. The Meeting culminated with a Ministerial Statement and a Pacific Response to the Programme of Action of the ICPD, which formed the basis for a collective Pacific pledge to the objectives of the ICPD PoA.

After ten years, the Pacific Island Countries have made considerable strides in achieving many of the indicators as set forth in the ICPD. However, it is also apparent that they will need continued support and commitment to maintaining these positive trends and improving some of the indicators. It is my hope therefore that this report will serve as a basis for determining progress and further achievements in the coming years.

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ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ARH	-	Adolescent Reproductive Health
CEDAW	-	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	-	Convention on the Rights of the Child
ECREA	-	Ecumenical Centre for Research, Education and Advocacy
EFA	-	Education for All
FP	-	Family Planning
FSM	-	Federated States of Micronesia
HIV	-	Human Immunodeficiency Virus
ICPD	-	International Conference on Population and Development
ICPD+5	-	The Five-Year Review of the ICPD
IEC	-	Information, Education and Communication
ILTS	-	Integrated Long-Term Strategy
IPPF	-	International Planned Parenthood Federation
LMIS	-	Logistics Management Information System
MCH	-	Maternal and child health
MDGs	-	Millennium Development Goals
MMRs	-	Maternal Mortality Ratios
NACA	-	National Advisory Committee on AIDS
NGO	-	Non-Governmental Organisation
NMW	-	National Machineries for Women
NSP	-	National Strategic Plan
PHC	-	Primary Health Care
PICs	-	Pacific Island Countries
PoA	-	Programme of Action
PNG	-	Papua New Guinea
PRSP	-	Poverty Reduction Strategy Paper
RH	-	Reproductive Health
RHCS	-	Reproductive Health Commodities Security
RHMIS	-	RH Management Information Services
RRRT	-	Regional Rights Resource Team
SDPs	-	Service Delivery Points
SPC	-	Secretariat of the Pacific Community
SPSS	-	Statistical Package for Social Sciences
STIs	-	Sexually Transmitted Infections
TB	-	Tuberculosis
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Population Fund
UNGASS	-	United Nations General Assembly Special Session
UNICEF	-	United Nations Children's Fund
UNIFEM	-	United Nations Development Fund for Women

CHAPTER 1: INTRODUCTION

In 1994 the international community reached an unprecedented global consensus on population issues during the International Conference on Population and Development (ICPD) in Cairo. The vision that was encapsulated in a 20-year Programme of Action was based on countries' own experiences and shed new light on the relationships among population, development and individual well-being.

The ICPD Programme of Action (ICPD PoA) set out a series of priority issues, including among others, population and development, gender equality and equity, reproductive health and rights and adolescents and youth. It described the actions needed in response, with agreed goals and a 20-year timeframe for achieving them, and identified the bodies responsible for action. The promise of the ICPD was to reconcile the imperatives of national development with cultural values and human rights. Implementing it means that countries themselves have taken ownership of population and development, on their own terms.

The first five-year review of the implementation of the Programme of Action was conducted by the General Assembly in 1999, which adopted, by consensus, the Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development. The review demonstrated that the ICPD goals were still relevant and that much progress had been made in advancing them. At the same time, it revealed that much greater and continued action was needed in certain programme areas. The Key Actions provided a new set of benchmarks for four priority issues: education and literacy, reproductive health care and unmet need for contraception, maternal mortality reduction and HIV/AIDS.

The 10th Anniversary of the ICPD, the mid-point of its 20-year Programme of Action, offered an opportunity to celebrate and look forward. In celebration of ICPD at Ten, activities have taken place at various levels including a Global Survey on the implementation of the Programme of Action which was sent to both developing and developed countries between April and June 2003, with a total of 169 countries completing the questionnaire.

Of the fifteen countries in the Pacific that were invited to participate, thirteen responded to the Global Survey and documented progress towards the ICPD goals and Programme of Action (PoA). The thirteen countries were: Cook Islands, Federated States of Micronesia (FSM), Fiji, Kiribati, Marshall Islands, Niue, Palau, Papua New Guinea (PNG), Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

The Global Survey was designed to capture progress achieved and difficulties encountered by countries in implementing the various commitments and recommendations contained in the ICPD Programme of Action and in the Key Actions for its Further Implementation (ICPD+5). The Global Survey assessed major sections of the Programme of Action: population and development; gender equality, equity and empowerment of women; reproductive health and rights; behaviour change communication and advocacy; partnerships; resources; data, research and training; and indicators.

This report documents the implementation of the ICPD PoA over the past decade in Pacific Island Countries with special emphasis on achievements, constraints and difficulties encountered during implementation. The Global Survey included actions taken, measures undertaken to address concerns and obstacles encountered.

The forty-seven questions included were related to population and development, gender equality, equity and women's empowerment, reproductive rights and reproductive health, adolescent reproductive health, HIV/AIDS, behaviour change and advocacy, data and research, partnerships and resources and best practices.

UNFPA Country Office for the Pacific sent out the Global Survey to fourteen Pacific Island Countries (PICs) in January 2003. Completed questionnaires from thirteen PICs were received by UNFPA Country Office in April 2003. Countries were requested to complete the questionnaires by a national multi-sectoral, multi-stakeholder group consisting of government, NGOs and where possible, UNFPA Country Office staff. Staff from the Office of the Pacific coordinated the receipt of the questionnaires. Data were manually coded and entered by the Technical Support Division of UNFPA, New York. Coding of open-ended questions was undertaken and data was crosschecked for accuracy and reliability. Data was analysed by CST Suva using Statistical Package for Social Sciences (SPSS) Version 11.5. For the PIC analysis, SPSS was used as well as manual crosschecking from the original questionnaires to ensure consistency and internal validity. In the Pacific Island Sub-Region, a total of thirteen out of fourteen countries (92.9%) responded, a response rate comparable to the Global Survey in other regions.

This report of the responses in the Pacific to the Global Survey is subject to the same limitations as the Global Survey. Detailed information on measures adopted and difficulties encountered in implementing ICPD was not possible. Key issues, success stories, major constraints and lessons learned ten years after ICPD were of primary interest in this survey. While responses to population and development were fairly similar, greater diversity was observed in the reproductive health field. A major issue related to this survey lies in the quality of the responses. When a multi-sectoral multi-stakeholder group in PICs formulated the responses to the questions' answers' were more comprehensive and complete. In countries in which a single individual answered the questionnaires, the responses were sometimes incongruent with the questions. In some countries where this occurred, the responses were often inadequate, less informative and difficult to code. Many PICs' responses reflected the view of the governments and not necessarily NGO/CSO perspectives. The difficulties encountered as a result of the lack of specificity and detail in the questionnaires prevented an in-depth analysis of programmatic interventions related to the ICPD PoA. Furthermore, the open-ended nature of the questions imposed difficulties in coding, limitations in analysis, differences in quality of answers and incomplete reporting of action taken.

The publication has been divided into five chapters; an introductory chapter and four subsequent chapters highlighting achievements and challenges in implementing the ICPD Programme of Action in the following areas: Reproductive Health, Adolescent Reproductive Health, Gender Equality, Equity and the Empowerment of Women and Population and Development. Where information gaps were identified, these have been supplemented with reports from meetings, field missions and workshops available to the UNFPA Office for the Pacific. References to the documents consulted have been added at the end of each chapter.

It has been widely recognised and reaffirmed that the Millennium Development Goals adopted in 2000 are also closely related to the ICPD and ICPD+5 agreements. Poverty cannot and will not be eradicated without achieving ICPD goals. Universal access to education and reproductive health care are crucial steps that can help to eradicate poverty. Reproductive rights are central to women's empowerment and gender equality and equity. Meeting these ICPD goals will pave the way toward achievement of the Millennium Development Goals.

Many of the goals identified in the ICPD PoA and the ICPD+5 Key Actions are similar to the Millennium Development Goals (Table 1.1). ICPD and MDG targets are similar for providing universal access to primary education, providing gender equality and women's empowerment, reducing child mortality, improving maternal health and reducing HIV/AIDS. Although a specific goal on reproductive health is not included in the MDGs, targets and indicators related to components of reproductive health (maternal mortality ratio; proportion of births attended by skilled health personnel; HIV prevalence rate among pregnant women and condom use) are included. It is hoped therefore that this publication will serve as contribution to the five-year review of the MDGs, which will take place later this year in New York.

Table 1.1: ICPD Goals and Millennium Development Goals and Targets

ICPD Goals and Objectives	Millennium Development Goals and Targets
....raise the quality of life through population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in context of sustainable development [para. 3.16]	<i>Goal 1: Eradicate extreme poverty and hunger</i> Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger
....countries should further strive to ensure complete access to primary school or equivalent level of education by girls and boys as quickly as possible, and in any case before 2015 [para. 11.6]	<i>Goal 2: Achieve universal primary education</i> Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women’s ability to control their own fertility, are cornerstones of population and development-related programmes [Principle 4]	<i>Goal 3: Promote gender equality and empower women</i> Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015
By 2015, 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 [para. 8.16]	<i>Goal 4: Reduce child mortality</i> Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
Countries should strive to effect significant reductions in maternal mortality by 2015: reductions by one half of 1990 levels by 2000 and further one half by 2015 [para. 8.21]	<i>Goal 5: Improve maternal health</i> Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
....by 2005, ensure at least 90 per cent, and by 2010 at least 95 per cent, of 15-24 age group has access to IEC and services to develop life skills required to reduce their vulnerability to HIV infection; that by 2005 prevalence is reduced globally, and by 25 per cent in the most-affected countries [ICPD+5 para. 70]	<i>Goal 6: Combat HIV/AIDS, malaria and other diseases</i> Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
...population issues should be integrated into formulation, implementation, monitoring and evaluation of policies and programmes relating to sustainable development [para.3.5]	<i>Goal 7: Ensure environmental sustainability</i> Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers
....strengthen the partnership between governments, international organizations and the private sector in identifying new areas of cooperation [para. 15.15a]	<i>Goal 8: Develop a global partnership for development</i> Target 12: 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) Target 13: Address the special needs of the least-developed countries (Includes: tariff- and quota-free access for least-developed countries’ exports; enhanced programme of debt relief for heavily indebted poor countries and cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction) Target 14: 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 15: 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 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

CHAPTER 2: PROGRESS IN THE PACIFIC IN REPRODUCTIVE HEALTH

2.1 Introduction

Motivation towards the achievement of reproductive rights and reproductive health as a fundamental human right was integral to the proceedings, Programme of Action (PoA) and sequelae of the International Conference on Population and Development (ICPD).

Reproductive Health is a state of complete mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and process. In the ICPD Programme of Action, reproductive rights is defined as the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and have the information and means to do so; the right to be free of discrimination and violence; and the right to attain the highest standard of sexual and reproductive health.¹

The ICPD framework for attaining reproductive rights and reproductive health states that all countries should aim to: (a) ensure that comprehensive reproductive health services, including family planning, are accessible, affordable and acceptable to all; (b) enable and support responsible voluntary decisions about family planning and other legal fertility regulation methods and to have the information and means to do so; and (c) meet the changing reproductive health needs over a person's life span.¹

All countries were urged to make accessible, through the Primary Health Care System, quality reproductive health services to all individuals of appropriate ages. These services included: family-planning counselling, information, education, communications and services; education and services for prenatal care safe delivery and postnatal care; prevention and appropriate treatment of infertility; prevention and management of consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood; and the prevention and management of harmful practices that impact sexual health. Countries were encouraged to implement innovative reproductive health programmes for adolescents and adult men, primarily aimed at improving decision-making in sexual and reproductive health matters, specifically family planning and prevention of Sexually Transmitted Infections (STIs), including HIV/AIDS.

The global paradigm shift, that occurred at ICPD, in the way population policies and programmes were perceived and reproductive health services were conceptualised, signified a major change in the mechanisms through which population and development goals would be achieved.² Instead of a population-control development approach, a people-centred, rights-based approach was set forth as a means for meeting people's needs for sexual and reproductive health. Personal choice and the right to sexual and reproductive health, including voluntary decisions about childbearing, were perceived as fundamental to the process of achieving better quality of life throughout the relevant life span of men and women.³ This shift in global thinking had major policy and programming implications for Reproductive Health in the Pacific.

The ICPD PoA's framework, which recognised the importance of integrating family planning and sexually transmitted infections services into maternal care, within the current health care systems, also had implications for health sector reform in most Pacific Island Countries (PICs).

At the ICPD+5, a special session to review progress towards meeting the ICPD goals, the United Nations General Assembly agreed on a new set of benchmarks which included reproductive health care and unmet need for contraception as well as maternal mortality reduction.⁴ Within the ICPD/ICPD+5 framework, mechanisms were presented for governments and civil society to

implement so as to acknowledge reproductive health as a basic human right and to improve reproductive health services for all people of appropriate ages.

Since ICPD, many PICs have committed to improving the status of reproductive health of their people. Integration of reproductive health, including family planning and sexual health, within primary health care services has been implemented to varying degrees in PICs. Emphasis on providing services for outer island and rural communities has been articulated but actual implementation has varied depending on available resources, political commitment and logistical difficulties related to widely dispersed small island populations.

A major objective of the Global Survey was to determine progress made by some countries in the areas of reproductive rights and reproductive health. In this chapter, the responses to the ICPD+10 Global Survey for these countries are summarised for the following areas of reproductive rights and reproductive health:

- § Promoting reproductive rights;
- § Monitoring and reporting implementation of reproductive rights;
- § Recognising reproductive health needs as priorities in health sector reform;
- § Integrating reproductive health into the primary health care system;
- § Increasing access to quality reproductive health services;
- § Reducing maternal morbidity and mortality;
- § Achieving Reproductive Health Commodities Security;
- § Expanding contraceptive choice;
- § Preventing and managing complications of unsafe abortion;
- § Reducing and managing STIs, including HIV;
- § Involving the beneficiaries of reproductive health services;
- § Major constraints to implementing the reproductive health approach;
- § Cultural context contributing and constraining promotion of reproductive rights and reproductive health.

2.2 Promoting Reproductive Rights

ICPD PoA states that “reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. 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.”^{1,2}

In the Global Survey, Pacific Island Countries were asked if they had taken any policy measures, legislative/institutional changes or other national level measures to enforce reproductive rights (such as free informed choice and informed consent, abolition of quotas, incentives, etc). Ten of the thirteen countries responded affirmatively whilst three countries reported not taking any measures to enforce reproductive rights. Measures undertaken to enforce reproductive rights by these ten countries are summarised in Table 2.1.

Table 2.1: Pacific Island Countries' Responses of Policy, Legislative or Institutional Measures Taken to Promote Reproductive Rights

Description of Measures	Countries
Formulated a new policy on reproductive rights and reproductive health	Marshall Islands, PNG, Samoa, Solomon Islands, Vanuatu
Implemented Institutional Changes/training in reproductive rights	FSM
IEC/Advocacy on reproductive rights and reproductive health	Kiribati, PNG, Solomon Islands, Vanuatu
Formulated national plans/programmes/strategies for reproductive rights and reproductive health	Cook Islands
Other measures	Cook Islands, Fiji, FSM, PNG, Tuvalu

Several countries, including Marshall Islands, PNG, Samoa, Solomon Islands and Vanuatu reported the formulation of new policies on reproductive rights and reproductive health. In the Marshall Islands, the National Population Policy states each citizen has reproductive rights; the Bureau of Primary Health Care includes reproductive rights; and the Women's Policy supports women's right to reproductive health care. Samoa responded that ICPD principles including reproductive rights were included in Samoa's Population Policy. In the Solomon Islands, similar Women and Youth Policies developed two years ago incorporated reproductive rights. In PNG and Vanuatu, policy changes have included the provision of free family planning, antenatal and delivery services in an attempt to improving access and utilisation. The basic principle that reproductive rights are essential human rights of all citizens was at the basis of decisions related to the provision of free services for all. Most PICs have adopted policies, based on the principle of free and informed choice for all couples and individuals, and provide services without financial charges.

Federated States of Micronesia (FSM) reported implementing institutional changes in their educational system, which permitted pregnant students to continue their education. Furthermore, FSM reported removing the requirement that parental consent was necessary for students receiving reproductive health services.

Kiribati, PNG, Solomon Islands and Vanuatu reported that advocacy campaigns and training programmes included promoting the reproductive rights of individuals. Although not reported in the Global Survey, it is well recognised that reproductive rights for youth have been included in advocacy and training programmes for adolescent reproductive health in Fiji.

The Cook Islands reported that national strategies for promoting reproductive health services and information/education and communication regarding reproductive rights were promoted by the government.

Five of the Pacific Island Countries reported making "limited" policies or legislative changes while five countries reported making "some" policies or legislative changes to promoting reproductive rights. Of the countries that responded negatively, reasons cited were that "reproductive rights have always been considered as services that are free"; "reproductive health is not a national priority"; and "reproductive rights are culturally sensitive".

The concept of reproductive rights may not be fully understood in some PICs where government reports include reproductive health but few mention reproductive rights or report on them. However, in many PICs, since ICPD, there have been developments in policies and programmes that should contribute to an enabling environment in which the reproductive rights of women can be fully recognised and exercised. Many countries in the Pacific have incorporated some form of legislative

or institutional change, which enhances the reproductive rights of women and men; whether it is explicit policy or the introduction of new family planning methods, which facilitate better options for couples. However, despite this progress, where education and social status of women remain low, enhancing reproductive rights of women cannot be fully achieved. Ensuring gender mainstreaming in policies and programmes in Pacific Island Countries is considered vital for achieving reproductive rights of women.

2.3 Monitoring and Reporting Implementation of Reproductive Rights

The ICPD PoA states that “governments at all levels are urged to institute systems of monitoring and evaluation of user-centred services and to ensure a continuing improvement in the quality of services. To this end, governments should secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision.”¹

In the Global Survey, countries were asked whether reproductive rights were included in the monitoring of the implementation of human rights. Only five of the thirteen Pacific Island Countries responded that reproductive rights were included in the monitoring of human rights. Pacific Island Countries’ responses to monitoring the implementation of reproductive rights are summarised in Table 2.2.

Table 2.2: Pacific Island Countries’ Responses of the Inclusion of Reproductive Rights in the Monitoring of the Implementation of Human Rights

Description of Measures	Countries
Monitoring through international conventions and reporting mechanisms	Cook Islands, Marshall Islands, Samoa
Monitoring through cooperation with NGO reporting mechanisms	Solomon Islands
Monitoring through various national and regional monitoring institutions	Cook Islands, Samoa

Cook Islands stated that monitoring the implementation of reproductive rights was part of human rights reports regularly submitted. Marshall Islands stated that monitoring was undertaken through reports to the Convention on the Rights of the Child (CRC). Samoa stated that monitoring was undertaken through international conventions such as the CRC, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), ICPD and the Beijing Platform of Action. Samoa reported taking leadership in driving and coordinating CEDAW activities in the South Pacific region. A regional CEDAW meeting was held in Samoa in April 2003. Samoa also reported monitoring through national and regional monitoring institutions. Solomon Islands reported getting assistance from UNDP (United Nations Development Programme) and non-governmental organisations to monitor reproductive rights. Of the countries that reported not monitoring the implementation of human rights, some countries stated a lack of capacity while others stated it was not currently considered a priority. The concept of monitoring reproductive rights was not fully understood by some of the questionnaire respondents.

Countries were also asked specifically whether Reproductive Rights and Reproductive Health were included in these countries reporting to human rights treaty bodies, including CEDAW.

A summary of relevant responses to this question is summarised in Table 2.3.

Of the thirteen countries, nine countries responded that their countries’ reporting to human rights treaty bodies, including CEDAW, included reproductive rights.

Table 2.3: Pacific Island Countries’ Responses of the Inclusion of Reproductive Rights in the Country’s Reporting to Human Rights Treaty Bodies

Description of Measures	Countries
Country regularly submits country reports to CEDAW	Cook Islands, Fiji, Kiribati, PNG, Samoa
Country is a signatory of CEDAW	Cook Islands, Fiji, Kiribati, PNG, Samoa, Tonga
Country submits reports to other Human Rights Treaty Bodies	Marshall Islands, Samoa, Tuvalu

Cook Islands, Fiji, Kiribati, PNG and Samoa reported that reproductive rights and reproductive health reporting is included in the human rights treaty bodies and that they regularly submit country reports to CEDAW. The majority of these reports were handled through Ministries/Departments of Women.

In addition to these countries, Tonga reported it was amongst the signatories to CEDAW. Tuvalu, Solomon Islands and Vanuatu have also ratified CEDAW. Countries that have ratified CEDAW but did not respond that they regularly submitted reports to CEDAW stated that these plans were in progress.

Marshall Islands, Samoa and Tuvalu governments reported other channels of reporting to human rights bodies such as CRC. While several countries responded affirmatively to countries reporting to human treaty bodies, none of them discussed relevant mechanisms of reporting.

Clearly, greater advocacy for inclusion of a reproductive rights framework is necessary to fully implement the ICPD PoA. There remains the need to link reproductive rights to population policies in many PICs in which policies have not been updated. Furthermore, while there has been progress in women’s empowerment programmes, much work needs to be accomplished to achieve gender equity and the realisation of reproductive rights in the Pacific.

2.4 Recognising Reproductive Health Needs of Women and Children as a Priority in Health Sector Reform

Among the key actions for further implementation of the ICPD PoA, adapted at the General Assembly in 1999, it was stated that “governments, in collaboration with civil society, including non-governmental organisations, donors and the United Nations system should give high priority to reproductive and sexual health in the broader context of health-sector reform, including strengthening basic health systems, from which people living in poverty in particular can benefit. Reproductive health-care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organisation and evaluation of services. Governments and other organisations should take positive steps to include women at all levels of the health-care system.”^{2, 3}

In the Global Survey, countries were asked whether reproductive health needs of women, men, adolescent and youth were explicitly recognised as priorities in the Health Sector Reform Package. Eight countries responded affirmatively. These countries were Cook Islands, Kiribati, Marshall Islands, FSM, PNG, Samoa, Solomon Islands and Vanuatu. The description of inclusion of reproductive health needs of women, men, adolescent and youth in the Health Sector Reform are included in Table 2.4.

Table 2.4: Pacific Island Countries' Responses to whether Reproductive Health Needs were Part of a Health Sector Reform Package

Description of Nature of Inclusion	Countries
Reform recognises health needs of adolescent/ youth	Cook Islands, FSM, Kiribati, Marshall Islands, PNG, Samoa
Reform recognises health needs of women (obstetric care)	Marshall Islands, PNG
Reform recognises health needs of women, men, adolescents/youths	Cook Islands, FSM, Kiribati, Marshall Islands, PNG

Some countries reported that while it seemed that minimal attention was paid to women's obstetric care, reproductive health needs were reflected in various ways in the Health Sector Reform Packages, the revitalised National Development Plans and the Health Sector Strategic Plans.

The reasons cited by the countries, that stated reproductive health needs are not explicitly mentioned as priorities in the health sector reform package, were that reproductive health was not recognised as a national priority or there was no health sector reform package.

Throughout the Pacific (with the exception of two countries), Health Sector Reform is in various stages of planning and implementation. Integral to these packages is the recognition that reproductive health is a priority issue. However, the real challenge lies in implementing these health sector reforms within an environment of limited resources and, in some countries, political instability. Ensuring quality of reproductive health services are delivered to all rural and outer island communities will be difficult if infrastructure and supplies are inadequate. Hence, the translation of political commitment into sustained change remains elusive in some PICs.

2.5 Integrating Reproductive Health Components into the Primary Health Care System

The ICPD PoA states that “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. Reproductive health care in the context of primary health care should, inter alia, include: family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breastfeeding and infant and women's health care; prevention of appropriate treatment of infertility; abortion as specified in PoA paragraph 8.25, 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 counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood.”¹

Countries were asked about the integration of reproductive health components into the Primary Health Care System before and subsequent to ICPD in 1994. Of the thirteen Pacific Island Countries, seven countries reported that reproductive health services had been integrated into the Primary Health Care system before ICPD. All thirteen countries responded affirmatively that measures had been taken to further integrate reproductive services components into the Primary Health Care System (subsequent to ICPD). A summary of these measures is provided in Table 2.5.

Table 2.5: Pacific Island Countries’ Responses of Specific Measures taken by Countries to Integrate Reproductive Health Service Components into the Primary Health Care System

Description of measures	Countries
Reproductive Health services expanded to include family planning	Fiji, FSM, Marshall Islands, PNG, Solomon Islands, Tonga, Vanuatu
Integration through institutional changes in reproductive health	PNG, Samoa
National plans/programmes/strategies in reproductive health	Palau, PNG
National policies integrate reproductive health	PNG
Information on STI and/or HIV/AIDS prevention integrated	Niue, Vanuatu
Information on treatment of infertility integrated	Vanuatu
Information on teenagers and youth integrated	Solomon Islands, Vanuatu
Integration through training of reproductive health providers	Solomon Islands, PNG, Vanuatu

While ten of the thirteen countries discussed “limited” measures, two countries discussed “some” measures and only one country, Vanuatu, discussed “many” measures to integrate reproductive health service components into the Primary Health Care system.

Most of the countries responded that Primary Health Care (PHC), before ICPD, had included maternal and child health as well as family planning. Subsequent to ICPD, reproductive health was integrated into PHC of which family planning was a key component. Tonga and Federated States of Micronesia reported promoting family planning through integrated service delivery and Information, Education and Communication (IEC) awareness.

PNG reported how reproductive health and safe motherhood had been promoted since ICPD to replace traditional maternal and child health (MCH) through institutional changes. In-service training of health workers and curriculum reform for pre-service health workers also included focus on emergency obstetrics care. PNG also discussed the integration of reproductive health into PHC through the renewed focus on upgrading health centre facilities to offer emergency obstetric care services.

Palau discussed the integration of reproductive health into PHC within the context of their national structure and programmes in Public Health.

Vanuatu’s integration of Reproductive Health into PHC has also involved meetings, workshops and training. Their reproductive health framework, conceptualised as a wheel, includes the key areas of family planning, counselling, adolescent reproductive health, reproductive tract infections/sexually transmitted infections, infertility, men’s partnership in reproductive health, a life cycle approach to maternal and child health, reproductive tract cancers, domestic violence and management of the consequences of abortion.

In the response from Solomon Islands, the integration of a rights-based approach and the promotion of men’s participation in Reproductive Health were cited as key areas of reproductive health that occurred subsequent to ICPD.

The challenges to integration of reproductive health components into PHC are formidable throughout the Pacific. In countries such as the Federated States of Micronesia (FSM), Marshall Islands and Palau, although the concept of reproductive health is well understood, reality dictates maintaining separate national Family Planning, Maternal and Child Health and STI/HIV/AIDS programmes due to the requirements dictated by federal funding sources. While at the dispensary or clinic level these

services are often provided in an integrated comprehensive fashion by a single health care provider, administration of these programmes remain vertical within the national and state departments of health.

Similar situations exist in other PICs where vertical programmes persist at tertiary centres and national and provincial/sub divisional levels while PHC services at service delivery points are integrated. It was reported that some managers of vertical programmes are reluctant to take on additional responsibilities related to integrated Reproductive Health Services as often they fear such responsibilities may further burden their workload and encroach on their colleagues' domains. On the other hand, at youth clinics in some countries, Solomon Islands comprehensive services are provided within the context of a recreation facility where IEC, treatment of STIs and provision of family planning services are provided to the youth.

In most PICs, mechanisms currently exist for facilitating referrals at various levels of the health care system. Integrating infertility care, reproductive cancer services, and management of complications of abortions at various levels of the health care system are limited by the number and capacity of health care providers, supplies and facilities and economies of scale in small island settings. In most PICs further training of health care providers in dealing with violence against women is needed to facilitate integration of these services at the peripheral levels.

Pacific Island Countries have developed a particular hybrid of integration, appropriate to the various scales of small island populations. This model allows countries to respond to the needs for RH services in various settings, incorporating mechanisms for coordination and referrals to higher levels.

2.6 Increasing Access to Quality Reproductive Health Services

One of the goals of ICPD is “universal access to reproductive health services through the primary health care system, with referrals to higher levels as appropriate, by the year 2015.”¹ Reproductive health services was considered integral to basic health services.

The Global Survey asked countries whether the governments had taken specific measures to increase access to quality reproductive health services. All thirteen Pacific Island Countries stated that governments had taken measures to increase access to quality reproductive health services. Some of the measures discussed are presented in Table 2.6.

Table 2.6: Pacific Island Countries' Responses of Specific Measures taken for Increasing Access to Quality Reproductive Health Services

Description of Measures	Countries
Free reproductive health services in all public health facilities	Cook Islands, Niue, PNG
Increase in number of Service Delivery Points	Cook Islands, FSM, Fiji, Marshall Islands, Samoa, Solomon Islands, Tonga
Allocation of more resources including equipment for reproductive health	PNG, Solomon Islands, Vanuatu
Decentralised health care and service delivery system	Fiji, Palau
Improvement of management and logistics in reproductive health	Cook Islands, Vanuatu
Provision of youth friendly services	FSM, Kiribati, Solomon Islands
Mobile reproductive health services	Fiji
Partnerships with NGOs, international organisations and private sector	PNG, Samoa, Tonga
Increased staff and training	Cook Islands, Kiribati, Marshall Islands, Palau, PNG, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu

While only three countries, namely Cook Islands, Niue and PNG, mentioned free reproductive health services in all public health facilities, most PICs provide free or very minimally charged basic health care services including reproductive health.

As expected, most PICs had increased the number of service delivery points to accommodate the needs of their populations. There was increased allocation of resources to equipment for Reproductive Health Care equipment; particularly in Fiji. Unlike the rest of the PICs, Fiji in an effort to move towards self-sufficiency now provides its own Reproductive Health (RH) commodities. UNFPA provides RH commodities for thirteen other PICs.

While most PICs have some form of decentralised health care, only Fiji and Palau stated this in their response. It is interesting to note that many PICs had decentralised health care systems even prior to ICPD in 1994.

Youth-friendly services are being provided in many PICs, including Federated States of Micronesia, Kiribati and Solomon Islands.

In an attempt to increase access in rural areas where there are no reproductive health care providers, Fiji stated it has a mobile RH clinic. This clinic provides integrated FP/STI/RH services.

Many countries have developed partnerships with NGOs, international organisations and the private sector for provision of FP services, prevention and management of STIs and other RH services.

Valid information, particularly the percent of the populations that have access to comprehensive and integrated RH information and services, is not available in many PICs. Data related to percentage of Service-Delivery Points (SDPs) providing three or more RH services are not available in many countries. Not only are the RH Management Information Services (RHMIS) in many countries inadequate, the indicators used, to determine the access and quality of RH services, are sometimes inappropriate. Hence, determining progress made since ICPD in improving access to RH services is difficult. Determining the quality of RH care provided can be a formidable task in situations where the health information system is rudimentary.

Access to RH services is uneven; basic RH services are not always available to populations residing in outer islands, atolls or rural areas despite the presence of SDPs. While upgrading of facilities and capacity building of health staff have occurred in all PICs to varying degrees, health care providers in many settings are often not well equipped to deal with basic emergency obstetric care or other RH services.

Quality of RH care varies substantially between and within PICs. Difficulties faced in providing high quality of care stem from the varying levels of technical competence of health care providers, a lack of adequate supplies/facilities, a lack of follow up or continuity of care and a lack of ongoing supervision. Factors that hinder access to quality RH care include geographical dispersion of small populations on outer islands as well as cultural/social inhibitions/barriers to RH services for disadvantaged groups such as adolescents and unmarried women. Despite these factors, progress in improving access to quality RH care continues to be made in most PICs.

2.7 Reducing Maternal Morbidity and Mortality

The ICPD PoA states that “countries should aim to promote women’s health and safe motherhood; to achieve a rapid and substantial reduction in maternal morbidity and mortality and reduce the differences observed between developing and developed countries and within countries. 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. All countries must expand the provision of maternal health services in the context

of primary health care. These services, based on the concept of informed choice, should include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programmes, adequate delivery assistance that avoids excessive recourse to caesarean sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning. All births should be assisted by trained persons, preferably nurses and mid-wives, but at least trained birth attendants.”¹

All thirteen Pacific Island Countries that responded to the Global Survey stated that measures had been taken to reduce maternal morbidity and mortality. Some specific measures reported by PICs in the Global Survey are cited in Table 2.7. While responses for various countries were not comprehensive, it is well known that many of these measures have been undertaken by most of the countries.

Table 2.7: Pacific Island Countries’ Responses to Specific Measures Taken for Reducing Maternal Morbidity and Mortality

Description of Measure	Country
Creation of networks of FP/STI clinics	Samoa, Solomon Islands
Improved prenatal and postnatal services	FSM, Marshall Islands, Palau, PNG, Tonga
Training of health care providers	Cook Islands, Fiji, Kiribati, Palau, PNG, Samoa, Solomon Islands, Tuvalu, Vanuatu
IEC/Advocacy to reduce maternal morbidity	Cook Islands, FSM, Fiji, Marshall Islands, Niue, Palau, Samoa, Solomon Islands, Vanuatu
Improved transportation for emergency obstetric care	PNG, Samoa
Promote partnerships with UN agencies/NGOs on reducing maternal health services	PNG, Samoa, Solomon Islands
Improving data collection and record keeping for monitoring	Kiribati, Samoa, Solomon Islands

Several initiatives have been undertaken in many countries in the Pacific. Most of the countries have improved prenatal and postnatal care, conducted training of health care providers and conducted IEC/Advocacy campaigns to reduce maternal mortality and morbidity rate. While Samoa and Solomon Islands cited creation of networks of FP/STI clinics, numerous other countries have also expanded these facilities over the past decade. PNG, Samoa and Solomon Islands reported making exerted efforts to improve transportation for emergency obstetric care as well as promoting partnerships with UN agencies/NGOs. Improving the information system as a basis for monitoring maternal morbidity was mentioned by Kiribati and Samoa. Solomon Islands has instituted a computerised Reproductive Health Surveillance System.

PICs did not specifically mention access to post-abortion services. In some of the larger PICs where morbidity from complications of unsafe abortion is not infrequent, the lack of access to post abortion services by vulnerable groups is an area of concern.

In the small island countries, Maternal Mortality Ratios (MMRs) do not provide a valid estimate of maternal health. Despite the efforts to improve RH services made by many PICs, the MMRs fluctuate widely. Given the small size of the populations for most PICs (e.g. Tokelau with 1,500 population or Niue with 1,600) and the relatively few births per annum, maternal deaths occur very infrequently and for several years not at all. When a maternal death does occur in a year, the MMR for that year explodes e.g. in 2002, Tuvalu had an 614 maternal deaths per 100,000 live births and Tokelau had an MMR of 170 maternal deaths per 100,000 live births. On the other hand, in previous years, when there were no deaths, the MMR was 0. In some of the more populous PICs, MMRs have remained over 100 (PNG, Solomon Islands, FSM).

Nine PICs report that the proportion of deliveries attended by trained/skilled health personnel exceeds 95%. These countries are Fiji, Nauru, Palau, Cook Islands, Niue, Samoa, Tokelau, Tonga and Tuvalu. The other countries report that greater than 85% of deliveries are attended by trained/skilled health attendants. For all countries, with the exception of PNG, these figures represent significant improvements since 1990-1994.

There is no room for complacency when reviewing maternal health services in the Pacific. Many countries are continuing to forge ahead with improvements in availability of basic and comprehensive emergency obstetric care to its population through training of health care personnel, use of nationally accepted, evidence-based protocols and upgrading of health facilities. Improved education/advocacy strategies in the community and strengthened mechanisms for transportation are also being instituted. However, implementing these strategies continue to be formidable challenges in resource-restrained settings where small populations are widely dispersed. The lack of appropriate data and indicators for monitoring maternal health and emergency obstetric care in the Pacific complicates the situation. Unless appropriate monitoring mechanisms are instituted, determining the progress of maternal health in the Pacific will continue to be difficult.

2.8 Achieving Reproductive Health Commodities Security

ICPD PoA states that “all countries should 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 to related reproductive health services which are not against the law.”¹

In the Global Survey, countries were asked if governments had taken measures to achieve reproductive health commodities security. Of the thirteen Pacific Island Countries, nine countries stated that their governments had taken measures to achieve reproductive health commodities security (RHCS). Responses cited for achieving RHCS are included in Table 2.8.

Table 2.8: Pacific Island Countries’ Responses to Specific Measures Taken for Achieving Reproductive Health Commodities Security by Pacific Island Countries

Description of Measures	Countries
Logistics management systems, procurement plans	FSM, Samoa, Vanuatu
Assistance from international agencies in securing/supplying commodities	Cook Islands, FSM, Kiribati, Marshalls, Niue, Palau, PNG, Samoa, Solomons, Tokelau, Tonga, Tuvalu, Vanuatu
Training of management/administration staff in logistics management	Vanuatu
Government partnerships with NGOs/private and religious sectors for reproductive health provision	Cook Islands, Tuvalu

Of the countries that stated no measures were taken by government to achieve reproductive health commodities security, reasons cited were “government is not currently aware that it is an issue” and “plans are currently underway to undertake measures”.

Measures discussed included logistics management systems and procurement plans, and training of management/administration staff in logistics management.

In the Pacific, RH commodities including contraceptives are supplied by UNFPA to the following PICs: Cook Islands, FSM, Kiribati, Marshall Islands, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. PNG receives some contraceptives from AusAID.

Fiji no longer receives contraceptives from UNFPA as Fiji purchases its own contraceptives. However, other RH commodities are supplied to Fiji. A regional depot, which services Pacific Island Countries, has been established in Fiji. Logistics are managed by UNFPA. Many countries also receive RH Commodities from Family Planning Associations and the International Planned Parenthood Federation (IPPF). Hence, in the majority of the PICs, assistance is received from international agencies in securing and supplying RH commodities.

In 2003, a meeting occurred of the Ministers of Health for Cook Islands, Fiji, Niue, Solomon Islands and Vanuatu to endorse a Pacific Plan of Action for RHCS in the Pacific. The Pacific PoA included agreement that each government would demonstrate political leadership to improve RH through ensuring it has in place and implements an up-to-date multi-sectoral policy in RH, integrated into national health policies, strategies and action plans to the fullest extent possible. It was pledged that efforts would be made in the establishment of a regional warehouse facility and in achieving the best value for money for the provision of the full range of RH commodities required in the PICs. Furthermore, commitment was made to ensuring adequate storage facilities and to instituting an efficient, regular and timely distribution and supply system. Training in improving RHCS and Logistics Management Information System (LMIS) was considered essential. In 2004, at the annual meeting of the Commonwealth Ministers of Health on the eve of the World Health Assembly, the support for the Pacific Plan of Action for RHCS was widened to include endorsement from the other PICs. Political commitment at the highest level has assisted in ensuring RHCS issues are being addressed in all PICs.

The logistical difficulties imposed by small island populations residing in widely dispersed atolls/islands, as well as expensive and often infrequent transportation have sometimes resulted in inadequate supplies being available in some centres and overstocking of nearly expired commodities in other centres. In some countries, storage of certain climate-vulnerable commodities at the peripheral clinics remains problematic where temperatures soar, humidity is high and electrical power does not exist.

There is a general need for improvement in quality assurance systems, in particular to monitor quality and viability during storage, transportation and distribution at user outlets. There is deficiency in trained health personnel in RHCS management such as logistics and forecasting throughout the Pacific. In November 2004, the first regional RHCS workshop is planned to improve the capacity of management in procurement, forecasting, monitoring and LMIS. Condom packaging is currently being improved and initiatives are being taken to make condoms accessible to socially disadvantaged groups.

While there has been substantial progress in the Pacific in RHCS, greater cooperation between partners supplying commodities could facilitate more efficient delivery of RH commodities. Clearly, training in procurement, storage, distribution, projections and LMIS by relevant staff as well as the institution of improved logistics management systems are needed to improve the situation in each PIC if the goals of achieving universal access to a wide range of family planning methods and commodities for prevention of STI/HIV are to be achieved.

2.9 Expanding Contraceptive Choice

ICPD PoA states “To meet the needs of the growing number of couples of reproductive age and to close the existing gap in services, family planning and contraceptive supplies will need to expand very rapidly over the next several years.”¹

In the Global Survey, countries were asked if governments had taken measures to expand contraceptive choice including emergency contraception and female condoms. All thirteen countries responded in the Global Survey questionnaire that some measures had been taken to expand contraceptive choice, including emergency contraception and female condoms. Various measures cited by the countries are included in Table 2.9.

Table 2.9: Pacific Island Countries’ Responses of Measures Taken for Expanding Contraceptive Choice including Emergency Contraception and Female Condoms

Description of Measure	Countries
Training of providers in contraceptive management	Marshall Islands, PNG, Solomon Islands
Availability of female condoms	PNG
Availability of emergency contraception	Cook Islands, Fiji, Marshall Islands, Palau, Tonga

Three Pacific Island Countries, namely Marshall Islands, PNG and Solomon Islands, cited training of providers in contraceptive management.

Female condoms are available in Papua New Guinea. PNG stated that female condoms are promoted more for protection against HIV/AIDS and STIs than for prevention of pregnancy. No other PICs reported using female condoms.

While five countries cited promoting availability of emergency contraception for patients, it is well known that the other Pacific Island Countries are also providing emergency contraception. However, as previously mentioned, emergency contraception is not popular and those most in need of emergency contraception e.g. adolescents and unmarried women, do not generally have access to it.

None of the countries discussed an increase in number of service delivery points, social marketing campaigns, improvement in logistics of contraceptive availability or subsidised free contraceptives. However, in the Pacific, contraceptives are provided by UNFPA to all countries covered through its programme, except Fiji. In most of these countries, contraceptives are provided free of charge to the clients at the clinics.

To further expand the contraceptive choice of the female condom, more education is required as the communities in most PICs are unaware of this method of contraception and HIV/STI prevention and thus there is no demand for it. The expansion of access to emergency contraception not only requires education of the community and health care providers but also involves removal of barriers to services for special groups such as adolescent and unmarried women in most PICs. Furthermore, because existing forms of combined oral contraceptives, progesterone only pills and copper T 380A can be used for the same purpose, some health care providers are less inclined to order specially packed emergency oral contraceptives. In some countries, emergency contraception has not been considered an acceptable form of contraception and have not been procured to date by the Ministry of Health.

2.10 Preventing and Managing Complications of Unsafe Abortion

ICPD PoA states that “governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion.”¹

In the Global Survey, countries were asked if governments had taken any measures to prevent and manage complications of unsafe abortion. Of the thirteen Pacific Island Countries, eight countries responded that measures had been taken by governments to prevent and manage complications of unsafe abortion.

Table 2.10: Pacific Island Countries’ Responses of Measures Taken to Prevent and Manage Complications of Unsafe Abortion

Description of Measures	Countries
Training of health care providers to provide post-abortion services	Solomon Islands
Provision of post-abortion services	Fiji, Palau, PNG, Samoa, Solomon Islands
Family planning services and contraceptive services available	Fiji, Samoa, Solomon Islands
Others e.g. awareness campaigns	PNG, Tuvalu, Vanuatu

In their responses, Fiji, Palau, PNG, Samoa and Solomon Islands cited their governments’ efforts to provide management of complications arising from unsafe abortion by improving the skills of health care providers. There is need for these services to be extended to other PICs.

Of the countries that did not cite any measures taken, reasons given were that “unsafe abortion is not a problem”, “there were restrictive abortion laws” and “abortion was illegal”.

In most PICs, the government policy governing abortion is that unless there is a high-risk medical condition in the pregnant women where her life is endangered or when rape has occurred, abortion is not permitted.

Data to support the prevalence of unsafe abortion is not available. In most countries, cases of complications of abortions are admitted to the main hospitals; and in some countries deaths due to illegal abortions have occurred with concomitant legal cases against the practitioners pending in court.

It would appear where unmet need for contraception is high and availability of quality family planning services is inaccessible to certain sectors of the population in more populous countries, unsafe abortion may be relatively high. The expansion/provision of adequate family planning services to groups at high risk of unwanted pregnancies is vital to reducing unsafe abortions. Furthermore, morbidity and mortality resulting from unsafe abortions can be potentially reduced if adequate post-abortion care is provided.

2.11 Reducing and Managing Sexually Transmitted Infections, including HIV/AIDS

The ICPD PoA states that countries should aim “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. Reproductive health programmes should increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health-care level. Information, education and counselling for responsible sexual behaviours and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.”¹

In the Global Survey, countries were asked if governments had taken any measures to reduce and manage Sexually-Transmitted Infections (STIs), including HIV/AIDS. All thirteen Pacific Island Countries stated that measures had been undertaken by government to reduce and manage STIs, including HIV/AIDS. Classification by action reported by PICs is tabulated in Table 2.11.

Table 2.11: Pacific Island Countries' Responses of Measures Taken to Reduce and Manage STIs including HIV/AIDS

Description of Measures	Countries
National plans/programmes/strategies	Cook Islands, Fiji, PNG
National policies on prevention/control of STIs	Marshall Islands
National commission/agency/ministry/desk established by government	PNG, Samoa
STI prevention, treatment and management service provision	Marshall Islands, Palau, PNG, Samoa, Tonga, Vanuatu
Partnerships with NGOs, UN (United Nations) and other international organisations	PNG
Intra-governmental agency partnerships for service provision	Samoa
IEC/advocacy campaigns on prevention and treatment	Cook Islands, Niue, PNG, Samoa, Solomon Islands, Vanuatu
Educational initiatives that target vulnerable populations	Kiribati, Samoa, Tuvalu

Respondents from five countries discussed national plans, programmes, strategies and policies for preventing and managing Sexually Transmitted Infections, with emphasis on HIV/AIDS. Several countries cited improvements in STI prevention and management. PNG and Samoa discussed inter-agency collaboration and partnerships. IEC/Advocacy campaigns and educational initiatives have been undertaken in several countries.

Subsequent to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in 2001, PICs were called upon to strengthen their response to HIV/AIDS. Although the overall prevalence of HIV in the majority of Pacific Island Countries appears low, there is substantial concern as the rates of infections are rapidly increasing in countries where the incidence of STIs is very high, teenage pregnancies are numerous and condom usage is low. While over 86% of HIV infections occur in Papua New Guinea, the number of unreported cases in the Pacific is unknown, as surveillance levels remain low in all countries.

A regional strategic plan 1997-2000 was developed to provide a framework for all stakeholders to address STIs/HIV/AIDS. Numerous initiatives in the Pacific have focused on preventive activities in youth. Examples include the UNFPA sponsored SPC Regional Adolescent Reproductive Health (ARH) Project, peer education programmes, church youth organisations, local NGOs (e.g. Wan SmolBag Theatre Group in Vanuatu), Pacific Life Stars Programme and Regional Youth Congress on AIDS. Theatre Group training by Wan SmolBag also was conducted in Kiribati, Solomon Islands, Tonga and Tuvalu.

In Table 2.12, the current status of national STI/HIV/AIDS laws, policies and strategic plans is summarised for selected PICs. While all countries have National AIDS Committees, it is evident that wide variation exists in the quality of STI/HIV/AIDS Strategic Plans and in the capacity of countries to respond effectively.⁶

A situation analysis suggests that countries lack the financial and human resources to continue the momentum to implement an effective and sustainable response.⁷ While numerous activities have occurred by NGOs and the ministries/departments of health, there is a need to coordinate these activities as well to improve STI surveillance and evaluate the impact of these activities in each country. The geographical dispersion of islands and lack of infrastructure on the larger islands have added to the difficulty associated with undertaking surveillance.⁶ Most PICs send specimens off-island for confirmation. There remains the need for further capacity building in counselling, education, clinical case management, infection control and STI/HIV/AIDS management programmes

in PICs.⁷ While a multi-sectoral approach to the development of the current 2004-2008 regional strategy signifies collaboration and partnership, coordination of activities at the country level could be further strengthened. The persistence of stigma and discrimination as well as cultural barriers to prevention for at-risk groups pose formidable challenges to addressing STIs and HIV/AIDS in PICs.

Table 2.12: National STI/HIV/AIDS Policies and Strategies in Pacific Island Countries

Countries	National Laws	National Policies	National Strategies/ Strategic Plans
Fiji	NACA Bill under review	Interim 2002 document	NSP 2004-6
Solomon Islands		National HIV Policy 2005-10	National HIV Strategic Plan 2005-10
Vanuatu		Endorsed in 2004	Endorsed in 2004
PNG	National HIV anti-discrimination Law passed (2003). National HIV/AIDS Management and Prevention Act (2003). Other National Laws pending.	Revised in 2004	NSP 2004-8
FSM	National Law pending	Planning phase	Pohnpei Strategic Plan
Kiribati	HIV AIDS Prevention & Management Bill	Updated in 2004	NSP 2004-8
Palau	HIV Law 2003 revised	Updating 1994 policy	2000 SP being updated
Guam	National Law	National Plan/Policy 2003	NSP 2004-8
Cook Islands	Public Health Act, July 2004	National Policy 1993, 2003	NSP 2004-8
Tonga			NSP in planning phase

2.12 Involving Beneficiaries of Reproductive Health Services

All thirteen countries stated that governments have taken measures to involve beneficiaries of reproductive health services.

Fiji, Marshall Islands, Palau and Solomon Islands reported consultation with and inclusion of community representatives and NGOs in reproductive health planning and programming. Papua New Guinea (PNG) reported the involvement of community-based organisations in policy and programme developments of RH projects and the creation of community/local action groups. Tuvalu reported public hearings to address reproductive health issues of concern. IEC/advocacy campaigns involving local beneficiaries were reported by PNG and Solomon Islands.

While all thirteen countries responded that measures had been undertaken to involve beneficiaries, specific measures undertaken were less clear in the responses.

None of the countries cited surveys to solicit consumer views, training of community health workers, training of peer educators or peer counselling, although it is well known that the training activities have been undertaken for peer educators and community-based distributors and are ongoing in some Pacific Island Countries.

In the Adolescent Reproductive Health programmes in most PICs, youth involvement in the planning and implementation of both IEC and service provision programmes has been a key feature. Peer

education programmes have been initiated in Fiji, Kiribati, Tonga, Solomon Islands and Vanuatu. These activities have included consultations with youth organisations and focus group discussions to determine the needs of adolescents in reproductive health. Research is needed to determine the impact and effectiveness of peer education programmes in these countries.

2.13 Major Constraints to Implementing the Reproductive Health

In general, there are major constraints in implementing the reproductive health approach and measures in the Pacific.

Constraints to implementing the Reproductive Health Approach in the Pacific discussed in the Global Survey, by the countries' respondents, included lack of financial resources and low budget allocations, lack of or poor communication, difficulty in reaching poor and/or rural people, lack or low supply of equipment and supplies, lack of human resources, negative attitudes and cultural constraints. Other constraints discussed by Pacific Island Countries' respondents, included influence of religious groups, inappropriate personnel involved in delivery of services, changing socio-cultural environment, lack of involvement of men, poorly trained staff and lack of adequate facilities.

Several respondents discussed ways in which constraints were overcome. While all Pacific Island Countries are recipients of aid for reproductive health services, several countries cited the provision of donor assistance as a means of overcoming financial constraints, particularly with regard to supplies, equipment, facilities and human resources. A few countries mentioned that building partnerships with international organisations and other institutes were contributing to capacity building as well as improving reproductive health service provision. To overcome negative attitudes and cultural/religious constraints to enabling environments, several countries discussed IEC/advocacy campaigns that were undertaken. Some countries discussed providing flexible hours for services as a means of overcoming some of the inadequacies related to lack of privacy and inconvenient hours of operation.

2.14 Cultural Context

Respondents discussed the socio-cultural conditions, beliefs and practices that both promoted and constrained reproductive rights and reproductive health in their countries. It is interesting to note that most Pacific Island Countries perceived culture as both contributing and constraining the promotion of reproductive rights and reproductive health. Four Pacific Island societies stated that culture was only a constraining factor to the promotion of reproductive rights and reproductive health, while two Pacific Island Countries cited that culture was only a contributing factor to promoting reproductive right and reproductive health.

Several countries discussed how young people were receptive to information, education and communication campaigns on reproductive rights and reproductive health. The involvement of traditional and religious authorities was discussed as providing an enabling environment for the promotion of reproductive health services because they played a pivotal role in community acceptance and mobilisation. Women's groups and the roles women have traditionally held in some Pacific Island societies, e.g. Samoa, were perceived as contributing factors to the promotion of reproductive rights and reproductive health. Women could be perceived as agents promoting positive change towards their empowerment and should contribute to cultural shifts in collective societal beliefs related to reproductive rights. Changes in societal attitudes were facilitating progress in some countries. In the Cook Islands, education of young people and families was contributing to more positive attitudes for promoting reproductive rights and improved decision-making.

In Vanuatu, traditional leaders and religious groups were becoming more accepting of reproductive rights and reproductive health which facilitated wider discussions, more open attitudes and shifts in societal thinking and beliefs. In Kiribati, the cultural practice of fathers and in-laws providing care for pregnant women and mothers was perceived as contributing to greater promotion of reproductive

rights and reproductive health through increased awareness and involvement of men in matters related to reproductive health. The cultural environment in which the private sector operated was also perceived as playing an important contributing role in promoting reproductive rights and reproductive health in some Pacific Island Countries.

On the other hand, many Pacific Island Countries respondents perceived cultural factors as constraining the promotion of reproductive rights and reproductive health. In several Pacific Island Countries, the lack of gender equality constrained the promotion of reproductive rights and reproductive health. In Solomon Islands, Kiribati, PNG and other countries, where males are generally the main decision-makers and most females are not aware of their rights, promoting a rights-based, gender-equitable approach to decision-making in reproductive health matters remains a challenge. With more information, education and communication as well as advocacy campaigns for gender sensitisation, it is hoped that changes in attitudes will occur more widely. In some countries, the strong conservative religious presence has prevented open discussions on sexuality and provision of contraceptive services especially for adolescents. In some outer islands, the older generation with conservative religious beliefs has been unwilling to accept sexual and reproductive rights, especially for adolescents and youth. In their responses, one of the countries cited misunderstanding stemming from cultural beliefs between health care providers and clients in relation to family planning as constraining promotion of reproductive rights. Socio-cultural attitudes on reproduction and sexuality have constrained progress in promoting reproductive rights in countries where discussion on sexual matters are forbidden.

2.15 Conclusion

It is evident that since 1994, substantial progress has been made in the Pacific, towards improving reproductive health and advancing reproductive rights, which were outlined in the ICPD PoA and endorsed by all PICs.⁸ However, continued advocacy with parliamentarians, senior planners and policy makers, communities and development partners is vital to ensuring sustainable change. Further substantial progress will not be possible unless broader issues such as gender inequality and male involvement in responsible reproductive health decision-making are adequately addressed in certain patriarchal Pacific Island societies. Sustained and coordinated action is needed by governments and its partners to address priority areas of concern in the Pacific: low contraceptive prevalence, high teen fertility rates, rising levels of HIV/STI infections and substantial maternal morbidity/mortality. The need to ensure that quality, comprehensive reproductive health services and IEC are available to the population, and the need to strengthen capacity in the planning, monitoring and evaluation of programmes will continue to present formidable challenges for most PICs during the post-ICPD+10 era.

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CHAPTER 3: PROGRESS IN THE PACIFIC IN ADOLESCENT REPRODUCTIVE HEALTH

3.1 Introduction

In Pacific Island Countries, more than 50% of the population is below the age of 25, with 18-20% of the population between the ages of 15-19 years.¹ The rising proportion of adolescent and youth populations is a consequence of past rates of high fertility and has implications for policy makers, strategic planners, and developers of sectoral programmes.²

The International Conference on Population and Development (ICPD) Programme of Action (PoA), in 1994, discussed the need to “address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS.”³ The rights of adolescents to health were further reinforced at the ICPD+5 Session in 1999.^{4,5} Among the Key Actions that were reaffirmed at the ICPD+5 was the provision of appropriate, user-friendly and accessible services to address effectively adolescent reproductive and sexual health needs, including reproductive health education, information, counselling and health promotion strategies.⁵ With the advent of the Millennium Development Goals (MDGs), further emphasis has been placed on addressing the needs of young people.⁶

Since ICPD+5, many Pacific Island Countries have included the needs of adolescents and youth among their national priorities. Many Pacific Island leaders have expressed concern at the high levels of teen pregnancies, sexually transmitted infections, and high-risk behaviours during this era of rising HIV/AIDS infections. Although culture and religion pose strong challenges to the promotion and implementation of adolescent reproductive health (ARH) programmes, relevant aspects of Pacific culture and religion can be utilised to support ARH during this period of “crossroads of change” from traditional, communal Pacific ways to modern, urbanised living.¹

Globally, countries are beginning to realise that sexual and reproductive health programmes need to be developed to address the diversity of adolescent and youth populations.⁴ Youth need to be included in the development and implementation of programmes and services, in which gender empowerment is integral.⁴ Furthermore, the promotion of life skills and livelihood skills is vital to the future success of the youth, particularly in resource-constrained countries.

The Global Survey assessed progress made in reproductive health (RH) since 1994. Adolescent reproductive health (ARH) was one of the areas of focus. In this chapter, the responses to the ICPD+10 Global Survey for these countries are summarised, according to the following issues in ARH:

- § policy and legislative measures taken to address rights and reproductive needs of adolescents;
- § introducing reproductive health education;
- § providing access by adolescents to reproductive health services;
- § special approaches for sub-categories of youth;
- § culture as a facilitating and constraining factor in the promotion of ARH;
- § livelihood skills programme; and
- § adolescents and youth participation in policy and programme development.

3.2 Policy and Legislative Measures Taken to Address the Rights and Reproductive Needs of Adolescents

The ICPD+5 Key Actions states that countries should “in order to protect and promote the right of adolescents to enjoyment of the highest attainable standards of health, provide appropriate, specific, user-friendly and accessible services to address effectively their reproductive and sexual health needs, including reproductive health education, information, counselling and health promotion strategies. These services should safeguard the rights of adolescents to privacy, confidentiality and informed consent, respecting their cultural values and religious beliefs and in conformity with relevant existing international agreements and conventions.”³

In the Global Survey, Pacific Island Countries were asked if they had taken any measures (policies, laws, programmes) to address the rights and reproductive health needs of adolescents.

Thirteen countries responded affirmatively to taking measures to address the rights and reproductive health needs of adolescents. Responses of measures undertaken are summarised in Table 3.1.

Table 3.1: Pacific Island Countries’ Responses of Policy, Legal and Programme Measures Taken to Address the Reproductive Rights and Reproductive Needs of Adolescents

Description of Measures	Countries
Laws/legislation developed and implemented	Papua New Guinea
Policies developed and implemented	Cook Islands, Fiji, Marshall Islands, Papua New Guinea, Samoa, Solomon Islands, Tonga
Instituted IEC/Advocacy campaigns	Fiji, Tonga
Instituted plans, programmes and strategies	Cook Islands, FSM, Fiji, Kiribati, Marshall Islands, Palau, Solomon Islands, Tonga, Tuvalu, Vanuatu
Established National Commission on Youth	Marshall Islands
Ratified UN Conventions	Cook Islands, Palau
Developed partnerships with national and international NGOs	Kiribati, Marshall Islands
Ensured national health care programmes include ARH	Cook Islands, Marshall Islands

Supplemented with information from Regional ARH Project.

In almost all countries, there have been efforts made to address the reproductive rights and reproductive needs of adolescents, since ICPD PoA, in 1994, and especially subsequent to ICPD+5, in 1999. These efforts range from policy, legislative and national commissions in some countries to instituting Information, Education, Counselling (IEC)/advocacy campaigns, and developing partnerships with national and international NGOs. Most countries have initiated ARH programmes.

In the Pacific, the UNFPA-sponsored, Secretariat of the Pacific Community-implemented, Regional ARH Project has made significant progress in promoting the rights of adolescents through in-country, in-school and out-of-school programmes and through implementing IEC/advocacy campaigns. In many PICs, the creation of an enabling environment to discuss the rights of adolescents is facilitated through efforts made by ARH coordinators and the stakeholders. From the time of initiation of programmes, the involvement of the gatekeepers: church organisations, community leaders, parents, teachers and youth themselves, were part of the overall strategy that Pacific Island Countries adopted. Only one country, Niue, responded that no measures had been undertaken to address the rights and needs of adolescents.

3.3 Introducing Reproductive Health Education

The ICPD PoA states that countries “should protect and promote the rights of adolescents to reproductive health education, information and care...include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviours, family-planning practices, family life, reproductive health, sexually transmitted infections, HIV and AIDS prevention.”³

In the Global Survey, governments were asked if they had taken any measures to introduce health education, including life-skills, in and out-of-school. Twelve of the thirteen countries responded affirmatively. Responses from the twelve countries are summarised in Table 3.2.

In their responses, seven countries namely, Fiji, Marshall Islands, Federated States of Micronesia (FSM), Palau, Papua New Guinea (PNG), Samoa, and Vanuatu discussed the inclusion in their school curricula of reproductive health and life skills. Kiribati reported extracurricular activities while Fiji and Tonga cited peer education programmes. Most countries discussed their out-of-school programmes and/or clinics in the context also of involving youth and school leaders in these initiatives. Training of teachers through workshops, which involved the youth, was discussed by both Tonga and Vanuatu. Teacher training workshops to increase ARH awareness and information among teachers and students also have occurred in FSM (Pohnpei State), Kiribati, Samoa and Solomon Islands. While it is well known that all countries have conducted reproductive health IEC and advocacy campaigns, this table only reflects the countries that mentioned this in their responses in the Global Survey. There has been substantial progress in the Pacific Island Countries in initiating reproductive health education in-school and out-of-school programmes. Countries are in various stages of implementation of their ‘family life curriculum’ in schools. In the out-of-school programme, especially those in which youth are actively involved, anecdotal evidence indicates that substantial progress has been made in bringing about greater awareness of the ARH issues among the youth themselves.

Table 3.2: Pacific Island Countries’ Responses of Measures to Introduce Reproductive Health Education

Description of Measures	Countries
School Curricula includes RH and/or Life Skills	Fiji, Marshall Islands, FSM, Palau, PNG, Samoa, Vanuatu
Extracurricular activities on RH and/or Life Skills	Kiribati
Peer education programmes	Fiji, Tonga, Vanuatu
Out of school youth programmes and/or clinics	Cook Islands, Fiji, Kiribati, Marshall Islands, FSM, Palau, Solomon Islands, Tonga, Vanuatu
Training of teachers and/or school staff	FSM, Kiribati, Samoa, Solomon Islands, Tonga, Vanuatu
IEC/Advocacy	Cook Islands, Palau, Solomon Islands
Primary School Livelihood Skills Education	PNG
Others	Cook Islands, FSM, Tonga, Tuvalu

Supplemented with information from Regional ARH Project

Fiji’s peer education programme, with the deployment and further expansion of its peer educators to all divisions, appears to have experienced significant growth. It appears that the successes of this project have largely been due to the enthusiasm of the ARH Coordinators and the dedication displayed by the youth themselves. Similarly, in the Solomon Islands despite the recent political instability and economic downfall, the enormous in-roads made in ARH have been largely due to the enthusiasm, dedication and vision of the ARH Coordinator in the country. Active community

advocacy initiatives, innovative talk shows and weekly newspaper dialogues have contributed to an environment that is conducive to addressing some ARH issues.

When asked about measures to provide access to information on reproductive health, including life-skills by adolescents, most of the countries responded that substantial measures had been undertaken. Some examples included:

- § the initiation of national education plans or programmes (Fiji and Marshall Islands);
- § media involvement (Kiribati, Palau, PNG, Samoa);
- § counselling programmes (Cook Islands); and
- § IEC programmes (Cook Islands, Fiji, Kiribati, Samoa, Tonga).

In the Pacific, the Wan SmolBag Youth Theatrical arts group is active in its efforts to improve access to reproductive health information to adolescents and youth. Besides the numerous programmes and theatrical performances undertaken in Solomon Islands, this community-based NGO has also conducted training programmes in other Pacific Island Countries: Kiribati, Solomon Islands, Tonga and Tuvalu, particularly in HIV awareness.

Youth associations and organisations have been established in most Pacific Island Countries. Youth-friendly services have been initiated in Kiribati, Marshall Islands, Solomon Islands, Tonga, Vanuatu, with youth-friendly clinics providing health information, education and counselling as well as ARH clinical services within the environmental/social context of a recreational centre. Anecdotal evidence indicates that this comprehensive approach within a youth-friendly environment appears to have enhanced the acceptability of services for the youth themselves.

Some PICs reported that difficulties faced providing reproductive health information to adolescents and youth related to lack of human and financial resources, inadequate government support and religious/cultural opposition. Constraints in these programmes were largely overcome through persistent dialogue and sustained advocacy with the youth, gatekeepers, partner organisations as well as through training of teachers.

Under the auspices of the Regional ARH project, numerous training resources and health education materials in adolescent sexual and reproductive health have been developed, disseminated and utilised widely in PICs.

3.4 Providing Access by Adolescents to Reproductive Health Services

The ICPD PoA states that “countries must ensure that the programmes and attitudes of health care providers do not restrict the access of adolescents to appropriate services and information they need, including sexually transmitted diseases and sexual abuse.”³ During the ICPD+5 in 1999, among the Key Actions governments were urged “to ensure that programmes and attitudes of health care providers not restrict access of adolescents to appropriate services, including prevention and treatment of sexually transmitted diseases, including HIV and AIDS, and sexual abuse and violence.” It was stated that “support should be given to adolescents who need counselling and services for responsible family planning practices.” These services should be “appropriate, user-friendly and accessible...and...safeguard the rights of adolescents to privacy, confidentiality and informed consent, respecting their cultural values and religious beliefs.”⁵

In the Global Survey, countries were asked if they had taken any measures to provide access by adolescents to reproductive health services. Twelve out of the thirteen countries responded affirmatively. The description of the measures taken is summarised in Table 3.3.

Table 3.3: Pacific Health Countries' Responses of Measures taken to Provide Access to RH Services by Adolescents

Description of Measures	Countries
Policy on RH service provision to adolescents	Cook Islands, PNG
Counselling provided on RH	Cook Islands, Tonga
Establishment of youth-friendly services/school based clinics	FSM (Pohnpei State), Fiji, Kiribati, Marshall Islands, Palau, PNG, Samoa, Solomon Islands, Tonga, Vanuatu
Training of health care providers/clinic staff	Fiji, PNG, Samoa, Solomon Islands, Tonga, Vanuatu
Media, IEC/Advocacy	Cook Islands, Kiribati, Tonga, Tuvalu

Only two countries, Cook Islands and PNG, reported explicit policy on providing access by adolescents to reproductive health care services.

Initiatives for adolescents and youth on counselling in RH have occurred in Cook Islands and Tonga. A recent regional workshop for schoolteachers was undertaken to enhance their ability to provide counselling services to adolescents in the area of STI/HIV/AIDS. In the Pacific, counselling services, particularly for adolescents in the Pacific, are generally weak and further training of counsellors is required as unwanted pregnancies, STIs, sexual abuse and rape are being increasingly recognised as emerging problems.

The establishment of youth-friendly services was reported in the questionnaires in several Pacific Island Countries including Federated States of Micronesia (Pohnpei State), Fiji, Kiribati, Marshall Islands, Palau, Samoa, Solomon Islands, Tonga and Vanuatu. An educational programme is conducted by the ARH nurse, at the Pohnpei school-based ARH clinic, to support the clinic services. Lessons learned in the Pacific suggest that in order for youth to feel comfortable enough to request services, such as contraceptive services, diagnosis and treatment of sexually transmitted infections (STIs); pregnancy testing, etc, they need to be in a non-threatening environment conducive to confidentiality and privacy. Hence, it appears that the location, appearance and environment of the clinics have had a major impact on whether available services are utilised. Services are more likely to be utilised if they are within a youth recreational centre where youth can slip away unnoticed to meet with the health care provider. Similarly, within school clinics, the attitudes of the providers impact the youth's utilisation of these services.

Training of health care providers appears to have had an impact on improving utilisation of services. Several countries reported training health care providers in ARH clinical services and ARH counselling skills: Fiji, PNG, Samoa, Solomon Islands, Tonga, Vanuatu.

Media and advocacy efforts have also been used, in many countries, to encourage utilisation of reproductive health services by adolescents. Cook Islands, Kiribati, Tonga and Tuvalu reported using IEC/advocacy to promote awareness and utilisation of ARH services.

Some of the factors reported to have constrained access to ARH services in the Pacific included lack of human and financial resources and religious and parental disapproval. However, continuous dialogue with the gatekeepers and sustained advocacy with communities, governments and NGO/international partners should assist in eventually overcoming these constraints.

3.5 Special Approaches for Subcategories of Youth

In the Global Survey, countries were asked whether they had developed special approaches to address the specific reproductive health needs of sub-categories of youth (younger/older youth; girls/boys; unmarried/married; urban/rural; working youth; indigenous, etc). Seven of the thirteen countries

answered that some approaches had been developed to address the special needs of sub-categories. These countries included Cook Islands, FSM, Kiribati, Palau, Solomon Islands, Tonga and Tuvalu. Cook Islands discussed the special workshops that are held for prison youth and the unemployed, particularly in the areas of substance abuse. Mental health counsellors were also involved in providing services to these youth. In FSM, an out-of-school programme (Outward Bound) and the Girl Scouts are doing special training in life skills for the respective subgroups of youth. In Kiribati, target groups for ARH programmes are school boys and girls and out-of-school adolescents. Palau stated that while migrant youth workers were not currently addressed, boys/girls, younger/older youth and unmarried girls were the focus of their programmes. While Solomon Islands' ARH programmes focus on urban youth, further sensitisation of health care workers to ARH issues in rural areas is planned. Tonga has also focused on urban youth and seafarers' families but will be placing greater focus also on rural youth in terms of access to rural adolescent health services. Tuvalu discussed their emphasis on youth within schools through school-based health education programmes.

Several countries were in the planning phases of addressing subcategories. A needs assessment in each of the Pacific Island Countries to determine the special subcategories' issues may be useful. In many countries, there is no special distinction between subgroups, and youth are treated as a homogenous group. Second-generation ARH programming in the Pacific needs to further address the issues specific to subcategories of adolescents.

3.6 Culture as a Facilitating and a Constraining Factor in the Promotion of Adolescent Reproductive Health

Within all societies there are norms that govern people's behaviour that are based on their age, stage of life cycle, gender, education, social class and cultural origins.^{4,7} Young people today are growing up in a "youth culture" influenced by many factors which create a context in which these values are often in conflict with the values of their parents and traditional Pacific societies. Such conflicts in the Pacific context often arise for young people as a result of perceived differences in gender norms and expectations; individual rights to education and services; and freedom of expression and behaviour. In the Pacific, the situation is further complicated by concerns about the high levels of unwanted teen pregnancies, sexually transmitted infections, gender-based violence, suicide, and substance abuse.⁸

In trying to determine progress towards ICPD PoA implementation, the Global Survey asked countries to *discuss ways in which the cultural context has contributed or constrained the promotion of ARH*. Of the thirteen countries, eight countries stated that culture contributed to the promotion of ARH while all thirteen countries described how culture constrained the promotion of ARH.

Some countries, namely Kiribati, Samoa and Tuvalu, discussed how the concept of the "community" in Pacific Island societies contributed to facilitating information exchange and how discussion of ARH issues is a unique process of working together for the good of all. They expressed the view that the mode of ensuring discussions of important issues, which occurs in community meetings, provides a forum for debate and resolution of issues for all community members. Another country stated that the cultural practice of separating males and females during dialogue related to sexual matters promotes more in-depth and comfortable discussion of sensitive adolescent sexual and reproductive health issues.

Solomon Islands discussed how the support and involvement of religious and traditional leaders in their ARH programmes had enhanced awareness of ARH issues in the community and resulted in acceptance and promotion of services and information for the young. Samoa discussed how respect for cultural norms has been used to promote services for the young adults. They reported that adherence to cultural appropriateness facilitated further promotion of ARH. Specific examples were not provided.

It is well known in all Pacific societies that sexual activity is not encouraged among unmarried youth and adolescents. Working with cultural or traditional leaders and religious groups to advocate the

concepts of abstinence and/or condom use for prevention of HIV/AIDS has contributed to parents being more supportive of adolescent programmes in some Pacific Island Countries. Where there have been some improvements in the gender equity in the Pacific Island Countries where the status of women is low, access to information and reproductive health services has improved. However, in these countries there is still substantial progress to be made; working in the rural areas and outer islands with cultural leaders and community leaders and enhancing male involvement in responsible decision-making and behaviour is vital for attainment reproductive health and rights in young Pacific women.

All Pacific island countries discussed cultural constraints to the promotion of ARH. A number of countries discussed how the adolescent phase of life was not recognised culturally. As a result, adolescents were still considered children and therefore not capable of independent decision-making nor ready for discussions related to human sexuality. This belief led parents to not agreeing with their adolescents' participation in ARH IEC programmes. Several countries stated the cultural inappropriateness of discussing adolescent sexuality. Kiribati, Niue and Tuvalu discussed the cultural taboo against open discussion of sexual matters. In this context, culture also served as a barrier for youth seeking reproductive health services, fearing negative repercussions should their parents find out. This was particularly considered an issue in smaller societies where maintaining confidentiality can be difficult. Anecdotal evidence suggests that some parents lack the skills to appropriately discuss sexual and reproductive matters with their adolescent children. One of the countries discussed how older males in outer island settings and rural societies particularly constrained progress in promoting adolescent reproductive health by imposing their traditional beliefs on young people and restricting open discussion of potential issues of conflict. PNG discussed the situation where hierarchical decision-making hindered progress of ARH programmes for youth. Some religious organisations were also perceived as barriers to ARH by one of the country respondents.

3.7 Livelihood Skills Programme for Adolescents

Because attaining productive livelihoods is important to adolescents and developing life skills is linked to economic return, these issues are central to reproductive health outcomes in the youth.⁴ In small islands and rural Pacific settings, these issues are of particular relevance where opportunities are limited.

In the Global Survey, countries were asked to describe progress and achievements in supporting young people in terms of livelihood skills (vocational training, employment) and life skills (critical thinking and decision-making).

Twelve of the thirteen countries reported making progress in supporting young people in livelihood skills and live skills development in: Cook Islands, FSM, Fiji, Kiribati, Marshall Islands, FSM, Palau, PNG, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. These countries' responses are summarised in Table 3.4.

Table 3.4: Pacific Island Countries' Responses of Measures Taken to Support Progress in Livelihood and Life Skills for Young People

Description of Measure	Countries
Provision of relevant educational system and Vocational/Entrepreneurial skills education	Cook Islands, FSM, Fiji, Marshall Islands, PNG, Samoa, Tonga
Provision of vocational/entrepreneurial skills education for out-of-school youth	Fiji, Marshall Islands, Palau, Samoa, Solomon Islands, Tonga, Vanuatu
Provision of entrepreneurial training and life skills for youth by NGOs	Fiji, Kiribati, Samoa, Solomon Islands, Tuvalu, Vanuatu
Provision of entrepreneurial training and life skills for youth by church groups and communities	FSM, Samoa, Tonga

Respondents from nearly all Pacific Island Countries reported making progress in livelihood skills and life skills development for young people. Several countries discussed the provision, within the educational system, of relevant vocational and entrepreneurial skills training. Several countries discussed vocational training apprenticeships for youth and technical training programmes. In Papua New Guinea, the government's policy and educational reforms have promoted strong rural livelihoods skills such as agriculture, village-based business skills and environmental awareness. Life skills development programmes in schools, in some countries, promote self-development, self-confidence with respect to entering the cash economy, and leadership skills.

Out-of-school programmes included Outward Bound Programme for life skills promotion, livelihood skills programmes tied to income generation and training courses/workshops for youth in agriculture and carpentry. United Nations Children's Fund, UNICEF, currently provides a Programme on Pacific Youth Life Skills Development for youth.

Foundation for the Peoples of the South Pacific, a regional NGO, has provided substantial training in livelihood skills development in Vanuatu; incorporating practical skills development, and employment skills training through business training workshops, computer training classes, cooking classes, sewing sessions and craft lessons. Youth are also taught to develop skills in small-scale income generation activities. In several other countries, other NGOs have been involved in promoting similar activities.

Religious organisations have also been involved in running similar livelihood skills and life skills workshops for youth in selected Pacific Island Countries.

None of the countries discussed whether governments provide jobs for youth, local level training for young women nor literacy programmes for indigenous youth.

Because of the young age structure of Pacific Island populations and the high unemployment experienced in many of these countries, high priority has been given by governments to developing programmes aimed at enhancing livelihood development. With strong government commitment, sustained multi-sectoral collaboration and involvement of development partners, further progress should be possible in this area.

3.8 Adolescents and Youth Participation in Policy and Programme Development

The ICPD PoA states that “adolescents must be fully involved in the planning, implementation and evaluation of ARH information and services with proper regard for parental guidance and responsibilities.”⁷ One of the Key Actions of the 1999 ICPD+5 was that “governments, civil society organisations at the national level and the United Nations are urged to consult youth organisations in the design, implementation and evaluation of policies and programmes for youth.”^{4,5}

To determine progress towards implementation of ICPD PoA as related to youth participation, the Global Survey asked countries whether adolescents and youth regularly participated in policy and programme development. Nine of the thirteen countries responded affirmatively. These countries were Cook Islands, Fiji, Kiribati, Marshall Islands, Palau, PNG, Samoa, Solomon Islands and Vanuatu. Their responses are summarised in Table 3.5.

Table 3.5: Pacific Island Countries' Responses of Measures Taken to Promote Youth Participation in Policy and Programme Development

Description of Measure	Countries
Involvement of youth formulation/ development/ implementation of pilot projects	Cook Islands, Kiribati, Marshall Islands, PNG, Samoa, Vanuatu
Involvement of youth in policy development	Cook Islands, Marshall Islands, Solomon Islands, Vanuatu
Holding of forums for youth to participate	Palau, PNG, Solomon Islands
Promotion of youth organisations to serve as a channel of their participation at the local level	Fiji, Kiribati, Palau

Several countries, namely Cook Islands, Kiribati, Marshall Islands, PNG, Samoa and Vanuatu have involved youth in formulating, developing or implementing youth projects. In the Solomon Islands, youth also participated in the national multi-sectoral strategic plan. In Samoa, youth have also been involved in developing grassroots programmes for youth, while in Fiji and PNG, youth were involved in developing AIDS prevention programmes through the peer education programmes.

Youth have been involved in youth policy development and national youth development plans in Cook Islands, Marshall Islands, Solomon Islands and Vanuatu. In the Solomon Islands, youth also participated in the National Multi-Sectoral Strategic Development Plan. In the Marshall Islands, the government recognised their need to participate and, through the National Youth Council, youth developed and recommended policy and programme changes that specifically addressed their needs. Tonga stated that while youth were not directly participating in the Tonga National Youth Council, they were consulted.

In Palau, the youth are regularly invited to participate in workshops on policy and programme development as well as debates, mock congress and other fora.

The promotion of youth organisations to serve as channels of communication at the local level has also occurred in Fiji, Kiribati and Palau.

While progress in the Pacific in youth involvement and participation policy and programme development is noteworthy, there is a continued need for youth to be regularly involved in the development of policies and programmes for youth across sectors including health. Mechanisms need to be instituted to facilitate their involvement in the resolution of issues aimed at youth at all levels.

3.9 Conclusion

From this review, it is evident that, since ICPD PoA and especially subsequent to the ICPD+5, Pacific Island Countries have placed Adolescent Reproductive Health as a priority on their national agenda. As a result, substantial in-roads have been made in addressing the needs of adolescents and youth. Particular progress is evident in the in-school programmes of many Pacific Island countries which include promoting better understanding of reproductive health issues; facilitating development of life skills and livelihood skills; and, in some countries, providing clinical reproductive health services to adolescents. In many Pacific Island countries, the out-of-school programmes that have particularly emphasised comprehensive youth-friendly clinical counselling and informational services within youth recreational centres have experienced greater success. While peer education programmes have met with relative success in terms of acceptability, monitoring mechanisms need to be strengthened in many countries. The impact on behaviour change of peer education programmes and IEC/Advocacy projects in the Pacific have yet to be fully evaluated. Further integration of ARH issues into the formal school system and training institutions will provide opportunities for improving ARH

awareness among the youth themselves. Emphasis needs to be placed on integrating ARH services into existing mainstream government and NGO health facilities to provide youth-friendly services.

A key factor to the success of the ARH programmes in the Pacific has been the involvement of youth themselves in the planning/development, implementation and monitoring. Youth themselves, the beneficiaries of these ARH projects should continue to be integrally involved in all phases of programme, policy and strategy development and implementation. Furthermore, harnessing the support of the “gatekeepers” such as parents, religious leaders and teachers from the onset should facilitate an enabling environment that promotes addressing the relevant ARH issues at all levels in Pacific societies. It is hoped that additional focus on young males should continue to facilitate greater respect for females in the younger generations.

The challenge for the next era, post ICPD+10, lies in determining and scaling up successful rights-based, gender-sensitive ARH programmes and in ensuring sustainability of these programmes in each of the Pacific Island countries.

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CHAPTER 4: PROGRESS IN THE PACIFIC IN GENDER EQUALITY, EQUITY & THE EMPOWERMENT OF WOMEN

4.1 Introduction

Over the past two decades, several international conferences have been held to provide direction to the advancement of women throughout the world. Pacific Island leaders and representatives of women's organisations have participated in these conferences hoping to ensure that gender equality, equity and empowerment of women eventually become a reality in their relatively small island societies.

In 1993, the World Conference on Human Rights, in Vienna, stated that “women's rights are human rights”. In 1994, the International Conference on Population and Development (ICPD), in Cairo, ensured women's rights, empowerment and health, which included sexual and reproductive health, were basic principles and integral goals of the Programme of Action (PoA).¹ In the ICPD PoA, principles, objectives and actions to be taken by the international community to improve the lives of girls and women, through the promotion and protection of women's human rights and the empowerment of women, were clearly detailed.

Governments were urged to establish mechanisms for women's equal participation and representation at all levels of the political process and public life, to eliminate all practices that discriminate against women, to promote women's economic security and to eliminate violence against women. Governments were urged to sign, ratify, implement and enforce laws and conventions, such as the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), and to implement fully the Declaration on the Elimination of Violence Against Women, the Vienna Declaration and Programme of Action adapted at the World Conference on Human Rights.¹ Gender-based disparities in the workplace were to be eliminated and gender-based analysis of development programmes promoted. Measures to eliminate exploitation, abuse, harassment, violence against women and rape were to be promoted.

To improve the status of the girl child, the ICPD Programme of Action called for special education and public information efforts to promote equal treatment of girls and boys with respect to nutrition, health care, education and social, economic and political activity, as well as equitable heritable rights. Countries were urged to ensure widest and earliest possible access by girls and women to secondary and higher levels of education, vocational education and technical training. Governments were urged also to promote laws that ensured women enter into marriages with free and full consent and to take action against infanticide, prenatal sex selection, prostitution and pornography. In terms of male responsibilities and participation, governments were urged to promote equal participation of men and women in family and household responsibilities and sexual reproductive health through IEC, legislation and fostering an enabling environment.

Pacific Island states were among the 179 countries that committed to achieving the goals at ICPD through the actions outlined in the Programme of Action.

The goals of ICPD were further reiterated at the ICDP+5 Special Session of the United Nations General Assembly in 1999.² The cross-cutting issue of gender was pervasive in the new set of benchmarks which included education and literacy, reproductive health care and unmet need for contraception, maternal mortality reduction and HIV/AIDS.² In 2000, at the Millennium Summit, Heads of States adopted the Millennium Development Goals, which specifically included promoting gender equality and empowering of women and improving maternal health.³ While important as a goal on its own, the equality of women was considered integral to the other Millennium Development Goals (MDGs).

Pacific Island Countries, regional and international organisations and non-governmental organisations have mobilised to promote the achievement of these ICPD/MDG goals in all sectors. However, varying degrees of commitment are evident and the relative lack of reliable data poses problems for effective monitoring.

The Global Survey conducted by UNFPA during 2003 included questions on gender-related issues and measures taken to address them.⁴

This chapter provides a summary of the results of the ICPD+10 Global Survey as they relate to gender equality, equity and the empowerment of women from the thirteen Pacific Island Countries, which responded. Action taken for protecting the rights of women, empowering women, addressing gender-based violence, eliminating gender disparities in education and enabling men's support for women's rights and empowerment as well as increased responsibility for their own and their partner's reproductive health were assessed. Pacific Island governments provided examples of actions, undertaken in the aforementioned areas, as testament of progress made towards achieving the ICPD goals. Cultural constraining and facilitating influences on women's empowerment were also discussed in the responses. Information from Pacific regional and national governmental and non-governmental organisations has also been utilised to supplement the information from the Global Survey to provide a current status of achievement towards ICPD goals in the Pacific.

4.2 Protecting the Rights of Girls and Women

ICPD states that “governments should eliminate all practices that discriminate against women; assist women to establish and realise their rights, including those that relate to reproductive and sexual health.”

ICPD PoA also states that “all countries should make greater efforts to promulgate, implement and enforce national laws and international conventions to which they are party, such as the Convention of the Elimination of All Forms of Discrimination against Women, that protect women from all types of economic discrimination and from sexual harassment, and to implement fully agreements and conventions that promote women's rights.”¹

Governments were encouraged to ensure that women can buy, hold and sell property and land equally with men, obtain credit and negotiate contracts in their own name and on their own behalf and exercise their legal rights to inheritance.

In the Global Survey, governments were asked if they had taken any policy, legislative or administrative measures *to protect the rights of girls and women*. All thirteen countries responded affirmatively to undertaking measures to protecting the rights of girls and women; six countries reported taking “many” or “some” measures while seven countries reported taking “limited” measures. In Table 4.1, Global Survey responses to questions pertaining to the various policies, administrative or legislative measures undertaken to protect the rights of children and women by the Pacific island countries are summarised. Table 4.1 was formulated on the basis of responses in the Global Survey questionnaire, which may or may not reflect a complete and accurate status with respect to the actions taken by respective governments. However, information from regional resources has also been added in an attempt to provide a summary of progress towards the achievement of ICPD goals in the Pacific.

Table 4.1: Pacific Island Countries' Responses of Policy, Legislative and Administrative Measures taken to Protect the Rights of Girls and Women

Description of the Measure	Countries
National commission established	Fiji, Marshall Islands, Palau, Samoa, Vanuatu
Constitution protection	Federated States of Micronesia, Marshall Islands
Policies on gender discrimination/ empowerment	Fiji, Marshall Islands, Palau, PNG, Samoa, Solomon Islands, Tonga, Tuvalu
Ratified UN Convention/Implemented Programme of Action/Platform	Cook Islands, Fiji, Kiribati, Marshall Islands, Niue, PNG, Samoa, Solomon Islands, Tuvalu, Vanuatu
National laws/legislation on women's rights	Fiji, PNG, Solomon Islands
National action plans on gender mainstreaming	Fiji
Developed IEC/Advocacy Programmes	Fiji, Marshall Islands, PNG

Supplemented by information from other UN sources

Many countries have formulated policies and amended constitutions to address women's legal rights. Papua New Guinea reported recent amendments to legislation, which included marital rape as an offence, and protection of women in rape, and implementing a national gender-related policy. The Regional Rights Resource Team (RRRT) from Fiji have been active, throughout the countries in the Pacific, in conducting training about women's legal rights, as well as advocating for women's rights through community workshops, on-the-ground staff and a nationwide network of community paralegals. In the Fiji Family Act, which was recently passed, special focus has been drawn to the rights of women for fair distribution of matrimonial property as well as equal rights of the girl/boy child born out of wedlock. Solomon Islands reported a National Women's Policy and similar measures, such as workshops for training of trainers for women's rights. Since October 2000, RRRT has trained nearly 100 community paralegals in human rights including women's rights in Solomon Islands. Vanuatu reported developing a gender equity policy as well as establishing a Department of Women's Affairs to promote the rights of women. Samoa reported establishing a Ministry of Women's Affairs, reflecting their government's commitment to the protection of women's rights. Palau, Federated States of Micronesia and Marshall Islands reported that their constitutions incorporate legal rights for all citizens, regardless of gender.

In general, greater political will by leaders and sustained programming efforts are necessary to translate commitment and obligation to ICPD into enhanced women's rights in the Pacific. Most countries of the Pacific subregion have ratified the Convention on the Elimination of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Some of the other countries are reported to be in the process of ratifying CEDAW through legislative processes. However, further progress in monitoring its implementation is necessary in all Pacific Island countries

Table 4.2: Pacific Island Countries that have ratified CEDAW and CRC as of July 2004

*Ratified CEDAW	**Ratified CRC
§ Federated States of Micronesia	§ Cook Islands
§ Fiji	§ Federated States of Micronesia
§ Kiribati	§ Fiji
§ PNG	§ Kiribati
§ Samoa	§ Marshall Islands
§ Solomon Islands	§ Nauru
§ Tuvalu	§ Niue
§ Vanuatu	§ Palau
NZ ratified on behalf of:	§ Samoa
§ Cook Islands	§ Solomon Islands
§ Niue	§ Tonga
§ Tokelau	§ Tuvalu
France ratified on behalf of:	§ PNG
§ French Polynesia	§ Vanuatu
§ New Caledonia	
§ Wallis & Futuna	

*Source: *Bringing CEDAW Home, December 2004*

**Source: * *UNICEF Pacific Annual Report, 2004*

4.3 Empowering Women

The ICPD Programme of Action states that “particular attention is to be given to the socio-economic improvement of women in developed and developing countries. As women are generally the poorest of the poor and at the same time key actors in the development process, eliminating social, cultural, political and economic discrimination against women is a pre-requisite to: (i) eradicating poverty; (ii) promoting sustained-economic growth in the context of sustainable development; and (iii) achieving balance between population and available resources and sustainable patterns of consumption and production. The ICPD Programme of Action calls for countries to act to empower women and to take steps to promote gender equality in all spheres of life, including the elimination of all forms of discrimination of the girl child, and the promotion of male participation.”¹

All countries in the Pacific that responded to the Global Survey reported that they had taken policy, legislative or administrative measures to promote the empowerment of women. Of the thirteen countries that responded affirmatively, seven countries reported “many” or “some” measures being undertaken to empower women, while four countries reported “limited” measures being undertaken. These responses are summarised in Table 4.3.

Table 4.3: Pacific Island Countries’ Responses of Policy, Legislative and Administrative Measures Taken to Empower Women

Description of the Measure	Countries
Efforts to include/increase female participation in governance.	Cook Islands, Federated States of Micronesia, Fiji, Marshall Islands, PNG
Empowering through education/training	Fiji, Kiribati, Niue, PNG, Samoa, Solomon Islands, Tuvalu, Vanuatu
Empowering through economic opportunities	Cook Islands, Marshall Islands, Solomon Islands, Tonga, Tuvalu, Vanuatu
Empowerment of women: plans/programmes/strategies	Marshall Islands, Federated States of Micronesia, Fiji, Tonga, Vanuatu
Legislation/law for empowerment	Fiji, PNG
Other measures	Kiribati, Marshall Islands, Niue, Palau, Samoa, Vanuatu

Several countries reported making concerted efforts to increase female participation in governance. In the Cook Islands, there have been efforts to increase representation of women as ministers, parliamentarian, mayors, village leaders and landowners. In the Marshall Islands, the National Women's Policy stipulates the appointment of women to all national economic task force committees, boards and authorities. In Papua New Guinea, financial incentives are offered to successful women in national elections as a strategy for increasing women's participation in governance at the national level and empowering women at the policy levels. Solomon Islands reported working towards enhancing women in power and in decision-making processes, during conflict and peace, from the highest ministerial level to the grassroots community level through the establishment of the Ministry of Women. In Vanuatu, the establishment of gender equity benchmarks for gender balance has governed appointments made by the Public Service Commission.

Several Pacific Island countries reported conducting workshops aimed at empowering women in various aspects of life from economic development to personal reproductive health decision-making. While only five countries reported enhancement of economic opportunities as a strategy for empowering women, it would appear that several other countries are working towards improving economic opportunities for women. In the Solomon Islands, United Nations Development Fund for Women, UNIFEM's Women, Peace and Security Programme supports women's participation and role in prevention and peace building through workshops. The Ecumenical Centre for Research, Education and Advocacy (ECEA) also has undertaken peace initiatives involving women in the Solomon Islands. Tonga and Vanuatu reported the promotion of development programmes that involved women as a strategy for empowering women. In Vanuatu, government support was pledged through development projects implemented by women's organisations and non-governmental organisations (NGOs) such as the Micro-Finance Institution for Women. Tonga reported that the Langafonua, a Fafine Tonga, Women in Law Association, Churches Women's Division and Women in Development Centre combined efforts to promote women's activities and empower women through workshops on advocacy and promotion of women in economic and social development. Furthermore, some PICs have established National Machineries for Women (NMW) that facilitate collaboration between women's agencies and women's NGOs, for the advancement of women.

None of the countries reported specific programmes for empowering marginalised women.

4.4 Gender-Based Violence

The ICPD Programme of Action stipulates eliminating violence against women and specifies that countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children. Countries were urged to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women, and take steps to assure that full assistance is provided to the victims for their physical and mental rehabilitation.¹

In the Global Survey, the thirteen Pacific Island countries reported measures taken to address gender-based violence, in particular against girls and women (female infanticide, domestic and sexual violence, etc). Eight countries reported undertaking "some" measures and five countries reported undertaking "limited" measures to addressing gender-based violence (Table 4.4).

Table 4.4: Pacific Island Countries' Responses of Policy, Legislative and Administrative Measures Taken to Address Gender-Based Violence

Description of the Measures	Countries
Services for victims	Cook Islands, Federated States of Micronesia, Fiji, Marshall Islands, Niue, Papua New Guinea, Samoa, Solomon Islands
IEC/Advocacy about gender based violence	Federated States of Micronesia, Fiji, Samoa, Solomon Islands, Tuvalu, Vanuatu,
Training services providers/government officials on gender-based violence	Fiji, Niue, Papua New Guinea
Law/Legislation on gender-based violence	Federated States of Micronesia, Fiji, Kiribati, Palau, Samoa

Several countries, namely Cook Islands, Marshall Islands, Niue, Federated States of Micronesia and Solomon Islands reported implementing services for victims of gender-based violence. The Fiji Women's Crisis Centre, a well-established operation, has provided counselling, legal, medical and other practical support services to victims of domestic violence for the past two decades. In the Cook Islands, a Women's Counselling Centre run by the NGO Punanga Tauturu has been providing services for victims and survivors of violence.

In Samoa, the Mapugasa o Aiga organisation has been active in addressing gender-based violence through service provision to victims as well as through advocacy campaigns. Tonga reported the establishment of a National Centre for Women and Children, in 2001, for addressing gender-based violence through advocacy programmes.

In the Solomon Islands, the Family Support Centre was established, more than six years ago, to provide counselling to victims. The Solomon Islands National Council of Women is involved in addressing gender-based violence. Workshops for recognition of the problem as well as awareness of family law and other legal rights have been held on a regular basis. Solomon Islands have also drafted instructions for a new Bill of Rights.

In PNG, an Integrated Long-Term Strategy (ILTS) on Family and Sexual Violence is being implemented in collaboration with civil society partners, and covers institutional strengthening, legal reforms, services for victims, rehabilitation programmes for offenders, community prevention and data collection. In PNG, numerous NGOs are providing services to victims of domestic violence.

In Vanuatu, the Chief Magistrate introduced new rules in the Magistrates Courts for granting Domestic Violence Protection Orders and security to summons as well as other legal measures to address this crime. NGOs, such as WanSmol Bag, are active in raising community awareness about domestic violence.

In the Marshall Islands, plans for a study on the status of violence against women and young girls were in progress so as to provide direction to the development of counselling and other services for addressing gender-based violence. In Niue, counselling workshops for women suffering from domestic violence were conducted and subsequently counselling services provided at a community-based centre. In the FSM, consolidated governmental and non-governmental strategic objectives included establishing community-based crisis management and counselling centres as well as services for victims, survivors and perpetrators of violence and abuse.

None of the countries specifically reported a national commission on gender-based violence or enforcement of gender-based violence laws/legislation.

In Fiji, as a consequence of CEDAW ratification, the adoption of a ten-year action plan (1999-2008) includes addressing violence against women and establishing a task force on violence against women. The adoption of the action plan marks significant progress towards eliminating gender-based violence in Fiji.

According to the Pacific Report on Eliminating Violence Against Women, the following initiatives in the Pacific have signified progress in addressing this issue.⁵

- § Expansion of the number of women able to access services through mobile clinics attended by trained and experienced counsellors, and establishment of new branches;
- § Community education, awareness-raising and information on rights and services using theatre, community groups, media campaigns and IEC materials;
- § Targeting of men and community leaders through awareness-raising and advocacy campaigns;
- § Promoting, negotiating and demanding peace and active strategies for disarmament and reconciliation in militarised communities;
- § Developing community-based responses and capacity;
- § Providing paralegal and legal assistance;
- § Drafting legislation and amendments and lobbying for law reform;
- § Monitoring implementation of laws and sentencing;
- § Training and educating key leaders and organisations such as churches, chiefs, civil society groups and the police;
- § Providing input into government working groups and structures on policy, programmes and legislative reform;
- § Using action research for services, community education, campaigns and law reform.

According to an assessment by UNIFEM documenting actions to end violence against women, women's organisations and NGOs have played a key role in working towards ending violence against women in the Pacific region.⁶ However, while considerable progress has been made through regional governments' recognition of violence against women, national policy, institutional and legal frameworks remain inadequate, with insufficient budgetary allocations and a relative lack of coordination.

4.5 Reducing Gender Disparities in Education

ICPD Programme of Action states that "Education is one of the most important means of empowering women with the knowledge, skills and self-confidence necessary to participate fully in the development process." More than 40 years ago, the Universal Declaration of Human Rights asserted that "everyone has a right to education." One of the stated objectives of ICPD is: "To ensure that all women, as well as men, are provided with the education necessary for them to meet their basic human needs and to exercise their human rights." Furthermore, all countries were urged "to ensure widest and earliest possible access by girls and women to secondary and higher education, as well as to vocational education and technical training, bearing in mind the need to improve the quality and relevance of that education. Countries must recognise that, in addition to expanding education for girls, teachers' attitudes and practices, school curricula and facilities must also change to reflect a commitment to eliminating all gender bias, while recognising the specific needs of the girl child." The Programme of Action called for universal education to be a reality in all countries by 2015.¹

The 2003 ICPD Global Survey included questions on progress made by countries to improve access to primary and secondary education, and to address gender disparities in education.

When asked about measures taking to address gender disparities in education, ten of the countries reported progress was being made. Eight of the countries reported "low" level of progress in reducing the gender gap while two countries reported "some" progress. None of the countries reported a

“high” level of progress, which indicates that there is substantial work that needs to occur in this area in the Pacific.

Vanuatu reported the establishment of the Education for All Policy (EFA) and the EFA National Plan of Action. The government has produced the Vanuatu Education Master Plan, which addresses eliminating gender disparities in primary and secondary school to achieve gender equality in education. Gender balance is also considered when allocating government-funded training scholarships in Vanuatu. This gender balance strategy of allocating all government-funded and aid-funded scholarships for addressing gender disparity in education was also reported by Tonga and the Cook Islands.

Federated States of Micronesia reported that after endorsement of the Convention on the Rights of the Child (CRC), the Education for All policy included allowing pregnant females to continue their education.

In Papua New Guinea, the Education Department, in May 2003, launched its gender policy, which included addressing gender disparities in education, especially secondary and tertiary and the inclusion of gender issues in high school/university curricula. Major educational curriculum reforms have been in progress since the mid-1990s to support the empowerment of women which included: incentives to poor families to send girls to schools; increased number of girls’ schools at secondary; and IEC/Advocacy campaign for gender equality/equity of education.

Constraints discussed were that sometimes boys were kept home to augment the family income and that education of boys and girls were valued differently. Other constraints cited included the lack of support provided by families and the lack of qualified teachers for certain professions.

Palau cited law/legislation for equal education. Of the countries that did not specify measures for reducing gender disparities in education, some stated that education was already free to all regardless of gender and others stated that there were no gender disparities in education.

All thirteen Pacific Island countries reported making progress to improving access to primary and secondary education. Five of the countries reported “low” level of progress while eight countries reported “some” progress was being made. No country reported a “high” level of progress in improving access to primary and secondary education. Many of the countries reported that primary school is free and compulsory for boys and girls. A few countries reported that secondary education is free but not compulsory and that there is increased public spending for schools.

Vanuatu reported the implementation of the Vanuatu Education Master Plan, which includes universal education for all school-aged children. With the Senior Secondary School Expansion project, new secondary schools have been built and in some schools, cut-off classes for certain ages have been modified. Tonga also reported the building of new government secondary schools in rural and outer islands as well as offering a wider range of subjects in the curriculum of secondary schools.

Similarly, in PNG efforts have been made to improve infrastructure and rural education facilities. Solomon Islands also reported the establishment of new primary and secondary schools; however since the ethnic problems and concomitant decline in economy, school attendance rates have dropped.

On another aspect, FSM reported that with the endorsement of CRC, FSM has adopted a policy that allows pregnant girls to continue their education. Marshall Islands reported an innovative “mentor project” to improve access to quality education in outer atolls where teachers from urban areas work closely with teachers on outer atolls by distance support and on-site training.

Niue and PNG reported incentives for poor families to send children to school or subsidised education by provincial governments for secondary and tertiary education for underprivileged children.

Countries cited the following constraints hindering further educational progress:

- § inadequate public budgets for education;
- § children kept home to augment family income;
- § increase in school fees;
- § various social and environmental calamities;
- § lack of qualified teaching personnel;
- § access in rural areas was limited;
- § insufficient number of public schools for the number of children.

4.6 Enhancing Men's Support to Women's Rights and Empowerment

ICPD Programme of Action states that “changes in both men’s and women’s knowledge, attitudes and behaviours are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions, regarding the size of the family, to the policy and programme decisions taken at all levels of government. It is essential to improve communication between men and women on issues of sexual and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private lives. Parents and schools should ensure that attitudes that are respectful of women and girls as equals are instilled in boys from the earliest possible age, along with an understanding of their shared responsibilities in all aspects of family life.”¹

The ICPD Global Survey posed questions to countries as to measures taken to enable men to support women’s rights and their empowerment.

Of the thirteen Pacific Island countries, seven countries reported that some measures had been undertaken to enabling men to have greater involvement in supporting women’s rights and their empowerment while five countries reported no measures had been undertaken.

Cook Islands, Niue, Federated States of Micronesia and Vanuatu reported the implementation of IEC and advocacy campaigns for raising awareness about men supporting women’s rights and their empowerment and for gender sensitisation. Samoa and Tonga discussed plans to encourage male involvement in Reproductive Health. PNG reported the development of legislation for paternity leave since the early 1980s as well as educators’ programme for encouraging male support for female candidates in national elections. Cook Islands reported the Ministry of Education and Health had revised the curricula to address issues on positive attitudes for boys and girls as well as gender equality.

Among the countries that did not cite specific measures to enable men to support women’s rights and their empowerment, some mentioned that men and women already had equal rights, that current plans target women and that socio-cultural attitudes provided a conducive environment.

In the ICPD 2003 Global Survey countries were asked whether there had been measures to ensure that attitudes that are respectful of women and girls as equals are instilled in boys.

Ten, of the thirteen Pacific Island countries, responded that some measures had been taken to instilling respectful attitudes in boys, and two countries responded that no measures had been taken (Table 4.5).

Table 4.5: Pacific Island Countries' Responses of Measures Taken to Ensure that Attitudes that are Respectful of Women and Girls are Instilled in Boys

Measures	Countries
Attitudes on gender equality advocated in organisations	Cook Islands, Federated States of Micronesia, Fiji, Samoa, Solomon Islands, PNG
Attitudes on gender equality instilled through family values	Federated States of Micronesia, Marshall Islands, Niue, Samoa
Review of curricula	Cook Islands, PNG
IEC/Advocacy campaigns on gender equality	Solomon Islands, Vanuatu
Youth, adolescent RH education plan/ programmes	PNG
Civic education on gender roles	Tonga
Other measures	Cook Islands, Fiji, Tonga

The promotion of gender equity awareness raising campaigns has been ongoing in the Cook Islands, Federated States of Micronesia, Fiji, PNG, Samoa, Tonga and Vanuatu. Many countries cited the Adolescent Reproductive Health programmes that incorporated IEC on gender-related campaigns in churches, schools, communities and youth groups as well as through the media: television, radio and newspapers. In some PICs, socio-cultural attitudes were cited as constraints to further progress in instilling respectful attitudes in boys. In the countries that reported no measures had been taken to ensure attitudes that are respectful of women and girls as equals are instilled, reasons given were that gender was not an issue and that women were already respected within the traditional cultural context.

With regard to measures taken *to enable men to take responsibility for their own and their partner's reproductive health*, seven of the thirteen Pacific Island countries reported taking "limited" measures while five of the countries reported taking "some" measures. The country that did not cite any measure discussed socio-cultural constraints.

Four of the countries reported education programmes for men on their own and with their partners. Six Pacific Island Countries reported IEC/Advocacy programmes on men's reproductive health and involvement. Other countries reported life skills education on stereotypes and gender roles. Solomon Islands reported initiating male only clinics. Four countries, namely Kiribati, FSM, Niue and PNG, reported promoting male contraceptive methods i.e. condoms and vasectomy. It is recognised that most of the other Pacific Island countries have vasectomy services but the level of acceptability and accessibility to potential clients is not well documented.

The Marshall Islands reported that well-coordinated programmes such as the Father's Day Seminar and the Men's Caucus on Health Issues, which targeted male audiences, have been successful where men have gathered to express their support for reproductive health. PNG cited the inclusion of male responsibility questions in their recent National Health Survey as a means of enhancing male support in reproductive health.

In Tonga, the Family Health Department is coordinating a "Male as Partners" programme, which advocates for males taking responsibility in their own and their partners' reproductive health. In Fiji, a "Men as Partners" project, funded by New Zealand through UNFPA, provided education, counselling and clinical services for males at the Vatukoula Goldmine. As part of this project, training programmes were held for miners to educate them about gender issues and their own responsibility in reproductive health. Similar programmes have been initiated at the Fiji Military camps and with rugby organisations in Fiji. Similarly, UNFPA has supported a "Male Involvement in Reproductive Health" project initiated in the Solomon Islands to complement existing male-only clinics.

4.7 Cultural Issues and Considerations

In the Global Survey, countries were asked to respond to how the cultural context in their countries contributed to, or constrained, the promotion of gender equality and equity, and women's empowerment. Of the ten countries that responded, three countries stated that the cultural environment did not discriminate against women. Ten of the countries responded that culture contributed to the promotion of gender equality while five countries responded that culture was a constraining factor (see Table 4.6).

Table 4.6: Classification of Countries based on Global Survey Responses as to how the Cultural Context Contributed or Constrained the Promotion of Gender Equality

Contributed:	Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Niue, Palau, Samoa, Tonga, Vanuatu
Constrained:	Fiji, Solomon Islands, Tonga, PNG, Vanuatu
Both:	Fiji, Solomon Islands, Tonga, Vanuatu

In the Cook Islands, it was reported that traditional chiefly titles being held by women have contributed to women holding leadership positions in government. In Kiribati, the cultural practice of husbands and the in-laws providing the care for pregnant women was cited as a cultural practice that promotes greater male awareness of reproductive health issues as well as improved understanding of the need for joint decision-making in reproductive health matters. In Samoa, the cultural context of women as “tamatei” was cited as contributing to women's progress towards empowerment as the family is aware of her position from birth to death and is responsible for her security and protection, respecting her and fostering her empowerment. Niue cited the diminishing population as a factor that enabled women to occupy leadership positions in community and in various socio-economic and subsistence groups rather than cultural factors.

In Fiji, cultural and social taboos were cited as impediments to promoting gender equality and women's empowerment. PNG stated that men are considered superior and women are considered subordinate to men. This cultural belief has placed limitations on women's freedoms, movement, opportunities and choices and contributed to high levels of maternal mortality and morbidity. While some gains towards women's equality have been made, despite the cultural constraints, this progress has been slow. In the Solomon Islands, it was reported that being both a patriarchal and matriarchal society, cultural values have constrained promotion of gender equality and women's empowerment; although change is occurring slowly. Tonga reported that the traditional ranking of women in family and cultural situations was high, which has contributed to the promotion of women's empowerment and equal status in society. However, because land was owned primarily by men, and women's responsibilities were traditionally tied to domestic duties, the promotion of gender equality has been constrained. In Vanuatu, constraints to progress towards gender equality included the widely held concept that women were inferior to men. The socio-cultural practice that rights to lands rests on male hereditary has restricted women's land rights especially after the death of their husbands. However, because of the pressure to promote gender equity, traditional leaders are becoming more inclined to include women in various community committees/associations, and this change, in and of itself, albeit slow, is bringing about some progress within the more traditional rural settings.

4.8 Conclusion

While significant progress towards women's equality and empowerment has been made by Pacific Island Countries through the sustained action of Pacific regional networks, governments, non-governmental organisations and civil society, there remain several constraints to its full achievement.

It is well recognised that in some PICs, culture is an enabling influence to the achievement of women's empowerment through the traditional leadership roles women hold and the respect given to

mothers. However, culture also remains a major obstacle to real progress in societies where women are still considered inferior, where sexual violence is rampant, and where any discussion pertaining to sexuality and reproductive health is forbidden. Whilst efforts already taken in the Pacific, such as the ratification of conventions on women's rights and children's rights by most PICs; the emergence of relevant legislation and policies specifically aimed at empowering women and eliminating gender discrimination in all spheres of life; the implementation of information, education and advocacy campaigns; and training on gender sensitisation, are noteworthy, these are not sufficient to closing the gender gap in Pacific Island Countries. Further sustained efforts by governments and civil society, particularly in strengthening mechanisms for enhanced capacity in the areas of gender and human rights, promoting greater male responsibility in reproductive health and increasing women's involvement in administration and policy making decisions, are vital to strengthening progress towards achieving Pacific Islands societies in which women are considered equal partners in all spheres of life and are free of all forms of discrimination.

In countries that have put progressive policy and legislation into place, sufficient resources need to be allocated to fully implement the legislative and policy changes. Furthermore, despite the advancement of women's rights in some of the countries, the lives of rural and outer island women are more affected by their customary status in society; thus in order to really monitor reproductive rights or gender equality, closer analyses of advancements at the community level are necessary. At the same time, the need for a critical mass of women in parliament and in senior government policy-making positions is vital in the Pacific. Enormous strides have occurred to advance ICPD PoA and reproductive rights in the Pacific. However, further progress in the Pacific will be limited unless the difficult issues related to women's fundamental inequality are addressed.

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CHAPTER 5: PROGRESS IN THE PACIFIC IN POPULATION AND DEVELOPMENT

5.1 Introduction

The ICPD Programme of Action (PoA) addresses population and development issues at two levels: (1) the overall framework of population and development work as an integrated whole - incorporating population, reproductive health, gender and sustainable development; (2) specific actions that are aimed at incorporating population factors into sustainable development strategies and addressing such issues as environmental protection, alleviation of poverty, and broad-based improvements in the quality of life. This chapter addresses the second of these levels.

Pacific Island Countries were among the strongest supporters of the ICPD PoA and have continued to support the Programme and the principles of the ICPD over the ensuing decade. In fact, the “Port Vila Declaration on Population and Sustainable Development” (1993) that reflected the collective concerns of the sub-region (including the views of Australia and New Zealand), foreshadowed many of the recommendations adopted by the ICPD in Cairo the following year.

Pacific countries have long recognised that while many of the more developed countries of the region have favourable social indicators, and in some cases the numerical targets proposed in the ICPD PoA have already been achieved, population patterns and trends are such that government action to address population and development linkages were justified. While population growth rates have been declining, they are still relatively high in the larger Melanesian countries. Age structures show a high proportion of young people, a situation that ensures high rates of natural increase even while individual fertility is declining. Rural-urban migration continues in many countries, contributing to urban growth and changing age structures in rural areas. Urbanisation is also contributing to the growth of informal settlements and pockets of urban poverty. With declining fertility and rising life expectancy, the populations of some countries are showing signs of ageing. International migration is producing declining populations in some countries while also reducing the skills needed to bring about sustainable development. These processes, along with other changes, present an on-going challenge to development efforts in the Pacific.

The ICPD+10 Global Survey was intended to find out the extent to which countries had taken action to address the issues noted above in accordance with the recommendations of the ICPD and ICPD+5.¹ In many cases however, it was completed by staff of health ministries; thus, the responses to questions related to Population and Development were interpreted within an RH context, and as a result, activities and policies adopted by other ministries tended to be under-reported. The following analysis reports the country responses to the Global Survey - supplemented by UNFPA’s own knowledge of the situation within each country. The analysis should be considered tentative until a more precise assessment can be conducted.

5.2 Integrating Population Issues into Development Strategies

The integration of population concerns into development strategies, plans and decision-making processes is a key objective of the ICPD Programme of Action, with the ultimate goal of improving the quality of life for present and future generations. Development strategies should reflect the medium and long-term implications of population dynamics and trends. Such integration may be expected to contribute to the eradication of poverty and the achievement of sustainable development.

¹ The Pacific response to ICPD up to 1998 was assessed in 1999 at a meeting of Ministers from Pacific countries (see references). The present paper does not incorporate information from that review.

Several questions in the Global Survey questionnaire were designed to ascertain whether countries had taken any steps to integrating population in their development strategies.

Two thirds of the countries that responded stated that they had taken “strong” action to integrate population concerns into development strategies, but in many cases what was being referred to was the incorporation of reproductive health into the Health strategy or plan.

A number of countries mentioned that they had formulated a national population policy and cited this as evidence for the integration of population into development strategies. However, the existence of a national population policy is not in itself evidence of integration. It depends on what the policy says about integration in the various sectors. It is, however, evidence of national concern about population issues, and in this sense many countries had taken steps to address population and development linkages.

A reasonable conclusion is that a large majority of Pacific Island Countries have taken some action to address population somewhere in their development strategies - either a population policy, a sector plan (usually health) or in outer islands development programmes. The level of sophistication in these exercises is usually weak with little analysis or interpretation of population patterns or trends. Little apparent use has been made of population projections or future scenarios and their implications for development - particularly at sub-national level. A number of policies still retain a primary emphasis on fertility reduction or focus on the strains between population and “resources”. Few policies (Papua New Guinea’s is an exception) fully reflect the ICPD principles of a rights-based approach and a focus on individual needs and welfare.

5.3 Population and Poverty Reduction

The ICPD PoA urges governments to integrate population into development strategies not only to promote broad-based development but also as a poverty-reduction strategy. In the Global Survey, countries were asked to determine whether countries had included population factors in their poverty reduction strategies—where such strategies have been formulated.

A high proportion of countries did not respond to this question or responded inappropriately. While three quarters of the countries that did respond appropriately indicated that population was taken into account in efforts to reduce poverty, poverty in most cases was taken to mean inequality or disadvantage, particularly in terms of access to services and markets, and primarily in outer islands. These responses reflect the fact that no Pacific country presently has, or is preparing, a Poverty Reduction Strategy Paper (PRSP), and few countries engage with the World Bank to formulate these. Poverty reduction is not yet a major focus of development efforts in the Pacific. While much analytical work has been done, there is no regional consensus on what constitutes poverty in the Pacific. Without a clear idea of the forms and extent of poverty, it is difficult to formulate strategies to address it. In at least one country (Papua New Guinea), however, the goals of the National Population Policy have been incorporated into an explicit national poverty reduction strategy programme.

The links between population processes and poverty in a Pacific context have yet to be fully articulated.

5.4 Population and the Environment

The ICPD PoA also encourages the integration of population into development strategies and plans in order to promote environmentally sustainable development. This implies that the linkages between population dynamics and the consumption and production patterns of countries be understood and addressed through environmental and other sector plans. The Global Survey asked to determine the extent to which this had occurred in the Pacific.

This is a weak area as indicated by the high rate of non-response to the question. Only 5 out of 13 countries that responded indicated that they had addressed population and environment in sectoral planning. This is probably an accurate assessment. However, it contrasts with the concerns about population-environmental linkages by leaders and officials. One of the consequences of population growth that has particularly concerned Pacific governments is the impact on the environment, which is particularly fragile in those countries made up of coral atolls. In such environments, management of waste arising from production and consumption presents many difficulties, as does the management of water resources.

While population issues are given some mention in environmental management plans, the implications of population change, combined with consumption patterns and production technologies are rarely drawn out to the extent necessary. The integration of population into sector plans is much more evident in the health and education sectors, and to a lesser extent in the youth sector. One possible explanation for the low response rate to this question is that countries take the view that a national population policy removes the need for a sector-based approach.

5.5 Population Ageing

The ICPD PoA recognises the significant changes in age structure that are occurring as a joint result of decreased fertility and increased longevity. As a result of these processes, the number and proportion of elderly is increasing rapidly. The PoA encourages governments to address the social security needs of the elderly, particularly elderly women. The Global Survey was intended to find out what actions governments had in fact taken to address population ageing.

A majority of countries indicated that they had taken some initiative or a major initiative to address the growing elderly population. Most of these initiatives relate to the health sector. Several countries suggested that the elderly are adequately taken care of by extended family networks and special government initiatives are not required. But these are mainly countries in which the over 60 population constitutes less than 5 percent of the population and the median age of the population is still below 20.

5.6 Internal Migration and Urbanisation

The ICPD PoA noted that many governments have expressed dissatisfaction with the internal distribution of population within their country. In particular, the rapid rate of urbanisation that exceeded the managerial capacity of local and national governments to respond to through the expansion of infrastructure and services. While urbanisation is an inevitable concomitant to economic development, a concern was expressed that rural-urban migration reflected the inequitable distribution of resources. The relative neglect of rural areas (the so-called “urban bias” in development policies and practices) helped to “push” people to seek an alternative livelihood in urban areas.

The Global Survey asked if governments had adopted explicit policies and programmes to influence internal migration movements to help achieve a more balanced spatial population distribution.

A large majority of countries indicated that they have undertaken activities to influence internal migration. The principle aim of these initiatives is to constrain rural-urban migration and the main strategy employed is to improve services and income opportunities in outer islands. Because the lack of education facilities in outer islands is a major reason for migration to urban centres, several governments have established high schools in locations where the number of students would not otherwise justify them and where it may be difficult to recruit teachers. The improvement of health services and the provision of sports facilities for youth are among the other strategies applied. Most governments in the region wish to retain socially viable communities in outer islands, but efforts to retain populations in remote areas have generally not been successful. Many of the programmes initiated by Pacific countries pre-date ICPD.

5.7 Urban Poverty

Related to the issue of rural-urban migration are the living conditions of the urban poor, many of whom are recent migrants. Governments are urged by the ICPD PoA to ensure that the urban poor have access to employment, credit, and basic social services, including reproductive health services.

The Global Survey asked governments to describe any steps they had taken to ensure that inhabitants of “slum settlements” had access to reproductive health information and services.

Most countries indicated that they had taken action to ensure that all areas in their country had access to reproductive health information and services, but qualified their answer by noting that their country does not have “slum” settlements. Most countries meant that they are taking steps to provide access to RH information and services in disadvantaged areas (such as outer islands) rather than “slums” as such. In countries where urban settlements *are* common (such as Fiji and PNG), the actual measures taken are vaguely described. It is therefore likely that little specific action has been taken to address the needs of such areas.

5.8 International Migration

International migration has reached an unprecedented scale, with large flows from the less to the more developed countries. The ICPD PoA recommends that governments of both receiving and sending countries should cooperate to ensure that the potential benefits of international migration are equitably distributed.

The Global Survey asked countries to indicate what measures they had taken to influence international migration patterns of any kind (inward, outward, legal, illegal, involuntary)

The majority of countries understood this question to be asking whether they had placed any restrictions on emigration, and the answer universally is no. Pacific countries consider the international migration (emigration) of their own citizens to be a basic right and don't attempt to influence outflow, even if they are concerned about its implications. Where governments have attempted to influence migration flows it is most likely that they have sought easier entry in Pacific Rim countries for their citizens. The outflow of skilled labour is a concern, but not to the extent that governments would attempt to curtail emigration, even if they had the means to do so.

5.9 Decentralisation

The decentralisation of political authority and responsibility to lower levels of government in order to promote local development is recognised as an effective development strategy in many countries. However, this implies that population factors would also need to be addressed at this level as well.

The Global Survey asked countries to indicate the extent to which they had taken population factors into account in local-level planning.

Most countries interpreted this question in terms of reproductive health rather than broader aspects of population (such as age structure or population distribution). Most countries in the region are too small to have much local level planning, and where local level planning is carried out (e.g. PNG) there are insufficient skills to integrate population or to do much local planning. Decentralisation has occurred in the larger countries (particularly Papua New Guinea and Solomon Islands), but planning skills are extremely limited. The integration of population into local planning requires substantial guidance from central planning authorities. UNFPA has supported efforts in Papua New Guinea but they are rarely sustainable below the level of a province.

5.10 Summary and Conclusions

Pacific countries remain highly supportive of the ICPD PoA but progress in implementing its recommendations has varied across the region. Most Pacific countries have taken significant steps toward the implementation of the recommendations of the ICPD PoA in the area of Population and Development, but weaknesses are apparent and many challenges remain. The rising trend of life expectancy throughout the region, with some UNFPA programme countries achieving female life expectancy above 70 years, is evidence that the broad quality of life is improving, particularly in the Polynesian and Micronesian sub-regions. However, significant obstacles to improving the quality of life face the less developed Melanesian countries of the Western Pacific where mortality remains high as a result of persisting infectious disease (malaria and TB in particular). While the primary focus of population programmes in the region during the decade since ICPD has been on reproductive health, a number of countries, including some of the larger ones (PNG and Solomon Islands) have developed multi-sectoral population policies based on the principles of ICPD. Other countries have taken steps to prepare population policies but have fallen short of reaching the stage of implementation. Little monitoring and evaluation of these policies has occurred and their practical value is questioned by some observers.

Less progress is evident in the integration of population into sector plans and strategies. While most countries have integrated reproductive health into their health strategies and plans, few have taken similar steps in education, youth, labour force, environment, or poverty reduction. Linkages between poverty and population dynamics remain poorly understood in the Pacific and poverty reduction as a development strategy is in its early stages.

The main challenge in the Pacific in the Population and Development area is building and/or sustaining national capacity to implement the ICPD PoA during the next decade. National self-sufficiency is difficult to achieve in such small countries with a limited supply of specialised expertise and few economies of scale in human resources development. Most countries are now capable of conducting a population census without substantial external support, but the capacity to process data and analyse and interpret census and survey results from a policy perspective remains limited. Regional institutions need to play a greater role and efforts to strengthen and support them will continue to be justified for some time to come.

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ANNEX 1: SELECTED INDICATORS FOR PACIFIC ISLANDS POPULATION CA 2000

Sub-regions/ Countries	ESTIMATED POPULATION 2004 (1)	PERCENT DISTRIBUTION (2)	POPULATION GROWTH RATE (%) (3)	PROJECTED POPULATION 2015 (4)	RATE OF NATURAL INCREASE (%) (5)	NET MIGRATION RATE (6)	TOTAL FERTILITY RATE (7)	TEENAGE FERTILITY RATE (15-19) (8)	INFANT MORTALITY RATE (9)	LIFE EXPECTANCY AT BIRTH		
										MALE (10)	FEMALE (11)	DIFFERENCE (F-M) (12)
MELANESIA	7,444,100	86.3	2.2	9,298,000	2.2	0.0	4.3	68	56.5	56.2	57.9	1.7
Fiji	836,000	9.7	0.8	891,100	1.7	-0.9	2.7	54	22.0	64.5	68.7	4.2
New Caledonia	236,900	2.7	2.6	292,600	1.4	1.2	2.4	24	6.9	69.9	77.6	7.7
PNG	5,695,300	66.1	2.3	7,236,200	2.3	0.0	4.6	70	64.0	53.7	54.8	1.1
Solomon Islands	460,100	5.3	2.8	588,700	2.7	0.1	4.8	72	66.0	60.6	61.6	1.0
Vanuatu	215,800	2.5	2.6	289,400	2.7	-0.1	4.8	92	27.0	65.6	69.0	3.4
MICRONESIA	541,300	6.3	1.5	655,100	2.1	-0.6	3.5	64	24.8	68.5	73.2	4.7
FSM	112,700	1.3	0.2	129,000	2.3	-2.1	4.1	51	40.0	66.6	67.5	0.9
Guam	166,100	1.9	1.5	193,800	1.7	-0.2	2.9	56	9.0	74.5	80.8	6.3
Kiribati	93,100	1.1	1.7	119,700	2.6	-0.9	4.3	71	44.0	61.2	66.9	5.7
Marshall Islands	55,400	0.6	1.4	66,100	3.7	-2.3	5.7	94	37.0	65.7	69.4	3.7
Nauru	10,100	0.1	0.3	11,300	2.3	-2.0	4	93	42.3	52.5	58.2	5.7
Northern Mariana Islands	78,000	0.9	3.3	109,300	1.9	1.4	1.6	64	5.0	72.5	77.8	5.3
Palau	25,900	0.3	2.1	25,900	1.3	0.8	2.5	63	17.0	65.5	71.9	6.4
POLYNESIA	635,750	7.4	1.1	723,050	2.1	-1.0	3.5	47	13.5	69.6	73.5	3.9
American Samoa	62,600	0.7	2.0	78,000	2.6	-0.6	4	56	8.5	69.0	76.0	7.0
Cook Islands	14,000	0.2	-3.7	12,100	1.5	-5.2	2.9	68	21.0	68.0	74.3	6.3
French Polynesia	250,500	2.9	1.8	307,200	1.5	0.3	2.4	59	6.9	69.2	74.1	4.9
Niue	1,600	0.0	-3.9	1,200	1.1	-5.0	3	35	29.4	66.8	71.2	4.4
Pitcairn Is	50	0.0	0.0	50	-	-	-	-	-	-	-	-
Samoa	182,700	2.1	0.9	201,900	2.7	-1.8	4.6	45	19.1	71.7	74.2	2.5
Tokelau	1,500	0.0	0.4	1,500	2.4	-2.0	4.8	45	33.0	68.4	71.3	2.9
Tonga	98,300	1.1	0.3	95,400	2.3	-2.0	4.1	17	19.0	69.8	71.8	2.0
Tuvalu	9,600	0.1	0.5	10,000	1.7	-1.2	3.8	36	34.0	62.4	64.7	2.3
Wallis and Futuna	14,900	0.2	0.8	15,700	1.4	-0.6	2.7	10	13.8	57.9	59.5	1.6
TOTAL	8,621,150	100.0	2.1	10,676,150	2.2	-0.1	4.2	66	51.3	58.0	60.0	2.0

Data sources: SPC Population Data Sheet, 2004. Note: Regional and Sub-regional estimates contained in columns 5-12 are the sole responsibility of UNFPA.

*Mortality and fertility figures range across the period 1995-2003, depending on the country. The mean reference date weighted by population size at the regional level is approximately 1999

- = Not available or not applicable



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