Current Status of Sexual and Reproductive Health: Prospects for Achieving the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals in the Pacific

Repositioning family planning as an integral development strategy for poverty reduction and as a mechanism for achieving fundamental reproductive rights needs to be acknowledged at the highest political level.

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The paradigm shift in population and development that occurred at the International Conference on Population and Development (ICPD) in Cairo, in 1994, from reduction in population growth for socio-economic progress to

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ensuring sexual and reproductive health and rights as a fundamental human right and as a means for improving the quality of life, has also become apparent in the Pacific. The Millennium Development Goals (MDGs) provide the current global framework for development efforts and were formally endorsed in 2000 by 189 countries, including Pacific island countries. The importance of sexual and reproductive health was not fully articulated during the formulation of the MDGs as an explicit goal. However, during the World Summit convened in 2005, world leaders endorsed the fundamental human right of "universal access to sexual and reproductive health services" – an additional target to the MDG 5, as a result of intense lobbying by sexual and reproductive health advocates, including the Prime Minister of Tuvalu. The full integration of the MDGs into national sustainable development strategies and plans outlining an allocation of a certain percentage of the national budgets to poverty reduction is requiring a lengthy internalization and implementation process for many Pacific island countries. Part of the challenge for many of those countries has been the relevance of the poverty definition and the prevailing perception by some country leaders that "poverty of opportunity" is the more fundamental issue.

The core components of the essential package of sexual and reproductive health care include antenatal, perinatal, postpartum and newborn care; high quality family planning information and contraceptives; prevention and treatment of sexually transmitted infections (STIs), including HIV, reproductive tract infections and cervical cancer; elimination of unsafe abortion; prevention of sexual violence and the promotion of healthy sexuality (Glasier and others, 2006b). Underpinning the provision of this essential package is the recognition that services provided will be especially focused on marginalized or most at risk populations, such as unemployed young people, people living on outer islands or in peri-urban settlements, seafarers and sex workers. This integrated essential package is especially important for the prevention of maternal deaths, unintended pregnancies and STIs, including HIV infections. While it is widely recognized that sexual and reproductive health (SRH) is embodied within MDGs 4, 5 and 6, SRH is a fundamental cross-cutting issue that contributes to the achievement of all MDGs and thus poverty reduction (Langer, 2006).

The sociocultural and demographic heterogeneity of Pacific island countries and territories, whose populations range from 6.3 million in Papua New Guinea to 1,200 people in Niue, adds to the complexity of monitoring progress towards achieving the MDGs in the Pacific. The difficulty of determining whether valid data exist for relevant indicators and the ambiguity of interpretation of certain indicators and targets within the context of very small populations poses

significant challenges to monitoring progress towards the achievement of the MDGs. Furthermore, the reporting of summary statements with average figures does not adequately capture the disparities that exist across socio-economic groups, rural/urban groups or main island versus outer islands. To further complicate the issue, there is no single set of SRH indicators that would appear appropriate for the Pacific; the relatively conservative sociocultural setting poses some problems to the measurement of sexual behaviour; routine health information systems do not capture the needed community-based data; and national demographic health surveys have not been previously undertaken in many countries in the region. In addition, information on access to care is largely unavailable for the region. The status of sexual and reproductive health and prospects for achieving the MDGs, as outlined in this article, was written bearing in mind these aforementioned constraints.

Maternal health

Improving maternal health is outlined in both the ICPD Programme of Action and the MDGs framework. The MDG target is to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015, which is similar to the ICPD goal of reducing the MMR by 50 per cent between 1990 and 2000 and a further 50 per cent between 2000 and 2015. However, with the exception of Papua New Guinea, the difficulty in measuring maternal health and tracking trends of maternal mortality in Pacific island countries and territories, whose populations are less than a million, is largely owing to the statistical instability and random fluctuation of indicators of maternal mortality for small populations with rare events. It would seem in the absence of any other measure of maternal mortality that the actual number of maternal deaths or multi-year moving averages of maternal mortality ratio would be more appropriate than single year maternal mortality ratio figures. An aggregate indicator of maternal mortality that takes into consideration maternal deaths, near misses, perinatal/neonatal mortality and relevant process indicators should be seriously considered as a substitute for the MMR especially for the Pacific setting.

In table 1, the maternal mortality ratios and percentage of births by skilled health attendants for selected countries for the time frames 1990-2005 is summarized.

Since wide fluctuations of MMR occur when single-year values are reported, it is therefore more appropriate to use three-five moving averages of MMR. Figure 1 reveals three-year moving averages of MMR for selected countries.

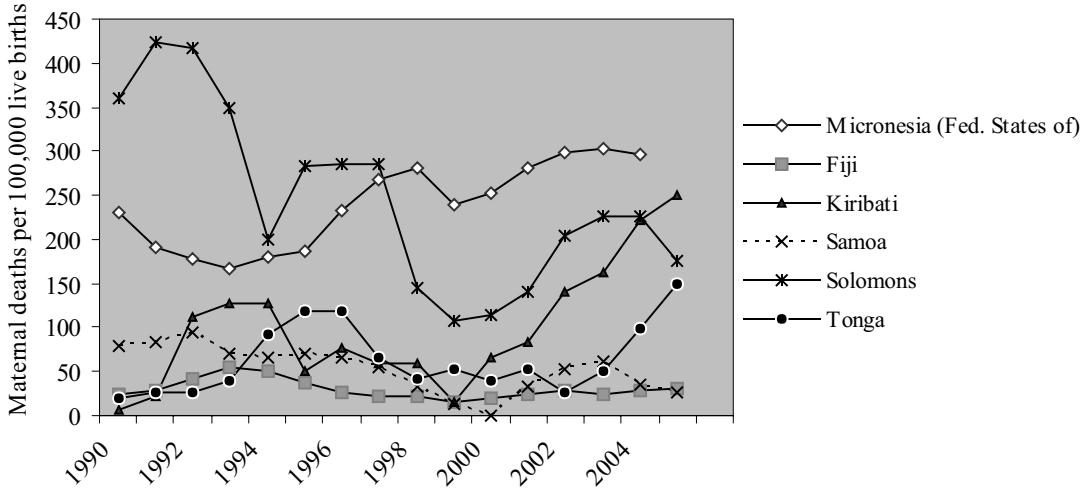
Table 1. Reported maternal mortality ratios and percentage of births by skilled health attendants for selected Pacific island countries, 1990-2005

	Maternal mortality ratio		Percentage of births by skilled birth attendants	
	Circa 1990 (reference year)	Circa 2005 (reference year)	Circa 1990	Circa 2005
Fiji	41 (1988)	38 (2005)	98	99
Kiribati	225 (1995)	284 (2005)	60	63
Micronesia (Federated States of)	213 (1990)	317 (2004)	90	88
Papua New Guinea	370 (1990)	330 (2005)	33	41
Samoa	140 (1991)	22 (2005)	76	89
Solomon Islands	550 (1992)	142 (2006)	85.4	86
Tonga	40 (1990)	113 (2006)	94	96
Vanuatu	89 (1992)	105 (2005)	79	93

Source: Pacific MDG Report (2004); NSOs & MOHs (2004-2006); UNFPA (2007a).

Note:Tuvalu 1 death 2005, Palau last death 1995, Cook Islands last death 1995.

Figure 1. Maternal mortality ratios (using three-year moving averages) for selected Pacific island countries, 1990-2005



Sources: UNFPA (2006); SPC (2006); MOH Annual Reports (1990-2006).

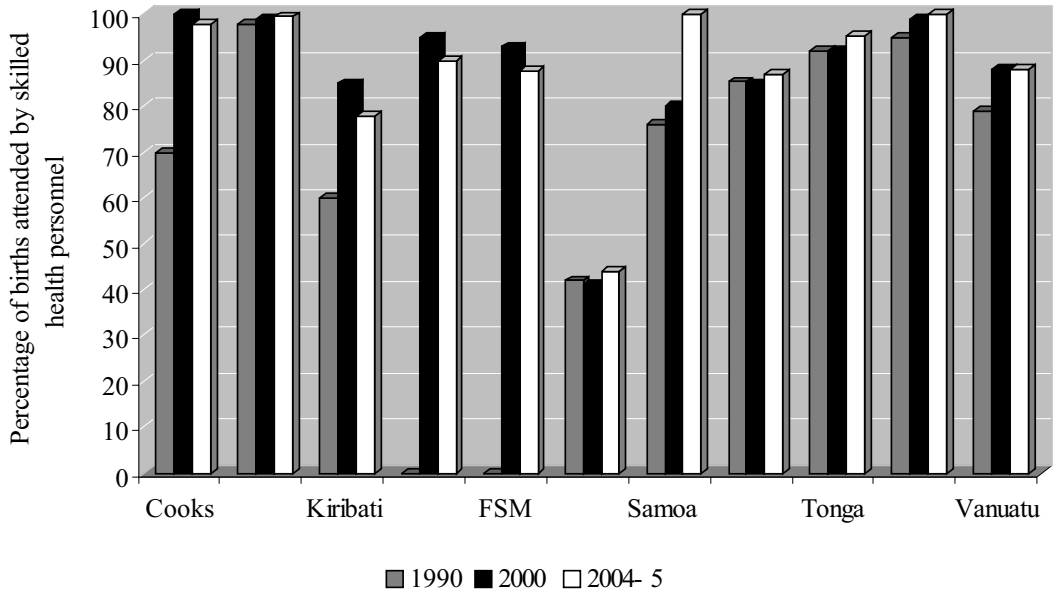
In spite of these limitations and also when reflecting on absolute number of maternal deaths, some conclusions can be drawn. For Papua New Guinea and Solomon Islands, Melanesian countries with initially high MMRs, some decrease in maternal mortality over the 15-year period under review is evident. However, the figures for Papua New Guinea should be interpreted with some caution as they are indirect estimates from mortality probabilities (SPC, 2005). While the Regional MDG report of 2005 states that Solomon Island figures may be an underestimate, a recent emergency obstetric care facility-based survey confirmed a lower number of maternal deaths in 2006 (UNFPA, 2007b). With the current trend, it would appear that Solomon Islands may be on track to meeting its MDGs target. For the rest of the Pacific, there are several countries in which relatively high numbers of maternal deaths continue to be of concern and it is unlikely that Papua New Guinea, the Federated States of Micronesia and Kiribati will reach their MDG target for 2015 if relevant interventions are not strengthened.

Countries in the region with consistently low MMR and low absolute numbers of maternal deaths include Fiji, Samoa and Tonga (with the exception of 2005 when there were six deaths which differed from the usual 0-2 deaths that have occurred since 1996). The estimate of the MMR for Vanuatu is similarly based on low numbers (two deaths). For countries and areas in which the MMR is particularly inappropriate as an indicator of maternal health, such as in the Cook Islands, Niue and Palau, there has not been a maternal death since 1995. In Marshall Islands and Tuvalu, there were no maternal deaths reported during 2005 and 2006. The difficulty in analysing progress towards achieving MDG Goal 5 in the Pacific and the need to take into account multi-year averages is also echoed in two papers in this special issue of the *Asia-Pacific Population Journal* (Hayes, 2007a; Haberkorn, 2007).

Among Pacific countries in which maternal death remains a major issue, leading causes of maternal deaths include postpartum haemorrhage, pre-eclampsia, obstructed labour, puerperal sepsis, and complications of unsafe abortion. In Fiji, the major causes of maternal deaths have been a result of heart disease and thrombo-embolic phenomena.

With the exception of Papua New Guinea and Kiribati, all countries in the Pacific report percentages of births by skilled health attendants exceeding 85 per cent in 2005. Palau, Niue and Tuvalu report that 100 per cent of all births are attended by skilled health attendants (SPC, 2005). Between 1990 and 2005, small increases in the percentage of births by skilled health attendants are evident across the region, with the exception of the Federated States of Micronesia, the Marshall Islands and Kiribati (see figure 2).

Figure 2. Percentage of deliveries by skilled birth attendants, 1990-2005, in selected Pacific island countries



Sources: PRISM (2006); NSOs & MOHs (1990-2005); UNFPA (2006).

However, interpretations should be made cautiously as there are inconsistencies in the definitions of skilled birth attendant in some Pacific island countries. There is some evidence to suggest that WHO's definition of what constitutes a skilled birth attendant is not being adhered to for calculation of this indicator. Nonetheless, it would appear that the majority of countries have reached or will reach their MDG/ICPD target by 2015 for this indicator that poses as a proxy determinant of maternal health.

Correlations suggest strong negative correlations between MMR and percentage of births by skilled health attendants. As would be expected, strong positive correlations are observed between infant mortality rates and MMR as well as high teenage fertility rates and MMR. Countries with relatively high infant mortality rates (exceeding 40 per 1,000 live births) are the countries in which maternal deaths are of concern: Papua New Guinea, Solomon Islands, Kiribati and the Federated States of Micronesia. However, unlike for MMR, all countries in the region have seen decreases in infant mortality rates since 1990 and the majority (except Papua New Guinea) have reached the 2005 ICPD target of 50 per 1,000 live births or one third of the 1990 rate (Hayes, 2007a).

While unsafe abortion also contributes to maternal mortality, reliable information on unsafe abortion in the Pacific is not available.

Family planning and unmet need for contraception

While family planning was considered a central tenet of sexual and reproductive health and rights in the ICPD Programme of Action, family planning programmes were given lower priority in the period following 1994 globally, as well as in the Pacific. The lack of political commitment, subsequent to the 1990s, was due to a failure to recognize universal access to contraceptive information and services as an explicit strategy for poverty reduction and as a fundamental reproductive right, at a time when religious and political conservatism, especially related to adolescent sexuality, were re-emerging (Cleland and others, 2006). These influences, besides donor fatigue and competition for limited resources for HIV prevention, resulted in fewer resources being made available for family planning programmes. As a result, family planning was overlooked during the formulation of the Millennium Development Goals even though it should have been recognized as one of the main strategies for poverty reduction and a means of facilitating women's empowerment, especially in countries with high fertility rates. Contraceptive prevalence rate (CPR) was included as an indicator under Goal 6 of combating HIV/AIDS, malaria and other diseases but not under Goal 5 of improving maternal health (Freedman, 2003). Unmet need for contraception was not included as an indicator for determining the extent to which SRH has been attained.

In the Pacific, family planning programmes were initiated in the 1960s in an attempt to enhance socio-economic development through population reduction as well as to improve women's and children's health (House and Katoanga, 1999). However, the diminishing emphasis of family planning in the Pacific paralleled its global waning in the 1990s despite the fact that many Pacific island countries had some of the highest total fertility rates in the world, as well as highest population densities such as in Ebeye in RMI. Culturally, Pacific islanders have had a preference for larger families believing that it is an investment which will enrich them later in life, through the larger number of children contributing to their socio-economic welfare (House, 2002). However, while many Pacific leaders believe only poverty of opportunity exists, there is evidence of growing overt poverty in many urban and outer island or rural areas.

In the Cook Islands and Niue, owing to negative population growth resulting from emigration to New Zealand and other countries, Governments have preferred to invest in repopulation strategies rather than family planning.

While the preferred criterion for determining how successful family planning programmes have been unmet need for contraception – proportion of married, fecund women who wish to avoid further childbearing or postpone having a child for two years and are not currently using contraception – few countries in the

Pacific possess any measurements of this indicator. Demographic Health Surveys (DHSs) and Reproductive Health Surveys (RHSs) have not been a tradition in the Pacific, which is very unlike other regions in the world. Prior to 2006, only two countries in the Pacific (Papua New Guinea and Samoa) had had a DHS conducted previously, while the Cook Islands had a RHS, bringing to only three the number of countries which have had measures of unmet need for contraception. By now, with the pressing need to measure the impact on socio-economic progress of demographic and health indicators, only three countries have conducted a DHS: Solomon Islands, the Marshall Islands and Tuvalu. There is an urgent need for all countries in the Pacific to conduct a DHS or a similar survey. In the absence of information on unmet need, contraceptive prevalence rate is used to determine the extent to which couples or women are trying to limit the number of children and control the timing of their pregnancies by using contraception.

In table 2, the contraceptive prevalence rates, total fertility rates (TFR) and adolescent fertility rates are compared and contrasted for selected countries.

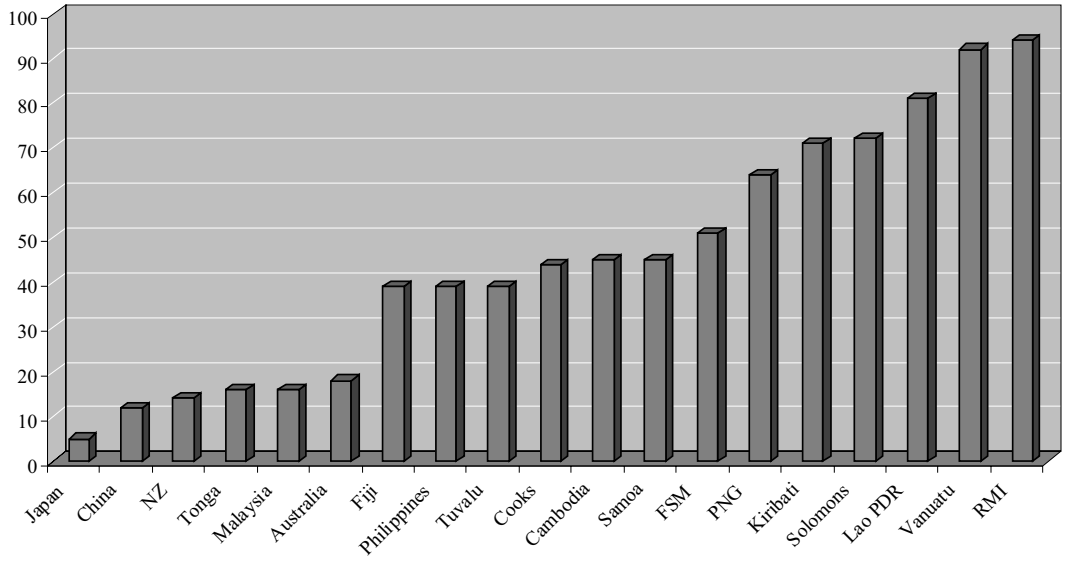
Table 2. Total fertility rate, age-specific fertility rate (15-19 years) and contraceptive prevalence rate in selected Pacific island countries, 1990-2005

	Total fertility rate		Age-specific fertility rate (15-19) (per 1,000 women)		Contraceptive prevalence rate (percentage)	
	Circa 1990	Circa 2005	Circa 1990	Circa 2005	Circa 1990	Circa 2005
Cook Islands	3.7	2.9	83.0	44.0	45.8	43.8
Fiji	2.9	2.7	65.0	39.0	31.0	35.5
Kiribati	4.5	3.5	51.0	71.0	17.4	22.1
Marshall Islands	6.9	4.5		94.0	30.6	42.0
Micronesia (Federated Sates of)	4.1	3.8	68.0	51.0	40.0	49.0
Samoa	...	4.6	22.0	45.0	18.0	31.0
Solomon Islands	4.8	...	101.0	69.0	10.6	10.0
Tonga	4.1	3.8	28.0	16.0	32.8	19.7
Tuvalu	3.4	3.7	30.0	39.0	39.0	31.6
Vanuatu	4.8	...	...	92.0	15.0	28.0

Sources: Pacific MDG Report (2004); MOH (2000-2005) and UNFPA Survey (2005-2007).

It is evident that for some countries which had particularly high levels of fertility (TFR >3), contraceptive prevalence rates were generally below 30 per cent in 2005 (Kiribati, Solomon Islands, Tonga and Vanuatu). To complicate any assessment of trends, it appears that under-reporting of contraceptive use may be occurring in some countries where significant declines in TFRs have occurred without concomitant increases in CPR. Women accessing contraceptives from private pharmacies, private practitioners and non-governmental organizations are often not routinely captured by the data compiled by the various ministries of health, on contraceptive prevalence rate. Validation of the CPR, especially by age, is urgently needed in most Pacific island countries. While measures of unmet need are not available for most of the Pacific, teenage fertility rates may serve as a proxy for unmet need in that age group. High teenage fertility rates in the Marshall Islands, Vanuatu, Kiribati, the Solomon Islands and the Federated States of Micronesia along with high total fertility rates suggest that unmet need among teenage girls in these countries may indeed be very high. Based on figure 3, it is evident that the Marshall Islands, Vanuatu, Kiribati and the Solomon Islands have among the highest teenage fertility rates in the world. This is particularly worrisome as approximately 60 per cent of the population is aged less than 25 in these countries and evidence is emerging that unsafe sexual behaviour among young people is highly prevalent in these countries (WHO, 2006).

Figure 3. Age-specific fertility rates (15-19 years) in selected countries of East Asia and the Pacific, 2004



Sources: SPC (2005); UNFPA (2006); Selected PICs' MOH Annual Reports (2005).

The proposed ICPD targets relate to narrowing the gap between the proportion of contraceptive use and the desire to space or limit one's children by approximately 50 per cent by 2005 and 75 per cent by 2010. In the absence of data on unmet need and considering that the CPR may be under-reported, one can only surmise that none of the countries in the Pacific come close to reaching any potential targets of satisfying unmet need. In four countries (Cook Islands, Solomon Islands, Tonga, Tuvalu), the contraceptive prevalence rates appear to have decreased, while in other countries they have remained stagnant or increased very slightly (UNFPA, 2007a). In countries that have shown a slight increase over time, two countries remain below 30 per cent (Kiribati and Vanuatu). The need to measure unmet need for contraception and validate the CPR in Pacific island countries, through DHS or related surveys, should be considered of utmost urgency for determining the status of sexual and reproductive health of the population as well as women's reproductive rights and empowerment.

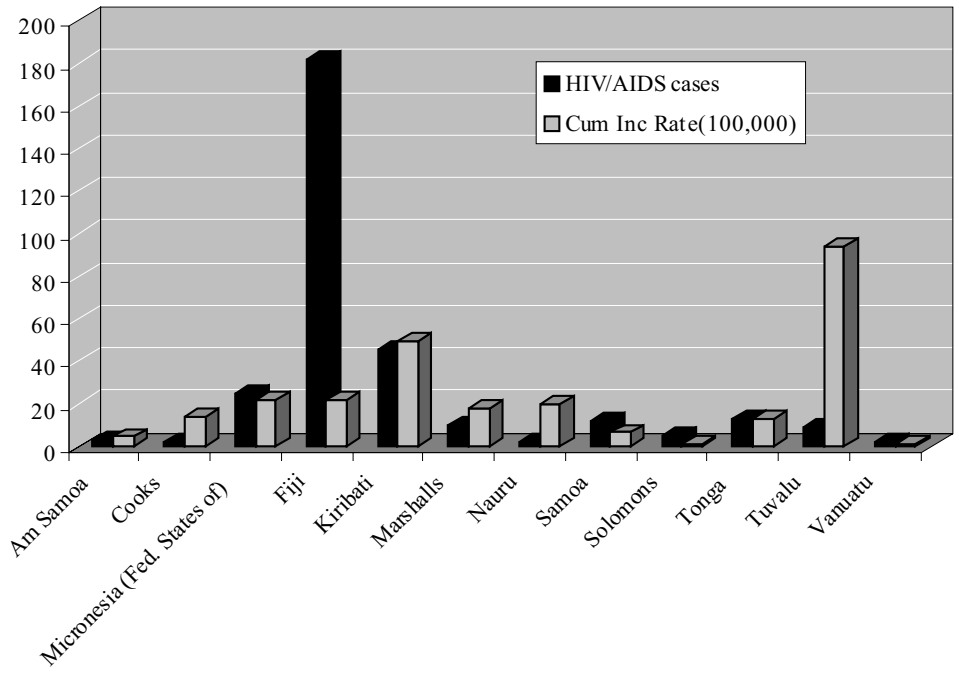
HIV and sexually transmitted infections

Goal 6 of the Millennium Development Goals, "Combat HIV/AIDS, malaria and other diseases", has six indicators that relate to HIV, three of which will be presented in this section. Limited data is available in the Pacific on HIV prevalence in the age group 15-24 or among pregnant women aged 15-24 years (SPC, 2005). While second generation surveillance studies have been undertaken in several Pacific island countries, pilot HIV surveillance and testing among pregnant women aged 15-24 years have yielded no new cases. To provide an idea of the status of HIV in the Pacific, the cumulative incidence of HIV cases and number of HIV cases in countries is illustrated in figure 4. The cumulative incidence (178 per 100,000) for Papua New Guinea is the highest in the Pacific and presents a generalized epidemic pattern – 1.6 per cent prevalence in the adult population (aged 15-49 years). Surveillance studies of antenatal women in Papua New Guinea reveal that the percentage of pregnant women that were HIV positive varied from 0 to 16.3 per cent in 2006 (National Aids Council, Papua New Guinea, 2007). The demographic impact of the HIV epidemic in this country has been discussed in an article published by Hayes in this issue of the *Asia-Pacific Population Journal*. It is estimated that by 2012 the prevalence of HIV will be 5 per cent in Papua New Guinea (Hayes, 2007b).

In the rest of the Pacific, while the absolute number of HIV cases is highest in Fiji, the cumulative incidence is highest in Kiribati and Tuvalu (exceeding 40 per 100,000 people). The current HIV situation in Kiribati and Tuvalu has largely been due to the importation of HIV by seafarers subsequent to their return from travels to

Asian countries and spreading it then to their families. In the Pacific, the mode of transmission of HIV has been predominantly heterosexual, while there is some evidence that perinatal transmission may be increasing in some countries.

Figure 4. Number of HIV cases and cumulative incidence of HIV cases in selected Pacific island countries, 2005



Source: SPC (2005).

Note: Papua New Guinea: 10,178 cases, cumulative incidence 178.8 per 100,000.

In table 3, results of the second generation surveillance studies (SGS) in six Pacific island countries are depicted for condom use at last high-risk sexual intercourse and percentage of population aged 15-24 with comprehensive and correct knowledge of HIV (WHO, 2006). It can be seen that low levels of condom use and low levels of comprehensive and correct knowledge about HIV exist in selected population groups in Fiji and Samoa. In Kiribati, the Solomon Islands and Vanuatu, there appears to be higher practice of condom use and awareness of HIV transmission, as a result of targeted on-going prevention activities.

Evidence suggests that there are high rates of STIs among Pacific island populations. Second generation surveillance studies revealed that the prevalence of chlamydia amongst pregnant women ranged from 6.4 per cent in the Solomon Islands to 29 per cent in Fiji (WHO, 2006). Of the six countries in which the study was undertaken, chlamydia prevalence among less than 25 year old pregnant women was

20 per cent or above in five countries (Fiji, Kiribati, Samoa, Tonga and Vanuatu). In Fiji and Samoa, chlamydia prevalence was higher than 30 per cent among women aged less than 25; rates that would be considered among the highest in the world.

Table 3. Indicators for high-risk sexual behaviour and condom use among at-risk population in selected Pacific island countries, 2005

	Fiji (n=303)	Kiribati (n=199)	Samoa (n=300)	Solomon Islands (n=374)	Vanuatu (n=326)
Condom use at last high risk intercourse – commercial	7.7	38.2	7.1	41.9	53.5
Condom use at last high risk intercourse – non-commercial	12.5	32.7	14.0	45.1	37.3
Percentage of population aged 15-24 years with comprehensive and correct knowledge of HIV	...	...	14.3	41.7	25.8

Source: WHO (2006).

Given the apparently high levels of unprotected sex, high prevalence of STIs, lack of knowledge about the disease and lack of adequate surveillance of HIV and STIs in many Pacific island countries, it is highly likely that halting or reversing the spread of HIV will only occur in countries, excluding Papua New Guinea, if effective interventions are strengthened among the population. In Papua New Guinea, the HIV situation is dire and it is unlikely that this country will achieve all of its goals and targets related to sexual and reproductive health and HIV by 2015. If SRH is to be realized in the Pacific, it is essential that the prevention and treatment of STIs, including HIV, is paramount among health promotion strategies targeting most at-risk populations.

Achievements

Although countries and territories in the Pacific have integrated reproductive health into primary health care, even prior to the ICPD in 1994, the quality of information and services in SRH care is in need of continued improvement. Some countries have adopted legislations/policies advancing reproductive rights but clearly there is need for further action. Pacific island countries have taken key measures to increase access to quality RH services through training and increased staffing, increased number of service delivery points and introduction of evidence-based guidelines in SRH, including family planning. In the Pacific ICPD +10 survey conducted by UNFPA, many countries reported taking action for promoting safe motherhood, such as improving antenatal care coverage, increasing percentage of

skilled birth attendants and instituting decentralized emergency obstetrics care (Robertson and Hayes, 2005). While many countries in the Pacific have expanded the choice of contraceptives, with implants and emergency contraceptives made available, access to these contraceptives for teenagers remains unsatisfactory.

Way forward

The need to advocate at the highest level for a strategic approach to SRH, including family planning and HIV, remains a challenge for most countries in the Pacific. Mobilizing governmental institutions, development partners, non-governmental organizations, professional associations and the private sector to harness their support to invest in SRH, family planning and STI/HIV services and to ensure reproductive health commodity security in the region should be considered a development priority. In most Pacific island countries, national reproductive health policies and/or strategies need to be updated or developed. Repositioning family planning as an integral development strategy for poverty reduction and as a mechanism for achieving fundamental reproductive rights needs to be acknowledged at the highest political level. While incorporation of SRH, including family planning and HIV, in national and subnational development plans has been achieved in most countries in the Pacific, the extent to which it has translated into national implementation strategies is unclear. There is an urgent need to promote access for all women and men, especially young people, living in rural areas and outer islands and disadvantaged or marginalized groups, to a full range of SRH information, family planning services and commodities. Strengthening national institutional capacity to identify and implement linkages for SRH and HIV has been discussed and strategies are currently being developed to better address this, including through pre- and in-service training in family planning and HIV counseling and testing. While four countries have updated their national family planning evidence-based guidelines (Federated States of Micronesia, the Solomon Islands, Tonga and Vanuatu), current family planning programmes in most countries should be strengthened. STI guidelines in the majority of countries need to be updated to reflect current epidemiological and drug-sensitivity patterns and available antibiotics. Obstetrical protocols in many countries have been introduced but there is a need to ensure that all service providers utilize those protocols and that women have access to quality comprehensive and basic emergency obstetrics care. There is also a need for targeted and sustained behavioural change communication campaigns in SRH, particularly in obstetrical care, family planning, STI and HIV prevention in groups most at risk. Concerted national efforts need to be made to strengthen SRH, including through repositioning family planning and upscaling STI/HIV programmes, and to address deeply-rooted gender-based inequities in order to achieve the Millennium

Development Goals and the Programme of Action of the International Conference on Population and Development in the Pacific.

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