WHO Country Cooperation Strategy for the South Pacific

2006 - 2011

TABLE OF CONTENTS

Foreword

The World Health Organization (WHO) has developed this Country Cooperation Strategy (CCS) to provide a strategic overview for improving health in the South Pacific region for the period 2006 – 2011.

This strategy is the result of careful planning and cooperation between WHO and the respective countries and areas, and we deeply appreciate the significant inputs of governments in the region, particularly ministries of health, as well as our partner organizations.

The size and scope of the Pacific islands covered by the Office has meant a diverse range of health challenges are being faced in the region. Small populations, remote locations, vulnerability to disaster and a rise in noncommunicable diseases are just some of the health challenges that WHO has been working with governments to help overcome and will continue to do in the future.

These health challenges will only be met with a comprehensive, clear strategy for the future and by working in partnership with governments, NGOs and other development organizations.

This strategy sets out the following strategic priorities WHO is working toward to contribute to sustainable health development in the region: (1) Reducing risk factors to human health arising from the environment, including natural and manmade hazards; (2) Strengthening public health and enabling equitable access to a primary health care-based health system providing good quality services, with particular attention given to the needs of people in the outer islands; (3) Reducing morbidity, mortality and disability in priority health areas including elimination of selected diseases; and (4) Supporting public health leadership and nurturing partnerships.

WHO remains deeply committed to ensuring that the strategy and plans outlined within the CCS are implemented effectively by continuing to provide the highest standard of technical support. We are confident that implementation of the strategy will contribute to lasting positive health outcomes for all the Pacific island countries and areas.

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Director, Pacific Technical Support Division

Acknowledgement

We greatly acknowledge the significant contributions of the governments of the Republic of Fiji, French Polynesia, Republic of Kiribati, Republic of Marshall Islands, Federated States of Micronesia, New Caledonia, New Zealand, Commonwealth of the Northern Mariana Islands, Republic of Nauru, Republic of Palau, Solomon Islands, Kingdom of Tonga, Tuvalu, Vanuatu and Wallis and Futuna. We particularly acknowledge the contributions of the Ministries and Departments of Health, other government organizations, United Nations agencies, multilateral and bilateral agencies and nongovernmental organizations in these countries in the development of this County Cooperation Strategy. We would also like to thank WHO staff at the country offices, the South Pacific office, Regional Office and Headquarters for giving valuable inputs and advice.

LIST OF FIGURES AND TABLES

LIST OF ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired immune deficiency syndrome
AusAID	Australian Agency for International Development
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
DOTS	Directly observed treatment, short-course
EC	European Commission
EPHF	Essential public health function
EPI	Expanded Programme on Immunization
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCTC	WHO Framework Convention on Tobacco Control
FPS	Fiji Pharmaceutical Services
FSMed	Fiji School of Medicine
FSN	Fiji School of Nursing
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross national product
HIV	Human immunodeficiency virus
ICP	Intercountry programme
IHR	International Health Regulations
JICA	Japan International Cooperation Agency
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
NCD	Noncommunicable disease
NGO	Nongovernmental organization
NZAID	New Zealand Agency for International Development
ODA	Overseas development assistance
PacELF	Pacific Programme to Eliminate Lymphatic Filariasis
PCC	Project Coordinating Committees
PHC	Primary health care
PIPS	Pacific Immunization Programme Strengthening
POLHN	Pacific Open Learning Health Network
PPHSN	Pacific Public Health Surveillance Network
SOPAC	Pacific Islands Applied Geoscience Commission
SPC	Secretariat of the Pacific Community
SPREP	Secretariat of the Pacific Regional Environment Programme
SSA	Special services agreement
STEPS	The WHO STEPwise approach to surveillance of risk factors for NCDs
STI	Sexually transmitted infection
STP	Short-term professional
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHG	United Nations Health Group
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

The World Health Organization's (WHO) Country Cooperation Strategy (CCS) for the 15 Pacific island countries and areas covered by the WHO Representative Office for the South Pacific sets out the strategic directions for WHO's work in 2006–2011. It is a great challenge to develop a joint strategy for a diverse group of countries that are in different stages of development and also have different health systems related to their past and current affiliations to the Commonwealth, France and the United States of America. It is also difficult to collect reliable data on health and health determinants from countries and areas with small populations and weak health information systems.

Pacific island countries and areas are undergoing social and economic changes, including: fast population growth, breakdown of traditional support systems, increasing poverty, migration and rapid urbanization. Many of the governments are currently planning or implementing health sector reforms in order to improve health services and health financing, and to better respond to the changing epidemiological situation. The major directions for health at the subregional level are provided by the biannual Pacific health ministers' meetings.

Diabetes, cardiovascular diseases and cancer are among the main causes of mortality within Pacific Island Countries. Adult and child obesity, physical inactivity, poor diet, tobacco use and alcohol abuse are the common risk factors for most of NCD which needs to be addressed through multisectoral action of health promotion and protection. The prevalence of NCD risk factors in the adult 25 to 64 age group continues to increase and is reaching critical levels in many Pacific island countries. Over half the populations of all countries are overweight and over 40% of the population of American Samoa, the Federated States of Micronesia, Kiribati, Nauru, and the Republic of the Marshall Islands are obese.

As over 80% of populations in Pacific countries live within 1.5 km of the ocean or within river basins, the increasing coastal inundation, soil salinity and erosion threaten fresh water and food security. Tsunamis, cyclones, typhoons, storms and floods, coupled with limited capacity to respond, has lead to many deaths from drowning and physical injuries, loss of property, and destruction of infrastructure. These threats are in addition to poverty, rapid movement of people and out migrations from outer islands to urban areas and to developed countries, the later resulting in rapid spread of diseases and depletion of human resources.

In most Pacific countries there is need to (a) analyze and identify bottlenecks and capacity needs of the health system at all levels, focusing on equity to services and quality of care; (b) make sector-wide investment cases to remove bottlenecks; (c) improve emergency obstetrics and neonatal care, reproductive health services including family planning ; (d) increase focus on nutrition as it relates to gestational diabetes, infant and young child feeding, micro-nutrients and food security; (e) provide STIs, including HIV, prevention and treatment and youth friendly health services; (f) provide multi-sector and integrated support to water and sanitation programming; and (g) ensure male involvement in reproductive health services.

Relatively good progress has been made by most Pacific countries in meeting the health related MDGs in spite of tremendous challenges. The revitalization of Primary Health Care with investments focused on the most remote and marginalized communities offers the best way to mobilize resources to achieve the health related MDGs by 2015.

1 INTRODUCTION

The CCS articulates a vision, a mission and working principles for all levels of WHO—Headquarters, Western Pacific Regional Office, WHO Representative Office for the South Pacific, and four country liaison offices in Kiribati, Solomon Islands, Tonga and Vanuatu. The CCS is based on a careful assessment of development challenges and health needs in the 15 Pacific island countries and areas. The CCS represents a balance between country priorities and WHO regional and Organization-wide strategic orientations and priorities including the and the Eleventh General Program of Work (2006-2015). It constitutes a framework for WHO cooperation in and with the countries concerned, highlighting what WHO will do, how it will do it, and with whom.

An important element of the CCS is to foster strategic thinking, by emphasizing WHO's roles as a leading international agency in technical and policy advice and as a broker, thereby moving away from routine programme support. It reconsiders WHO priorities in the Pacific in light of strategic considerations, and intends to broaden WHO partnerships at the country and subregional levels in a complementary way.

This CCS reflects contributions of WHO staff in the South Pacific Office, the four country liaison offices and the Regional Office. In addition, a delegate from the Pan American Health Organization provided very useful contributions based on a similar exercise in the Caribbean countries. The CCS also takes into account other analytic and priority-setting processes linked to health in the region conducted by subregional organizations and by donor agencies.

Pacific island countries are working closely with several subregional organizations, and this collaboration provides opportunities to coordinate the international assistance in the health sector more effectively. The CCS presents a good opportunity for WHO to review its work in the South Pacific during the last few years, to assess its future priorities and to draw up a strategic medium-term agenda for the next five to six years.

2 COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 Geographic, population, macroeconomic, political and social context

Geography

The 15 Pacific island countries and areas covered by the WHO Representative Office for the South Pacific are spread out in the Pacific Ocean between 130 degrees east longitude to 130 degrees west longitude and 15 degrees north latitude to 48 degrees south latitude across 33 million square kilometres (km^2) of ocean. This area is more than three times the size of Europe. Most of the Pacific island countries are made up of small islands separated by vast distances of ocean.

Largely along racial and cultural grounds, French explorers divided the Pacific into three major subdivisions: Melanesia (Black Islands), Micronesia (Small Islands) and Polynesia (Many Islands). These subdivisions are still sometimes used. In Micronesia, for example, most of the islands in the Marshall Islands and Kiribati are tiny, low-lying corals and atolls. With the exception of Nauru, all Pacific island countries and areas are multi-island countries. Some countries span a distance of several thousand kilometres. Kiribati, for example, stretches 5000 km across the central-western Pacific. The countries can also be grouped according to their historical connections to the United States of America, France or the Commonwealth. New Zealand and Australia are two Commonwealth countries.

New Zealand is one of the 15 countries covered by the Representative Office. This developed country plays a major role in providing development aid to other countries in the region and technical support to WHO through several collaborating centres. Australia also plays an important role, but it is outside the coverage of the Representative Office.

Figure 1 shows the Pacific island countries and areas covered by the WHO Representative Office, and Table 1 highlights the core indicators for these countries and areas.

Figure 1: Map of Pacific island countries and areas covered by the WHO Representative Office for the South Pacific

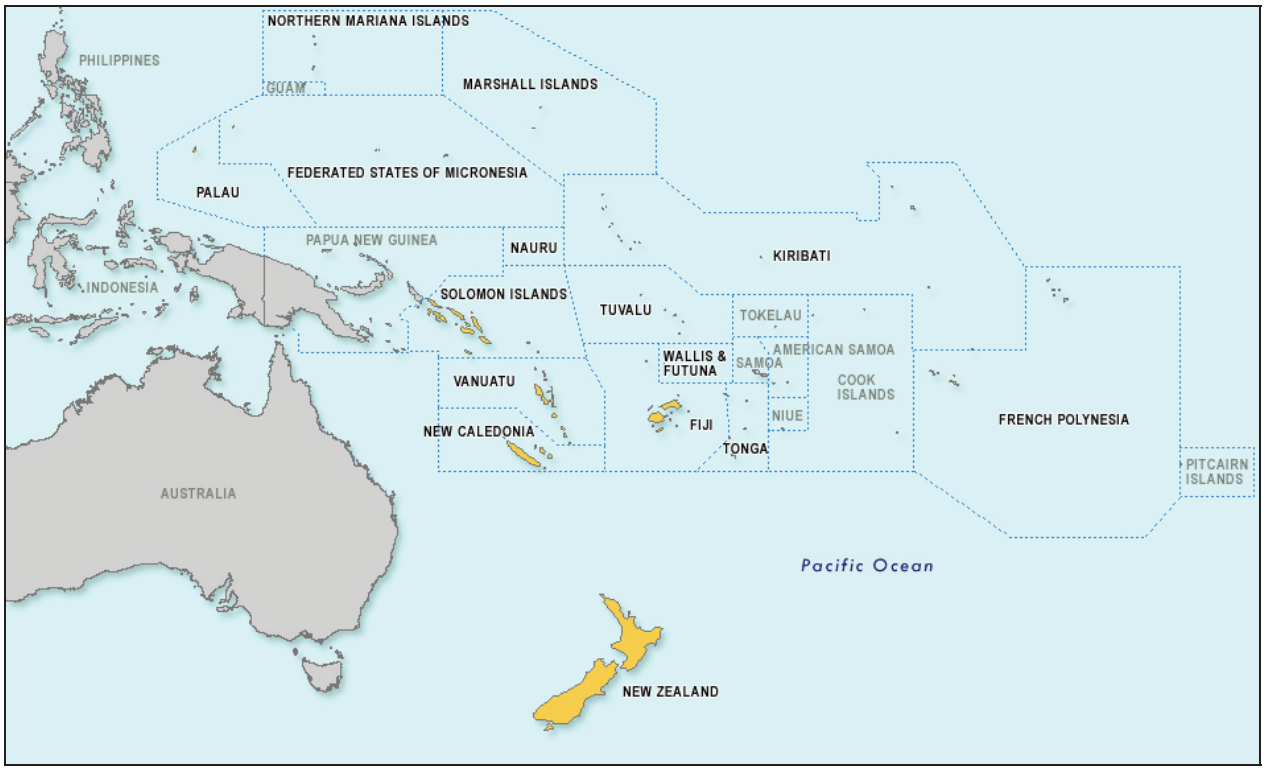

NORTHERN MARIANA ISLANDS
PHILIPPINES
GUAM
MARSHALL ISLANDS
FEDERATED STATES OF MICRONESIA
PALAU
PAPUA NEW GUINEA
NAURU
KIRIBATI
INDONESIA
SOLOMON ISLANDS
TUVALU
TOKELAU
AMERICAN SAMOA
WALLIS & FUTUNA
SAMOA
COOK ISLANDS
VANUATU
NIUE
FRENCH POLYNESIA
NEW CALEDONIA
FIJI
TONGA
PITCAIRN ISLANDS
AUSTRALIA
Pacific Ocean
NEW ZEALAND

Table 1: Core indicators for countries and areas covered by the WHO Representative Office for the South Pacific

	Country or area	Historical group	Total population (000)	Annual population growth rate		Urban population		Surface area (000 km²)	Number of islands	Gross domestic product (GDP) per capita		Human Development Index (HDI)	Adult literacy rate	
			2008	Year	(%)	Year	(%)	2007		Year	(US$)	2006	Year	(%)
1	Fiji	Commonwealth	837 (2007)	2007	0.70	2007	51.80	18.33	332 islands and atolls	2007	3 312	0.74	2002	92.9
2	French Polynesia	French territories	264	2002–2007	1.20	2007	46.10	3.52	118 islands and atolls	2005	23 214	ND	2007	94.7
3	Kiribati	Commonwealth	97	2008	1.80	2007	43.70	0.81	33 atolls	2006	653	ND	2005	91.0
4	Marshall Islands	US affiliates	53	2008	1.00	2007	70.70	0.18	30 atolls and 1152 islands	2007	2 854	ND	–	ND
5	Micronesia, Federated States of	US affiliates	108		-	2007	22.40	0.70	607 islands	2006 est	2 254	ND	2000	92.4
6	Nauru	Commonwealth	9	2002–2006	-1.00	2007	100.00	0.01	1 coral atoll	2006	2 773	ND	2005	95.0
7	New Caledonia	French territories	249	2006	2.50	2007	64.40	18.58	6 islands	2007 est	38 300	ND	2007	91.0
8	New Zealand	Commonwealth	4269	2008 est	1.00	2007	86.40	270.69	ND	2005	24 996	0.94	2006	89.0
9	Northern Mariana Islands, Commonwealth of the	US affiliates	63	2008 est	-1.70	2007	91.00	0.47	14 islands	2005	12 638	ND	–	ND
10	Palau	US affiliates	21	2008	0.60	2007	79.60	0.44	300 islands	2007	8 423	ND	2005	99.9
11	Solomon Islands	Commonwealth	535	2008 est	2.70	2007	17.60	28.37	922 islands, 347 inhabited	2006	753	0.59	–	ND
12	Tonga	Kingdom	103	2008	0.40	2007	24.40	0.65	169 islands, 36 inhabited	2006 est	2 319	0.77	1995–2005	99.0
13	Tuvalu	Commonwealth	10	2008	0.30	2007	49.00	0.03	9 coral atolls	2002	1 139	ND	–	ND
14	Vanuatu	Commonwealth	233	2008	2.60	2007	24.30	12.19	4 main islands, 80 smaller islands	2002	1 179	0.69	1995–2005	74.0
15	Wallis and Futuna	French territories	15	–	ND	2005	0.00	0.14	3 islands and 20 islets	–	ND	ND	2003	78.8

est, estimate; km^2, square kilometres; ND, not determined; US, United States
Source: Country Health Information System, WHO Western Pacific Regional Office, 2009

Population

The total population of the 15 Pacific island countries covered by the WHO Representative Office is only 6.6 million. In general, these countries have young populations due to relatively high fertility rates and medium to high mortality among the adult population. Of the total population, 34%–45% are under 14 years of age. However, in some countries, population ageing is becoming an issue.

The region is becoming more urbanized. About 40% of the total population live in towns.[1] Overpopulation in urban areas may be hampering development plans and is challenging efforts to improve health and health services.

Political systems, governance and security

In most countries, a democratic style of government co-exists with traditional social systems. The military government in Fiji, which has been in place since the 2005 coup, has promised elections in 2014. Tonga is a monarchy. American Samoa, the Commonwealth of the Northern Mariana Islands and Guam are territories of the United States of America, and Wallis and Futuna, Tahiti and New Caledonia are territories of France.

Most of the Pacific island countries are implementing public sector reforms supported by various stakeholders, e.g. Asian Development Bank (ADB), Pacific Islands Forum Secretariat and United Nations Development Programme (UNDP). These reforms strive to reduce duplication in government ministries and to create efficient and sustainable public services. However, there is a real danger of imposing broad-brushed reform packages that are unsuitable for these small island economies. The inappropriateness of some economic reforms designed by international financial institutions has become a familiar talking point during ministerial and other high-level meetings.

Decentralization, which is often a component of these reforms, began in a number of countries in the early 1990s. While it has been successful in some of the Pacific island countries, in others, decentralization has gravely disrupted programmes that were previously performing well. Responsibilities were transferred to the lower levels of government, but proper financial resources and skills were not.

Ethnic conflicts and unstable political situations are common in some Pacific island countries and regularly threaten socioeconomic development. The conflict in Solomon Islands between 1999 and 2003 plunged the country into economic collapse and destroyed decades of progress in health. The maternal mortality rate increased from 125 per 100 000 live births in 1999 to 295 per 100 000 in 2003. Frequent government changes have been seen in the region, for example in Nauru, Vanuatu and French Polynesia. Fiji experienced coups in 2000 and again in 2005.

A number of security issues are threatening the achievement of development priorities in Pacific island countries. These threats vary from country to country and include ethnic and social tensions, land disputes, socioeconomic disparities, weak governance and erosion of cultural values. To address these issues, an important priority is to ensure effective governance. This will require strong political will, transparent and accountable financial management, a socially responsible private sector, more robust media, and increased participation of civil society in the national development process. In many countries, there has been increased national and international support for strengthening of governance as well as community empowerment.

[1] United Nations Development Programme. *Pacific Human Development Report*. New York, 1999.

Economy

Small populations, remote locations, expensive telecommunications and transportation and poor infrastructure make it difficult for Pacific island countries to develop internal markets and to compete successfully in the global marketplace. Many economies rely on one or a few commodities, making them vulnerable to changes in market prices and demand. Large proportions of the populations are engaged in subsistence agriculture, and the public sector remains the largest employer in many countries. Within the past decade, a growing number of people have migrated to urban areas in search of jobs. Many others have migrated to other countries in search of better income, and loss of skilled and educated staff is of great concern. The resultant diasporas have contributed enormously to the economies of Pacific island countries. The following examples illustrate the vulnerability of economies in small island countries.

In Fiji, the sugar industry has lost its domination in the economy. In recent years, tourism has become the country's main source of income, followed by remittances from overseas workers. Migration is a growing concern in Fiji. Tens of thousands of people have migrated to New Zealand, Australia, the United States of America and Kuwait due to an unstable political situation and better opportunities for work and education.

The largest income earner in Tonga is the pumpkin industry, which exports mainly to Japan. Although this cash crop has been important for farmers in Tonga and for the national economy, it has also created problems when the prices are lower than expected. The fishing industry, which focuses on tuna and snapper for export, has experienced reducing catches for a number of years and many companies have been forced to reduce operations or close permanently. Tonga imports most of its goods from Australia and New Zealand and the depreciation of the Tongan *paanga* has resulted in higher costs. An estimated 100 000 Tongans live and work in Australia, New Zealand and the United States of America, and their contributions to the economy through remittances are very important.

Limited resources and over exploration for natural resources are causing serious difficulties in some countries. For example, in the tiny island of Nauru, revenues have traditionally come from exports of phosphates, but reserves are expected to be exhausted within five to 10 years. In anticipation of the exhaustion of Nauru's phosphate deposits, substantial amounts of phosphate income have been invested in trust funds to help cushion the transition to alternative sources of revenue and to provide for Nauru's economic future. However, there has been almost no return on these investments and, in many cases, even the principal has been lost.

In terms of agriculture, the central plateau has limited value, but some parts of the coastal belt are available for cultivation. Coconut, banana and papaya are the main fruit crops and small quantities of vegetables are also grown. However, cultivated crops are for home consumption only. Most necessities, including most food and fresh water, are imported from Australia and New Zealand. There are frequent disruptions to supplies of food, fuel,

equipment and materials. The Government, also the biggest employer, faces repeated interruptions due to a shortage of funds for salaries and other running costs.

In Kiribati and Tuvalu, fees for foreign fishing licenses substantially support the economy, in addition to revenue remittances from workers overseas and interest from government reserve funds in Kiribati and from the Tuvalu Trust Fund.

Over the last two decades, the New Zealand economy has changed from being one of the most regulated in the Organisation for Economic Co-operation and Development to being one of the most deregulated. New Zealand has a market economy with sizeable manufacturing and services sectors complementing the export-oriented agricultural sector. Energy-based industries, forestry, mining, horticulture and tourism have expanded rapidly over the past two decades.

The changing picture of poverty

Despite very low cash incomes in some of the Pacific island countries, poverty has historically not been seen as an important problem because of the availability of subsistence resources and the strength of social networks. Until recently, many people and leaders in Pacific island countries have resisted the idea that poverty exists. However, a large portion of the population in these countries is vulnerable to poverty through catastrophic illness or injury, loss of income, natural disasters and limited economic opportunities. Studies undertaken by ADB concluded that poverty and hardship are much more widespread than generally believed, with at least 20% of households in 12 of 13 Pacific island countries facing such a reality. The populations at highest risk are those without access to land. For them, loss of income would be disastrous.

Poverty and income disparity are emerging concerns. Due to the complexity of poverty in the region, focusing on economic growth alone will not lead to eradication of poverty. Nonetheless, it is crucial that economic growth be pursued in order to promote sustainable development. All Pacific island countries are facing challenges in achieving sustainable positive economic growth. ADB recently warned of growing poverty in the region, where 43% of the population is ‘disadvantaged’. According to ADB the following key issues affect all Pacific island countries: lack of good governance; fast population growth; declining educational performance; weakness of the private sector; breakdown of traditional support systems; and the urban elite capturing most benefits of modernization. Development challenges include: disappointing macroeconomic performance; increasing poverty; increasing environmental degradation; and limited progress in gender equality. Population growth, youth unemployment, rapid urbanization, and other pressures are also reflected in growing disaffection among the youth.

Gender equity and human rights

Women have made significant progress towards equality and empowerment in the Pacific island countries, but they remain disadvantaged in many areas, including education, employment, and political representation. The progress is not uniform across the region.

Countries have made various commitments to follow international declarations and conventions on human rights, equity, violence, good governance, etc. Improved awareness of gender equity and human rights issues is slowly making an impact.

Birth registration, which is recognized in the Convention of the Rights of the Child, plays a role in the compilation of correct and valid vital statistics. Many children are not registered until they start school or travel abroad. The number of females in secondary schools has

increased significantly in most countries, with Solomon Islands and Vanuatu being the notable exceptions.

In some countries, women cannot inherit property and are not entitled to half of the marital assets in the case of divorce. As legislations on these concerns are being formulated and enforced increasingly in Pacific island countries, the definitions of terms are being debated and articulated within the Pacific context to avoid the adoption of foreign concepts. For information on selected gender equity indicators, please refer to Annex A.

Millennium Development Goals

The United Nations Millennium Declaration, put forth during the Millennium Summit in September 2000, marked a strong commitment from world leaders—including Pacific islanders—to the rights to development, to gender equality, to eradication of poverty, to peace and security and to sustainable human development.

By the end of 2007, eight Pacific island countries had produced national MDG reports and six others were in the process of preparing them. The MDG framework is also being used in the Pacific Plan for Strengthening Regional Cooperation and Integration. As countries and areas assess the progress they have made, they must face the challenges of developing relevant national indicators and collecting reliable data.

According to the last regional MDG report (2004), which was produced by the Secretariat of the Pacific Community (SPC) and UNDP, substantial progress has been made against certain indicators. The region will meet some MDG targets (e.g. primary school enrolment, equality and empowerment of women) and compares favourably to other regions in a number of areas. The progress achieved in these areas indicate that the efforts made by the governments resulted in positive outcomes. Other indicators demonstrate very slow progress and, in some cases, a worsening of the status (e.g. ensuring environmental sustainability; combating HIV/AIDS, malaria and other diseases).

Relatively good progress has been made by most Pacific countries in meeting the health related MDGs in spite of tremendous challenges. However, progress varies significantly across the region and within countries. Greater efforts will need to be made if the Pacific island countries are to achieve the MDGs.

Vulnerability to disasters

Pacific island countries are vulnerable to earthquakes, tsunamis, cyclones, volcanic eruptions and drought, but with varying levels of risk. Among all the countries, Vanuatu has the highest risk of natural disasters. Some of the small Pacific island countries are also vulnerable to projected climate change, which will result in rising sea levels. With limited human and financial resources, countries are also particularly exposed to changes in disease patterns and to regional or subregional outbreaks.

2.2 Health profile

Pacific island countries are at different stages of the demographic and epidemiological transition. Some populations are still experiencing relatively high mortality and fertility, while others manifest lower mortality and declining fertility. The Pacific region faces a “triple burden” of communicable diseases, noncommunicable diseases and injuries, the result of the epidemiological transition. Rapid urbanization, growing income inequality and ongoing social and cultural changes often have a negative impact on health as well.

Table 2 provides data by country on some health status indicators. However, these data must be interpreted with a caveat, noting the weaknesses of the health information system in the Pacific island countries. A recent analysis reveals substantial uncertainty about mortality levels in the region.[2]

[2] Taylor R, Bampton D and Lopez A. Contemporary patterns of Pacific island mortality. *International Journal of Epidemiology*, 2005, 34(1):207–214.

Table 2: Selected health status indicators in the Pacific island countries and areas

	Country or area	Life expectancy at birth (years)				Infant mortality rate		Infants born at a low birth weight		Under-five mortality rate		Total fertility rate		Maternal mortality ratio	
		Year	Total	Male	Female	Year	per 1000 live births	Year	(%)	Year	per 1000 live births	Year	per woman	Year	per 100 000 live births
1	Fiji	2004	68.6	66.5	70.7	2002	17.8	1998	9.5	2002	22.35	2002	2.9	2002	35.3
2	French Polynesia	2000	ND	70.5	75.4	2003	6.9	2001	7.0	2002	9.0	2002	2.4	2002	0.0
3	Kiribati	2003 est	ND	59.0	70.0	2000	43.0	2002	8.2	2000	69.0	2002	4.1	2002	103.0
4	Marshall Islands	2002	62.7	61.1	64.6	2002	29.0	1999	12.0	1999	48.0	2000–2005	4.6	2002	74.0
5	Micronesia, Federated States of	2003 est	70.0	68.0	71.0	2003	21.0	2000	18.0	2003 est	23.0	2002	3.8	2003	317.0 [a]
6	Nauru	2002	62.7	59.7	66.5	2002	12.7	–	ND	2002	19.0	2002	3.9	2002	300.0
7	New Caledonia	2002	73.5	69.9	77.6	2002	6.9	2002	7.0	2002	9.06	2002	2.4	1991–2002	31.6
8	New Zealand	2002	78.9	76.6	81.2	2004 est	5.6	2000	6.3	2003	6.34	2003	2.0	2000	8.8 [b]
9	Northern Mariana Islands, Commonwealth of the	2004 est	75.7	73.1	78.4	2004 est	7.3	2000	19.0	1999	7.0	2004 est	1.3	2000	0.0
10	Palau	2003 est	71.3	65.5	75.4	2003	13.7	1998	9.0	2002	29.0	2003	1.6	1998	0.0
11	Solomon Islands	2004 est	ND	61.9	63.1	1999	66.0	–	ND	1999	73.0	2002	4.5	2003	295.0
12	Tonga	2003	70.0	70.0	72.0	2004	14.6	2002	2.5	2001	17.0	2003	3.4	2004	83.3
13	Tuvalu	2002	65.0	64.0	67.0	2003	21.6	2000	5.0	2003	32.4	2002	3.8	2002	0.0
14	Vanuatu	2003	68.3	67.1	70.1	1999	27.0	2003	3.0	1999	33.0	2002	4.2	1998	96.0
15	Wallis and Futuna	2003 est	74.3	73.1	75.5	2003 est	5.9	–	ND	–	ND	2003 est	3.1	–	ND

est, estimate; ND, not determined

[a] Figure based on childbearing age (15–44 years old).

[b] One of the direct maternal deaths occurred in 1932 but was registered in 2000.

Sources: Core Indicators 2005, Health Situation in the South-East Asia and Western Pacific Regions; and Western Pacific Country Health Information Profiles 2005 Revision.

Noncommunicable diseases

Diabetes, cardiovascular diseases and cancer are among the main causes of mortality across the Region. Adult and child obesity, lack of physical exercise, diabetes, peripheral vascular disease and cardiovascular disease have common risk factors, all of which lead back to a change in lifestyles over the years. The challenge now is to change lifestyles again, this time promoting healthy living, with the help of mass media and "healthy public policy".

Using the WHO STEPwise approach to surveillance of risk factors for noncommunicable diseases (NCD), also known as STEPS, field work and data collection have been completed in Fiji (in the year 2002), Nauru (2004–2006), American Samoa (2004), Tokelau (2005), the Marshall Islands (2002), the Federated States of Micronesia (Pohnpei)(2002), and Kiribati (2004–2006). Table 3 summarizes the scientific, national, updated and comparable data of the STEPS surveys in the seven Pacific island countries.

Table 3. Prevalence of noncommunicable diseases risk factors in the 25–64 age group by gender in seven Pacific island countries

NCD risk factors	Fiji		Nauru		American Samoa		Tokelau		Marshall Islands		Federated States of Micronesia (Pohnpei)		Kiribati	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Daily tobacco use	27.6	5.9	45.4	53.2	38.1	21.6	44.5	48.9	35.3	5.4	34.8	16.1	74.0	45.4
Binge drinker	30.0	13.5	31.0	19.3	49.6	33.9	44.1	24.5	43.6	34.6	35.1	22.0	71.8	49.2
Low fruit and vegetables [a]	--	--	98.3	95.9	87.9	85.6	93.4	89.2	91.7	90.5	81.3	82.4	99.2	99.4
Low physical activity [b]	--	--	47.1	57.1	58.6	66.0	26.7	57.3	45.3	55.2	55.7	73.5	41.8	57.3
Overweight [c]	52.4	71.5	93.0	93.6	92.7	94.4	92.4	94.6	77.1	83.2	63.9	82.7	78.2	84.6
Obese [c]	20.6	37.1	72.3	77.2	69.3	80.2	71.0	77.5	37.9	52.2	30.0	55.8	41.7	58.9
Diabetes [d]	14.6	17.6	23.8	21.7	52.3	42.4	47.2	40.5	27.5	29.2	26.4	37.1	29.6	26.7
Hypertension [e]	21.0	22.1	32.7	20.4	40.9	27.5	18.3	20.2	17.4	14.3	26.8	15.6	20.9	14.0

[a] Fewer than five combined servings of fruit and vegetables per day
[b] Less than 600 MET minutes per week
[c] Overweight: body mass index ≥25 kg/m^2, Obese: body mass index ≥30 kg/m^2
[d] Capillary whole blood value ≥6.1 mmol/L and/or currently on medication for diabetes
[e] Systolic pressure ≥140 mmHg and/or diastolic pressure ≥90 mmHg or currently on medication for raised blood pressure
Sources: STEPS Reports of Fiji (2002), Nauru (2004–2006), American Samoa (2004), Tokelau (2005), the Marshall Islands (2002), the Federated States of Micronesia (Pohnpei, 2002) and Kiribati (2004–2006.

During the WHO Workshop on Human Resource Development for Mental Health in Pacific Island Countries, held in Nadi, Fiji in 2003, participants reviewed the growing burden of mental illness in Pacific island countries and the challenges faced in delivering mental health services and providing educating/training on mental health. It was recommended that mental health should be advocated at meetings and in advocacy materials.

Many Pacific island countries have seen a rapid increase in the number of private cars and trucks. However, the road network and traffic regulations have not developed at the same pace. This has led to an increasing number of accidents. Several countries in the Pacific experience higher road traffic mortality rates per capita than industrialized countries, despite the lower number of cars per capita and the shorter distances driven. Few countries have seatbelt legislation, and even fewer countries have laws and capacity to control alcohol use

and driving. Road trauma is the most important cause of death in Tonga, where 24 young adults died in traffic accidents in 2003; it is believed that alcohol use was a cause in all the crashes. Legislation against driving while intoxicated is very weak, and the police have no equipment to check drivers for blood alcohol content. Doctors still rely entirely on clinical signs for establishing intoxication, and no laboratory test is set up for measuring alcohol in blood. Furthermore, seatbelts are not compulsory in Tonga, and only 1% of drivers use them.

Though accidents make up an increasing proportion of the total burden of disease, accidents occurring during work and leisure are underreported and have so far received little attention.

Cancer is growing in importance in the region as communicable diseases are being brought under control and life expectancy is increasing. Health information systems are not adequate to reliably review trends in cancer incidence. Indications of increases in cancer over time could be a result of better diagnostic capacity, better access to health care and implementation of screening programmes. Although the majority of cancers are preventable, it is important to focus on cancers that represent a large burden of disease (i.e. a large proportion of total cancers in region) and where effective and affordable interventions exist. In Pacific island countries, those cancers are likely to be liver cancer, which can be prevented through immunization against hepatitis B; lung cancer, which can be prevented by reducing smoking rates; and cervical cancer, which can be prevented through effective treatment and prevention of sexually transmitted infections (STI). Oral cancer caused by betel nut chewing is a problem in particular countries and cultures in the region and can be prevented by improving awareness. Breast cancer screening with mammography has been discussed in some countries, but it is unlikely to be a cost-effective intervention at this point in time.

In addition, there is a significant opportunity to reduce tobacco use and exposure to tobacco smoke through rapid implementation of the WHO Framework Convention on Tobacco Control (FCTC). All countries in the region have ratified the WHO FCTC and are now bound by its provisions.

Nutrition, food security and food safety

Prevalence of overweight and obesity in Pacific island countries and areas is among the highest in the world. In many of these countries and areas, the proportion of the population that is overweight is increasing and people are becoming overweight at an earlier age. The prevalence of overweight was 93.5% in American Samoa, 93.5% in Tokelau and 93.3% in Nauru, which were the top three countries/areas with the highest prevalence of overweight. Overweight has multiple causes. Common risk factors include physical inactivity (as people do not need to work as hard to produce food), improved transportation, increased access to and consumption of imported food, and limited healthy food choices due to poverty. Traditional cultural preferences for “being big” persist, and the connection between food consumption, obesity and illness is often poorly understood. In some countries, undernutrition of young children remains a serious health problem, existing in parallel with overnutrition.

Nonetheless, programmes that address nutrition are in place. A regional plan of action for nutrition is under development and a number of Pacific island countries are developing national action plans and policies to address this issue. The countries are also in the process of developing national NCD plans based on WHO STEPS. Vitamin A deficiency has long been a health problem within Micronesian countries. Malnutrition, which is also present, is often related to worm infestation, difficulty of growing vegetables in many of the islands, and high cost of imported foods. A recent survey among schoolchildren in 27 schools in 13

Pacific island countries found that prevalence of helminthiasis was 32.8% (with variation among the schools from 0% to 100%). Helminthiasis was found to be strongly associated with anaemia, stunting and underweight.[3]

Food safety is an increasingly important issue for public health and international trade. Food safety not only protects human health, but also facilitates increased opportunities for international trade in food. For many of the small Pacific island countries, food exports can either play a significant role in increasing gross national product (GNP) or, in circumstances where exports are blocked because of a lack of effective food safety control, have a negative impact on GNP, along with potentially significant social consequences. The Commonwealth of the Northern Mariana Islands reports bacterial food poisoning as the leading cause of morbidity. Many other countries collect data on diarrhoeal diseases, but the role of food or water as vehicles is not determined. In the Marshall Islands, gastroenteritis is the leading cause of morbidity; other foodborne and waterborne diseases such as fish poisoning, amoebiasis, typhoid and cholera are among the 10 leading causes of morbidity. In Kiribati and Tonga, diarrhoeal disease is the third leading cause of ill health. However, the role of food is poorly defined in each case. Very little of the data collected, however, are specifically applied to better risk management through effective and focused food safety programmes.

Despite such a situation, countries often lack or have outdated laws and standards and, while most recognize the need to modernize their standards in accordance with Codex Alimentarius, many have yet to do so. Furthermore, varying standards of enforcement, education and training among different countries and areas contribute to an uncertain understanding of levels of food safety and quality across the Pacific. National capacity to analyse food also varies, with some governments unable to isolate or identify common foodborne pathogens and chemical hazards from food. Protecting human health in today's global food market is therefore an important challenge, and one that must be addressed through effective food safety control systems. Some of the countries are developing food safety legislation and regulations, including Hazard Analysis at Critical Control Point and the international Codex Alimentarius for imported food.

Tuberculosis and leprosy

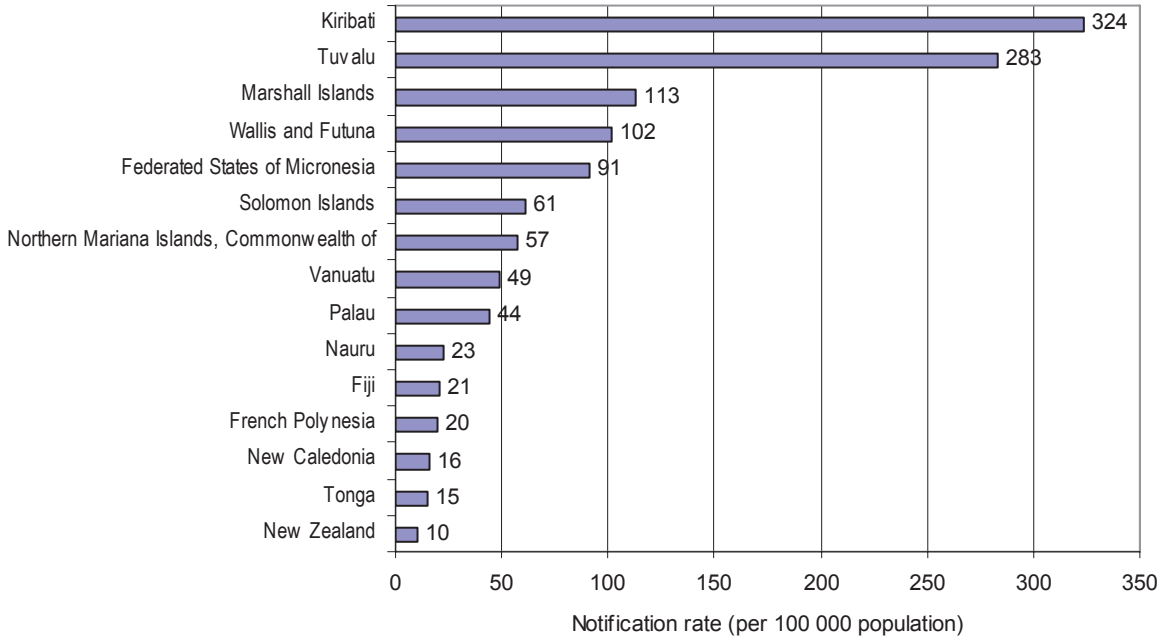
Recognizing the unique situation of Pacific island countries and areas, SPC, WHO and its Member States endorsed a *Pacific Strategic Plan to Stop TB* in 2000. Tuberculosis control measures have been very successful, and Pacific island countries and areas have a lower burden of TB than the regional average. Within the group of Pacific island countries and areas, there are large variations in notification rates, some which are very high (Figure 2).

HIV prevalence is very low in the region and HIV infection is unlikely to have an impact on TB incidence currently. However, if HIV infection spreads, it will influence the spread of TB, and may wipe out years of progress in TB control.

With the exception of Kiribati, the burden of tuberculosis is relatively low in Pacific island countries. The directly observed treatment, short-course (DOTS) programme was introduced in most countries in the region between 1997 and 1999. In 2003, DOTS coverage was 99.6%. Good progress has been made in many of these countries for TB control.

[3] Sharp D et al. Environmental influences on helminthiasis and nutritional status among Pacific schoolchildren. *International Journal of Environmental Health Research*, 2004, 14(3):163–177.

Figure 2. Notification rate (per 100 000 population) of all tuberculosis cases in Pacific island countries and areas, 2003.



Nearly all of the 15 Pacific island countries and areas have eliminated leprosy as a public health problem. The Marshall Islands and the Federated States of Micronesia have not yet reached the elimination target, and the disease remains a public health problem in these two countries. In addition, Kiribati has recently lost its elimination status. Leprosy control activities need to be integrated better with the general health services.

HIV/AIDS and sexually transmitted infections

The total number of reported HIV-positive cases has risen steadily since 1995. By 2005, about 2000 people were living with HIV/AIDS in the South Pacific (Table 4). In recent years, the number of reported HIV and AIDS cases has increased in Tuvalu, Kiribati, the Federated States of Micronesia and the Commonwealth of the Northern Mariana Islands. HIV is primarily a sexually transmitted infection in the region.

Table 4: Cumulative reported HIV and AIDS data (as of December 2004 or date specified)

	Country / Area	HIV including AIDS	Mid-year population	Cum Rep. HIV cases per 100,000 pop	AIDS (AIDS deaths)	Male (HIV including AIDS)	Female (HIV including AIDS)	Unknown (HIV including AIDS)
1	Fiji *	200	848 000 #	21.8	34 (11)	117	83	0
2	French Polynesia**	254	257 000 #	97.0	96(96)	181	73	0
3	Kiribati	46	93 100	49.4	28 (23)	30	16	0
4	Marshall Islands	10	55 400	18.1	2 (2)	3	3	4
5	Micronesia, Federated States of	25	112 700	22.2	15 (12)	14	11	0
6	Nauru	2	10 100	19.8	1 (1)	2	0	0
7	New Caledonia**	283	237 000 #	119.4	105 (105)	208	73	2
8	New Zealand*	1 147	4 028 000 #	28.5	733 (623)	890	257	0
9	Northern Mariana Islands, Commonwealth of the	25	78 000	32.1	2 (1)	12	13	0
10	Palau	8	20 700	38.6	4 (3)	5	3	0
11	Solomon Islands	5	460 100	1.1	2 (2)	2	3	0
12	Tonga	13	98 300	13.2	9 (8)	7	6	0
13	Tuvalu	9	9 600	93.8	2 (2)	8	1	0
14	Vanuatu	2	215 800	0.9	2 (0)	0	2	0
15	Wallis and Futuna	1	14 900	6.7	1 (0)	1	0	0
	Total	**2 030**			**1 036 (889)**	**1 480**	**544**	**6**

Most of cases were reported as of December 2004, except *as of December 2005 and **as of October 2005.
Data on mid-year population for 2004 were from SPC Demographic Sections, # population data for 2005 were from United Nations Population Division.
All data are supplied by official country reporting authorities. Reported cases do not reflect total disease burden. Case numbers are influenced by access to testing, testing uptake and notification rates.
Source: The World Health Organization and the Secretariat of the Pacific Community, June 2006

Underreporting of HIV in Pacific island countries is evident and is due to several possible factors, including: limited available testing and surveillance facilities; poor access of at-risk populations to HIV testing sites; poor perception of risk among the general population; most people getting tested only when they are ill with AIDS-related infections; weakness in AIDS diagnosis; stigma related to HIV/AIDS; and differing quality of reporting systems between countries. Private doctors do not always report cases. Testing is encouraged in some countries, but not all. Many Pacific islanders travel freely and therefore are sometimes tested overseas.

Few HIV seroprevalence studies have been conducted in countries. Limited data have been collected in some countries among blood donors, pregnant women, patients visiting STI clinics and immigrant groups. HIV prevalence is very low in these countries.

Although HIV prevalence remains low in most countries in the region, there are many significant risk factors that raise concerns on the possible spread of HIV/AIDS in the region. These include: high prevalence of other STI; high rate of teenage pregnancies indicating risk-taking behaviours and low use of condoms; migration out of and within the region; risky practices (tattooing and polygamy); low status of women compared to men; cultural taboos that prevent open discussion of sexual matters; customary practices and cultural norms that encourage multiple sex partners; and religious beliefs that discourage the use of condoms and contribute to unsafe sex.

Data on STI in the region are limited to passive surveillance. In 2005, a survey funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was conducted in six sentinel Pacific island countries: Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu.

The results of second generation surveillance (SGS)[4] indicated a ripe scenario for the spread of HIV/AIDS in Pacific island countries. The survey showed that sexually transmitted infections, such as *Chlamydia*, are common in the Pacific, which threatens to serve as an easy entry point for HIV. The average rate of Chlamydia ranges from 6% in Solomon Islands to 29% in Fiji. In addition, the risky behaviour among people travelling between the Pacific and neighbouring countries with high rates of HIV, such as Papua New Guinea, raises the alarm of HIV/AIDS escalating. In addition the survey indicated the following: (1) limited knowledge about how HIV is transmitted; (2) unsafe sex, such as low rates of condom use, particularly among the young; (3) high rates of multiple and casual partners; and (4) existence of commercial sex.

Hepatitis B

Pacific island countries and areas have some of the highest hepatitis B infection prevalence figures in the world (Table 5). The risk of developing chronic infection is highest in early childhood. By 2002, all national immunization programmes had added hepatitis B vaccine to their schedules; however, the hepatitis B vaccine is not yet fully integrated in all programmes, and many infants are not reached by routine services.

Table 5: Prevalence of hepatitis B infection in Pacific island countries and areas

Country or area	Best pre-vaccine estimate by WHO (%)	Pre-vaccine estimate by WHO in 1997 (%)	Official pre-vaccine estimate (%)
Fiji	11	11	
French Polynesia	3	10	3
Kiribati	29	31	
Northern Mariana Islands, Commonwealth of the	5	5	
Marshall Islands, the	12	12	
Micronesia, Federated States of	15	12	15
Nauru	20		40
New Caledonia	6	8	
Palau	20	12	20
Solomon Islands	21	20	
Tonga	18	20	
Tuvalu	15		
Vanuatu	21	19	
Wallis and Futuna	8	8	

Source: Western Pacific Regional Plan for Hepatitis B Control through Immunization, January 2003.

Diarrhoea and waterborne diseases

Diarrhoea and waterborne diseases remain major causes of morbidity in many Pacific island countries and areas. Outbreaks of typhoid, cholera and other waterborne diseases demonstrate the limitations of the current surveillance and response systems, the need for better preparedness for outbreaks, and the need for better surveillance of water quality.

Vectorborne diseases

Malaria is endemic in Solomon Islands and Vanuatu. In Solomon Islands, malaria remains a very significant public health problem, although the implementation of a five-year plan of action based on the National Malaria Control Policy (1993) has progressed well and has achieved several targets. In 2003, Solomon Islands reported 91 606 confirmed malaria cases (annual incidence of 199.8 per 1000 population) and 71 malaria deaths. Chloroquine-resistant falciparum and vivax malaria were prevalent.

[4] World Health Organization. *Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in Six Pacific Island Countries (2004–2005)*. Geneva, 2006.

In Vanuatu, the incidence of malaria has recently increased in certain areas. An in-depth review of the malaria programme in February 2004 by a WHO consultant found that only 12% of the population was protected by bednets. The annual parasite incidence was 79 per 1000 in 2003, same as in 1997, and 45% of the cases were vivax malaria. Due to low coverage with insecticide-treated bednets (ITN) and difficulties in re-treatment, a decision was made to adopt long-lasting insecticide treated nets (LLIN) as a new tool for vector control. There is also concern of parasite resistance to the current first-line treatment regime.

Dengue is a major public health issue in the region. In the early 1970s, the Pacific experienced a re-emergence of dengue after an absence for more than 25 years. Since then, several Pacific island countries and areas have experienced significant outbreaks and epidemics of dengue fever, including cases of dengue haemorrhagic fever and dengue shock syndrome. The epidemics are difficult to predict, but historically, they have been cyclical, occurring roughly every three to six years. In the last 10 years, two major epidemics have occurred, one from 1996 to 1999 (dengue serotype 2) and one from 2000 until 2003 (dengue serotype 1), affecting an estimated 35 000 to 40 000 people each time. High morbidity during outbreaks is often observed and, in some countries, more than 20% of the total population has been affected during an epidemic. Mortality during outbreaks has been low, but in a few instances, there have been reports of high mortality among children.[5]

Lymphatic filariasis is endemic in 16 out of 22 Pacific island countries and areas.[6] With 10 countries implementing mass drug administration in 2004, the total population covered was 1.49 million people. Results from a recent mid-term evaluation in five countries showed a 39% reduction in filarial antigen, as well as a reduction of more than 91% in microfilaraemia.[7]

The Pacific Programme to Eliminate Lymphatic Filariasis (PacELF), formed in 1999, continues to lead the world. In 2003, Samoa became the first Pacific island country to complete five full rounds of mass drug administration using a combination of albendazole and diethylcarbamazine (DEC). Four additional countries and areas—Cook Islands, French Polynesia, Niue and Vanuatu—have since completed five rounds of mass drug administration and are conducting final evaluations to determine next steps towards elimination.[8]

Emerging diseases

Emerging diseases are “infections that newly appear in a population, or have existed but are [rapidly] increasing in incidence or geographic range.” In this document, emerging diseases include: newly emerging diseases such as severe acute respiratory syndrome (SARS), avian influenza A(H5N1) and Pandemic (H1N1) 2009; re-emerging and resurging known diseases; and known epidemic-prone diseases such as cholera and typhoid.

In the Pacific, outbreaks of known infectious diseases such as typhoid fever, seasonal influenza, cholera, dengue fever, leptospirosis, measles and rubella continue to occur in many countries and areas. For example, the Marshall Islands reported more than 300 cholera cases in 2000, and the Federated States of Micronesia reported about 3500 cholera

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5 *Dengue in the Pacific island countries and areas*. Paper presented at the Meeting of Ministers of Health for the Pacific Island Countries, Apia, Samoa, 14–17 March 2005.

6 The Pacific Programme to Eliminate Lymphatic Filariasis (PacELF) covers 22 Pacific island countries and areas: American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, New Caledonia, Niue, the Commonwealth of the Northern Mariana Islands, Palau, Papua New Guinea, the Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna.

7 *PacELF Progress Report*, January–December 2003.

8 *The Work of WHO in the Western Pacific*, 1 July 2003–30 June 2004.

cases that same year. Cases of Influenza A have been reported in French Polynesia, New Caledonia, Guam and Fiji since 2000. Although the Pacific island countries have not yet experienced any outbreaks of avian influenza A(H5N1), any country in the Pacific is vulnerable to newly emerging diseases, including a pandemic influenza. No country is immune to the potentially rapid spread of infectious diseases due to migration, rapid urbanization, globalization, and the growing tourism industry. As in other countries, emerging diseases will continue to pose significant public health threats and cause potentially severe negative economic and social impacts in the Pacific. Pacific island countries urgently need to strengthen their public health surveillance and response systems to be ready to detect early and respond rapidly to any kind of emerging diseases and other public health events.

Maternal and child health

The maternal mortality ratio (MMR) is declining in most Pacific island countries, yet some of these countries may not meet their MDG targets for 2015. It is also important to note that maternal health in the region cannot be effectively assessed using only the MMR, which has a large annual random variation due to the small number of cases in small populations.

The primary requirement for realizing further reduction in maternal mortality lies in improving access to quality obstetric care, including emergency services. As such, WHO is helping Pacific island countries to manage complications of pregnancy and childbirth and is introducing the *Essential Care Practice Guide for Pregnancy, Childbirth and Newborn Care* in Pacific island countries in collaboration with the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA) and Fiji School of Medicine (FSMed). The most recent data demonstrate that the maternal mortality figures throughout the region are below the average for developing countries (440 per 100 000 live births), and that figures for all but Solomon Islands are below the average for South-East Asia and Western Pacific Regions (110 per 100 000 live births).

Child and infant mortality rates are also declining in most of the region, but significant regional and subnational disparities remain. A continuing emphasis on primary health care (PHC), including immunization and more effective education regarding nutrition, is needed. The regional strategy for child survival, developed jointly by WHO and UNICEF in 2005, emphasizes the integration of child health, maternal health and neonatal health programmes and activities, and places the utmost importance on high coverage of cost-effective child health interventions.

Under-five mortality rates in the region are currently below the average for developing countries (90 per 1000 live births in 2002), and most are well below the average for South-East Asia and Western Pacific Regions (43 per 1000 live births in 2002). In some countries, improvements in child health will require increased efforts in addressing communicable diseases, including malaria (Solomon Islands and Vanuatu) and diarrhoeal diseases.

Pacific island countries and areas have made significant achievements in protecting their populations, particularly children, from vaccine-preventable diseases since the establishment of the Expanded Programme on Immunization (EPI) in the early 1980s. These achievements include:

(1) eradication of poliomyelitis and certification of the polio-free status in 2000;
(2) interruption of endemic measles virus transmission in the region since 1998;
(3) introduction of hepatitis B vaccine into the EPI schedules of all countries;
(4) high reported immunization coverage (>90%) for most countries; and
(5) establishment of a regional electronic disease surveillance network—the Pacific Public Health Surveillance Network (PPHSN).

Leading causes of death in children under five years of age include acute respiratory infections, diarrhoea, malaria (Solomon Islands and Vanuatu only), perinatal complications and injuries.

Water and sanitation and waste management

Access to both safe water and adequate supplies of water are vital for human health and development. Unsafe water is one of the root causes of ill health, particularly for children. Although data are available in Pacific island countries, the nature of the definitions used in each country hampers regional comparison. However, ongoing problems related to water quality and resource availability highlight the need for more accurate information and the need for implementation of the Pacific Framework for Action on Drinking Water Quality and Health, which was endorsed by the Pacific ministers of health during their biannual meeting in March 2005.

Kiribati has experienced significant population growth and a sudden increase in dwellings in the urban area of South Tarawa as a result of internal migration. The main water supply for South Tarawa is a subterranean water lens in the northern part of the atoll. This limited supply is over-stressed by poor reticulation to homes, growing demand and illegal connections and is threatened by housing encroachment onto land above the water lens and widespread use of inappropriately located pit toilets, water-seal toilets, and (less often) septic tanks. Relatively few houses have rainwater catchment tanks. Although well water is used mainly for washing, contaminated drinking water is a common source of illness.

Although access to safe water is a common concern, water resources are not always used properly. For example, the water losses in the Tarawa distribution system in Kiribati may be as high as 50%.[9] The World Bank estimates that losses could be reduced to 25%–30%, saving 3000 cubic metres (m^3) of valuable potable water daily.

WHO, in cooperation with the Japan International Cooperation Agency (JICA) and the Secretariat of the Pacific Regional Environment Programme (SPREP), organized a four-week training course on municipal solid waste management in Pacific island countries, which was held once every year from 2001 to 2005. The participants were technical and managerial staff of the ministry responsible for solid waste management (in most cases, the ministry of health or environment). A follow-up activity will be to organize workshops involving decision-makers, in order to mobilize resources to implement the action plans developed by the technical officers.

In addition to general guidance and support to the course session, WHO's specific input to this collaborative activity has been health care waste management, while SPREP has prepared a draft regional master plan for solid waste management. This collaboration will continue to support countries in solid waste management. JICA's future support will be to address specific problems in selected countries (e.g. the Marshall Islands, Palau, Samoa and Vanuatu). WHO will continue to support countries in health care waste management. In

[9] World Bank. Cities, Seas and Storms, Managing Change in Pacific Island Economies, Vol II. Managing Pacific Towns. Washington, 2000.

this connection, JICA plans to post a short-term expert in medical waste management in its Suva office, and WHO will coordinate with JICA in providing its support to countries. The three agencies will collaborate in organizing workshops involving decision-makers, and the first of such workshops was conducted in Samoa in November 2005.

2.3 Health systems development

Evolution of the health system in Pacific island countries and areas

In the three French areas and territories (French Polynesia, New Caledonia and Wallis and Futuna), the health system is based on the French system, and most funding is provided through the French Government. The population has universal access to heath at all levels of health care through a social health insurance scheme. The first level of care is anchored by general practitioners, and referrals to tertiary care services are sent either to France or, more recently, to Australia. Overall, the system has an adequate supply of health professionals, nearly all of whom were trained in France.

Under Compact Agreements with the United States of America, health systems in the Marshall Islands, the Federated States of Micronesia and Palau are supported to different degrees by grants from the Government of the United States, and have access to technical agencies in that country. In the Commonwealth of the Northern Mariana Islands, which is under United States administration as part of the United Nations Trust Territory of the Pacific, the health system is fully funded by the United States. Health expenditure per capita is high in all these countries. Their funding sources influence management and organization of health services and also the training and registration requirements for health professionals.

Countries in the Commonwealth-based group are independent states with historical ties to the British colonial health system. Countries fund most of their health services with support from the Australian Agency for International Development (AusAID) and New Zealand Agency for International Development (NZAID). Generally, health services are free at the point of care. For the training of health professionals, these countries rely heavily on FSMed and the Fiji School of Nursing (FSN). In the case of nursing, each country trains nurses to the certificate level. For post-graduate medical training, candidates are encouraged to do clinical attachments in Fiji or Papua New Guinea, where formal registration for practice is not required.

In Vanuatu, since its independence, there has been an amalgamation of the French and English systems. This process of reform is still evolving.

Subregional health policy orientations and priorities

In Pacific island countries, health is increasingly on the development agenda at the highest level. The Pacific Island Leaders Forum endorsed a health agenda for the region as well as the Pacific Regional Strategy on HIV/AIDS, 2004–2008. The issue of HIV/AIDS has also been addressed by Pacific Parliamentarians (e.g. Suva Declaration 2004). The major direction for health at the subregional level is provided by the biannual Pacific health ministers meetings. The countries have adopted a concept of “Healthy Islands”, a broad-based and participatory approach to health protection and health promotion that integrates various initiatives and programmes.

At the biannual meeting in Tonga in 2003, Pacific health ministers agreed to assess health risks and implement multisectoral plans for the following issues: diabetes and

noncommunicable diseases, diet and physical activity, Tobacco Free Initiative, mental health, environmental health and HIV/AIDS. In the meeting in Samoa in March 2005, the health ministers agreed on strengthening actions and collaboration on healthy lifestyles and supportive environments, communicable disease control, surveillance and outbreak response, and human resources on health including effective management through partnership, and collaborative approaches to deal with migration of skilled health workers and the utilization of the Pacific Open Learning Health Network (POLHN).

Important earlier subregional health policy recommendations by the Pacific health ministers meetings cover essential public health functions (EPHF) and health legislation.

Through the EPHF approach, public health can be more systematically defined, planned and evaluated, while maintaining flexibility for different country contexts. The approach has been discussed by the WHO Regional Committee for the Western Pacific and at a consultation meeting for the Pacific. To date, case studies have been completed in Fiji, Solomon Islands and Kiribati.

In many countries, health legislation is outdated or lacking, and ministries of health do not have the capacity to develop the necessary legal briefs and regulations. Enforcement of existing legislation is often weak. Recently, WHO provided technical assistance to several Pacific island countries to review health legislation. New approaches, such as a common database similar to the LEYES database in the Pan American Health Organization, need to be explored.

Subregional sharing of resources and services

Pacific island countries have a strong tradition of sharing resources and developing common approaches for addressing health development issues. The following examples highlight this tradition:

(1) Pacific Public Health Surveillance Network (PPHSN) is a model of a successful regional system for early warning, laboratory support and response to outbreak-prone conditions. The original set of diseases (influenza, dengue, measles, rubella, typhoid, cholera, and leptospirosis) has been broadened to include HIV/AIDS and other STI, tuberculosis, agents of bioterrorism, acute fever and rash syndrome, neonatal tetanus and ongoing surveillance for acute flaccid paralysis.

Three services are currently available, one for each operational step in surveillance and response to communicable diseases (detection, verification, and response):

(a) PacNet (for alert and communication), created in 1997, is an e-mail and fax listserv for a network of public health professionals interested or working in the Pacific. It allows communication, especially "early warnings", of epidemic threats, consequentially raising awareness and preparedness levels.

(b) LabNet (for identification and confirmation of pathogens) aims to build a network of laboratory services linking national laboratories to four subregional laboratories in Fiji, French Polynesia, Guam and New Caledonia, which have agreed to provide selected diagnostic services and send specimens to reference laboratories in Australia, New Zealand and the United States of America for further testing, if needed. However, the Pacific TB Laboratory initiative has not yet been integrated into the PPHSN. In the future, it would be good for PPHSN to consider taking on the tasks that come under the Pacific TB Laboratory initiative, so that PPHSN encompasses all laboratory issues in the Pacific, including TB.

(c) EpiNet (for investigation and response). Multidisciplinary national/area teams trained in outbreak preparedness, investigation and response are expected to be the first responders when outbreaks are detected.

(2) The **Pacific Open Learning Health Network (POLHN)** for continuing education offers courses that specifically address the health development issues for the Pacific island countries. Open learning centres have been established in 12 countries. A number of self-learning modules have been developed and are available through different media, including online, web-based courses as well as post-graduate courses from FSMed.

(3) While the ministers of health of Pacific island countries have recognized the benefits of establishing a bulk drug procurement scheme, most countries choose to continue their individual procurement of pharmaceuticals for various reasons. Fiji has offered to procure pharmaceuticals through Fiji Pharmaceutical Services (FPS) for Pacific island countries. As FPS has been improved through Japanese aid, it would be timely to intensify efforts to formally establish a suitable bulk drug procurement scheme involving some or all of the countries.

Challenges of health systems development

Service delivery to isolated populations

A major challenge for countries is the provision of services on an equitable basis to populations that are scattered over many islands. The logistical problems of ensuring reliable, uninterrupted and good-quality primary health care on remote islands include infrequent transport links, costly communication and high operational costs. In some countries, development efforts may bypass poor or most disadvantaged regions, and services (when they are available) are of low quality, especially for the poor. Logistics is contributing to the disparity in service delivery. For instance, Kiribati consists of 33 coral atolls, including three island groups, which span over a distance of around 5000 km. To travel the 3200 km distance between Christmas Island (the easternmost part of Kiribati) and the main atoll, Tarawa, one has to fly via Honolulu and Fiji. The only alternative is to travel 14 days by boat.

Governments have instituted a wide range of approaches to provide basic-level health care to the entire population; for instance, aid posts are available on most islands. However, it is not evident what progress has been made in recent years.

Inadequate coverage of secondary and tertiary care services makes medical evacuations a common feature of the health systems in all Pacific countries. The geographical layout of the region requires disproportionate percentage of health funds to be spent on medical evacuations, both within and outside the country. Many patients cannot be evacuated and treated for shortage of funding.

Quality of health services varies between the countries and within countries. However, the variance is difficult to assess because no agreement on standards or guidelines for best practices exists. Countries now need to expand the objectives of the health system to include not only coverage of services, but also quality of care.

The role of traditional healers varies widely across the Pacific. Traditional practices need to be catalogued and reviewed as regards to harms and benefits of these practices.

The use of e-health and telemedicine, which could alleviate some of the coverage issues, is limited in the region. Evidence from the Solomon Islands' experience has demonstrated the value of telepathology in improving health services and reducing the need for out-of-country referrals.

Decentralization

Most Pacific island countries, especially the larger nations like Solomon Islands, Vanuatu and Fiji, have undergone a process of decentralization of health planning, management and provision of services as part of the overall public sector reform agenda in the last five years. In many instances, this process has been externally driven, and has seen a concurrent shift in donor assistance for health from the central to the peripheral level. True government ownership within this process has often been limited, and there is now recognition by the governments for greater participation through partnerships with donors and greater input as to where the assistance is directed.

The effectiveness of decentralization for Pacific island states needs to be evaluated, and best practices should be shared. In developed countries, blood transfusion services are centralized to ensure the high quality and safety of blood supplies. The pros and cons of centralization need to be assessed in this and other areas of work in the context of Pacific island countries.

Perception of health and illness by the community

Appropriate health care-seeking behaviour in the communities is an important factor for delivery of health services. Misperception of illness and health in the general population is a serious challenge. There is widespread lack of awareness of risky and health-promoting behaviour, and there is little involvement by local communities in health-promoting activities. Key risks include behaviours and environments that increase the risks of communicable and noncommunicable diseases, and the risks associated with unsafe sexual behaviour.

Health care financing

Most Pacific island countries provide free government financed health care to all citizens. This guarantees a relatively fair health system in terms of financial access, but geographical access remains a big problem for countries with dispersed populations. Health care financing continues to be a major issue for many governments. In general, the level of health spending in countries is insufficient to address the many health challenges that they face (Table 6). Many health systems are dependent on donors' funding, especially for public health functions and for human resources development. A few countries, including Samoa and Tonga, have set up national health accounts to calculate the overall expenditure on health care; Fiji has also indicated interest in this.

Table 6: Health care financing and health expenditure in the 15 Pacific island countries and areas, 2002

Country or area	Total expenditure on health		General government expenditure on health		Private expenditure on health as % of total expenditure on health	General government expenditure on health as % of total government expenditure	External resources for health as % of total government expenditure	Out-of-pocket expenditure as % of private expenditure on health
	as % of GDP	per capita US$	as % of total expenditure on health	per capita US$				
Fiji	4.2	94.0	64.6	60.0	35.4	7.5	5.6	100.0
French Polynesia	ND	ND	ND	ND	ND	ND	ND	ND
Kiribati	8.0	49.0	98.8	49.0	1.2	10.2	3.0	100.0
Marshall Islands	10.6	210.0	67.3	141.0	32.7	10.9	22.7	100.0
Micronesia, Federated States of	6.5	143.0	88.2	126.0	11.8	8.8	n/a	40.0
Nauru	7.6	656.0	88.8	582.0	11.2	9.2	n/a	100.0
New Caledonia	ND	ND	ND	ND	ND	ND	ND	ND
New Zealand	8.5	1255.0	77.9	978.0	22.1	15.5	0.0	72.6
Northern Mariana Islands, Commonwealth of the	ND	ND	ND	ND	ND	ND	ND	ND
Palau	9.1	439.0	91.0	400.0	9.0	11.4	n/a	100.0
Solomon Islands	4.8	29.0	93.2	27.0	6.8	11.8	41.0	49.2
Tonga	6.9	91.0	73.5	67.0	26.5	15.8	24.0	100.0
Tuvalu	4.4	78.0	46.7	36.0	53.3	1.5	n/a	100.0
Vanuatu	3.8	44.0	73.6	32.0	26.4	12.8	19.5	45.8
Wallis and Futuna	ND	ND	ND	ND	ND	ND	ND	ND

ND, not determined
Source: *The World Health Report 2005: Make every mother and child count*. Geneva, World Health Organization, 2005.

With minor exceptions, primary health care services in the Pacific island countries are either free of charge or heavily subsidized by the governments. However, the percentage of out-of-pocket payments, especially for drugs and specialized health services, varies and can reach up to 35% of total health spending (e.g. Fiji, Vanuatu).

Several governments, including Fiji's, have embarked on the development of health insurance schemes, encouraging both commercial and community social health insurance systems. Currently, prepayment schemes (health insurance) are not common. Those that exist are limited to selected groups, such as government employees, and sometimes do not cover family members. Social health insurance (when the entire population is covered through a prepayment system) has implementation problems because the formal workforce and the tax base is small in most countries, and effective mechanisms for collecting health insurance fees are difficult to establish.

Planning and management of human resources

Pacific island countries and areas face the following planning and management issues and challenges:

(1) lack of comprehensive national health development plans to guide the development of human resource strategies and plans;
(2) limited and unreliable health workforce data and information;
(3) inadequate capacity for human resource planning among managers at all levels;
(4) health workforce shortages or oversupply, an inappropriate mix of skills, uneven geographic and health facility distribution, and gender inequalities;

(5) poor working conditions and incentives, leading to low productivity and morale and staff losses; and
(6) low-quality education and training of health professionals, coupled with poor linkage between health service needs.

The availability of an adequate number of skilled health professionals has been recognized as a major strategy within the “Healthy Islands" initiative (Table 7). The issue of ‘brain drain’ and its impact on the implementation of the Healthy Islands strategies were particularly articulated at the Pacific island ministers of health meeting in Palau in 1999, with an appeal to WHO for support. As the training of highly skilled health professionals in many small island countries is done in overseas institutions, the loss of skilled health professionals is very costly. Concerted and effective actions need to be taken to manage migration to reduce its negative impact and to ensure that source countries also benefit from the emigration of their skilled health professionals.

Health information systems

The national health information systems are at various levels of development in the Pacific island countries. Many countries still have deficiencies in their vital statistics of births and deaths. Incomplete or late birth registration creates problems with the denominator for estimating child health indicators. This has been highlighted by recent studies in a number of countries where the difference between the actual and reported immunization rate was 20%–30%. The low rate of death registration and the poor quality or absence of cause-specific death certificates also contributes to unreliable vital statistics in some countries.

Existing data are not well utilized. Data are insufficiently disaggregated to be useful for planning and monitoring of disparities in health conditions and in use of services. There is a lack of coordination among the many regional and international agencies that are working to assist countries in this area. The situation is further aggravated by burdensome requests from donors to the governments.

Table 7: Health workforce and hospitals in the 15 Pacific island countries and areas

	Country or area	Physicians			Dentists			Pharmacists			Nurses			Midwives			Hospital beds		
		Year	Number	per 10 000 population	Year	Number	per 10 000 population	Year	Number	per 10 000 population	Year	Number	per 10 000 population	Year	Number	Per 10 000 population	Year	Number	Per 10 000 population
1	Fiji	2003	373	4.5	2003	56	0.7	2003	87	1.05	2003	1648[a]	19.8	–	ND	ND	1999	2097	26.2
2	French Polynesia	2004 est	447	17.8	2004 est	113[b]	4.1	2004 est	100	4.0	2000	824	35.9	2000	93	15.8	2003	971[c]	39.3
3	Kiribati	2004	20	2.2	2004	3	0.3	2004	2	0.2	2004	238	26.5	2004	32	3.6	2004	140	15.0
4	Marshall Islands	2000	24	4.6	2000	4	0.8	2000	2	0.4	2000	152	29.3	–	ND	ND	1999	105	20.7
5	Micronesia, Federated States of	2003	ND	5.7	2003	ND	1.2	2003	ND	1.5[d]	2003	ND	21.1	2003	n/a	1.8	2000	329	30.7
6	Nauru	2004	5	5.0	2004	1	1.0	2004	4[e]	4.0	2004	48	47.5	2004	2	2.0	2004	60	59.4
7	New Caledonia	2002	476	22.0	2002	126	5.8	2002	97	4.5	2002	1128	52.3	2002	83	3.8	2002	888	40.8
8	New Zealand	2003	8790	21.9	2003	1582	4.0	2002	3808	10.2	2004	34 660[f]	85.3	2004	3780[g]	9.3	2002	23 825	59.9
9	Northern Mariana Islands, Commonwealth of the	1999	31	4.5	1999	3	0.4	1999	4	0.6	1999	123	17.7	1999	14	2.0	2000	82	11.8
10	Palau	2003	25	12.3	1998	2	1.1	1998	1	0.6	1998	126	14.4	1998	1	0.6	1998	90	49.7
11	Solomon Islands	2003	57	1.3	1999	26	0.6	1999	28	0.7	2003	605 [g]	13.3	1999	23	0.5	2003	881	19.3
12	Tonga	2003	32[h]	3.9	2003	23 [i]	2.3	2002	4	0.4	2003	342	33.7	2002	21	2.1	2004	296	29.1
13	Tuvalu	2003	4	4.2	2003	2	2.1	2003	2	2.1	2003	30 [j]	31.4	2003	10	10.5	2001	56	55.6
14	Vanuatu	2004 est	29	1.4	–	ND	ND	–	ND	ND	2004 est	312 [k]	14.5	2004 est	50	2.3	2003	397	19.1
15	Wallis and Futuna	2003	11[l]	7.4	2003	4	2.7	–	ND	ND	–	ND	ND	2003	5	3.4	2003	74	49.5

est, estimate; ND, not determined

[a] Figure includes assistant nurses.

[b] Figure includes dental surgeons.

[c] Figure includes observation beds.

[d] Figure refers to pharmacy technicians only.

[e] Figure refers to dispenser only.

[f] Figure includes 3780 midwives.

[g] Figure includes nurse aides.

[h] Figure includes government doctors.

[i] Figure includes dental officers and dental therapists.

[j] Figure includes bachelor and diploma graduate nurses.

[k] Figure includes nurse practitioners and nurse aides.

[l] Figure includes physicians and specialists.

Sources: Core Indicators 2005: Health Situation in the South-East Asia and Western Pacific Regions; and Western Pacific Country Health Information Profiles 2005 Revision.

2.4 Summary of key challenges and opportunities

Demographic, environmental and socioeconomic factors

- Young population in general, and ageing population in some countries;
- Overpopulation in some islands;
- Vast geographic distances, isolation, remoteness, difficult and time-consuming connections;
- Fragility of the environment, and difficulties in arranging clean water and sanitation;
- Vulnerability to disasters;
- Food safety;
- Limited natural resources;
- Small multi-island states;
- Growing tourism industry in some countries;
- Great diversity in the region (political set-up, colonial background, French and American influence on the countries' systems);
- Globalization – travel and trade;
- Specific understanding of poverty in the Pacific (poverty of access and opportunity);
- Rapid urbanization, growing income inequality and ongoing social and cultural changes with negative impact on health;
- Reliance on donor assistance;
- Security and ethnic conflicts; and
- Diseconomies of scale.

Health sector development

- Implementation of essential public health functions;
- Delivery of primary health care to remote areas;
- Perception of health and disease by the community, role of traditional healers and health promotion;
- Health sector financing mechanisms including health insurance, catastrophic expenditures leading to poverty, human resources development and management, e-health, open learning;
- Migration of skilled health staff;
- Public health legislation, health regulations and their enforcement;
- Quality of health care;
- Weak health information systems;
- Equipment acquisition, maintenance and standardization;
- Drug supply – bulk procurement and subregional procurement schemes;
- Limited opportunities for telemedicine (e-health) and teleconferencing; and
- Influence of donors.

Disease burden

- Epidemiological transition – double burden of communicable and noncommunicable diseases;
- Alarming epidemic of noncommunicable diseases, communicable diseases and injuries;
- Communicable diseases including diarrhoeal diseases, tuberculosis, HIV/AIDS and malaria;
- Susceptibility of Pacific island countries to outbreaks – PPHSN, GFATM; and
- Increasing suicide rate and increasing abuse of drugs, alcohol and kava.

3 DEVELOPMENT COOPERATION AND PARTNERSHIPS: TECHNICAL COOPERATION, AID EFFECTIVENESS AND COORDINATION

3.1 Overall trends in development aid

Historically, overseas development assistance (ODA) to Pacific island countries has been substantial (measured in per capita terms), in part because of the Pacific's relatively small population sizes. Geographic factors, including the region's overall isolation, as well as the dispersed nature of most Pacific island populations, have also contributed to the high cost of aid delivery to the region. Although the Pacific's share of the global aid budget has declined, per capita aid levels in the region continue to be high when compared with other regions. Net ODA received by some countries has declined, and the proportion of aid directed to the Pacific by two of the region's primary donors—Australia and New Zealand—has generally declined as well.

Within the health sector, the focus of ODA has shifted from recurrent government budgetary support to more specific and targeted health issues. In addition, support has shifted from a regional general approach to direct support to country-specific programmes, through the government aid channels.

3.2 Major external agencies in health sector

Pacific island countries receive bilateral ODA primarily from Australia, New Zealand, Japan and China. In addition, the Governments of the United States of America and France provide considerable assistance directly to their territories and those countries with which they have close political ties. Also, Taiwan (China) provides assistance to those countries with which it has trading and diplomatic relationships. Australia and New Zealand extend their support to several Pacific island countries; other donors are more focused in their development aid.

Australia, New Zealand and Japan also contribute substantially to regional and global organizations that support health sector development in the Pacific, such as WHO, SPC, ADB and the World Bank. The European Union (EU) has become an important donor in recent years. Regional or subregional information on levels and sources of ODA are currently not compiled, making identification of donor support levels and target areas difficult to analyse.

Many other global funding initiatives and regional bodies are involved in providing technical and funding assistance for health in the Pacific islands countries. These include GFATM, SPC, South Pacific Applied Geoscience Commission (SOPAC) and the Pacific Islands Forum Secretariat. Two countries are also eligible for support under the Global Alliance for Vaccine and Immunizations. Other major contributors are the World Bank and ADB who provide both grant assistance and long-term "soft" loans.

3.3 Aid coordination

WHO recognizes the benefits of partnerships with other donors, multilateral agencies and nongovernmental organizations (NGOs) for coordinated and strategic approaches to aid delivery. However, coordination between countries, donors and other partners can be further strengthened. Although it is generally agreed that coordination of donor assistance is the responsibility of the governments, there is a clear need for a coordinating body.

The World Health Assembly (WHA) sets the overall global strategy for health. This is then further refined at the regional level through the Regional Committee meetings. Selected health issues and subregional strategies are discussed at the biannual Pacific health ministers' meetings. The Commonwealth health ministers' meeting also coordinates health activities and agendas among Commonwealth countries. Although there is no overarching mechanism or framework for coordination between countries and partners, several intercountry health projects are functioning as bodies themselves, responsible for monitoring and overall coordination. Examples are PacELF, Pacific Immunization Programme Strengthening (PIPS), GFATM, PPHSN, United Nations Health Group (UNHG) and Council of Regional Organisations of the Pacific. Better coordination of donor support would ensure that contributions are maximized, initiatives yield the best possible benefit, potential synergies among programmes are realized and duplication is minimized.

In some countries, external assistance and development partners' activities are coordinated by the ministry of foreign affairs or the economic policy and planning departments. Coordination is often carried out through project coordinating committees or interministerial committees with donor membership. The role of the project coordinating committee is to ensure complementarities and to avoid duplication or overlapping of donor programmes. Some ministries of health have set up their own internal coordinating body, which is usually chaired by the director of health planning; this body sets strategic directions for the reform programme and monitors the development of all new programmes and projects.

Where multilateral donors—World Bank, ADB, International Monetary Fund, EU—are involved, governments organize annual roundtable coordination meetings. In other situations, informal meetings have taken place between United Nations agencies, embassy representatives and NGOs with an interest in health, with the objective of improved coordination. There is a dearth of information regarding the performance of these relatively new coordination mechanisms.

The United Nations country teams in Pacific island countries consist of staff from UNDP, UNFPA, Food and Agriculture Organization of the United Nations (FAO), United Nations Education, Scientific and Cultural Organization (UNESCO), UNICEF, World Meteorological Organization, International Labour Organization, United Nations Development Fund for Women (UNIFEM) and WHO. Meetings between country teams and agency heads are held regularly. UNFPA, UNICEF and WHO are implementing collaborative programmes in some countries. Within the United Nations system, efforts have been made over the past five years through the Common Country Assessment (CCA) and the United Nations Development Assistance Framework (UNDAF) process to coordinate the assistance by various agencies. However, only four countries completed their CCA by the end of 2004. The CCA/UNDAF process fell short of being an effective mechanism for coordinating the United Nations family of agencies and for planning dividends for the Pacific island countries.

A new generation of UNDAF, which commenced in late 2005 for the Pacific subregion, represents the first region-wide response to the operation reform process of the United Nations. It is a product of several partnerships in development, including United Nations

country teams in Fiji and Samoa covering a total of 15 agencies, offices and programmes, and between the United Nations and the governments of 14 Pacific island countries.

The recent generation of UNDAF is intended as a programming tool, and its process of development has sought to address the deficiencies of its predecessor through a regional approach, genuine government consultation, deeper joint implementation and monitoring structures, and universal United Nations participation. Moreover, the current UNDAF is responsive to past criticism of the United Nations' lack of focus and participation in national development dialogues and the non-harmonized nature of its work.

In response, the United Nations country teams in Fiji and Samoa have sought not only to implement the reforms for their own multicountry offices, but also to jointly coordinate agency activities on a regional scale.

The United Nations has identified four priority or outcome areas for intervention in the Pacific: (1) equitable economic growth and poverty reduction, (2) good governance and human rights, (3) equitable social and protection services, and (4) sustainable environmental management. These areas emerged from the extensive situational analysis on regional and national needs and priorities, and were reaffirmed through government and regional consultations.

The Pacific Plan, which was endorsed by Pacific Islands Forum Leaders at the annual Pacific Islands Forum Meeting in October 2005, serves as a blueprint for regional development. The aim of the Pacific Plan is to enhance and stimulate economic growth, sustainable development, good governance and security for Pacific island countries through regionalism.

The overall concept of regionalism under the Pacific Plan is for countries to work together for their joint and individual benefit. However, there are three specific concepts of regionalism that the Forum Leaders would like to involve, and they are:

- Regional cooperation: Setting up dialogues or processes between governments. Services (e.g. health, statistics, audit) are provided nationally, but often with increased coordination of policies between countries.

- Regional provision of public goods/services: Pooling national services (e.g. customs, health, education, sport) at the regional level. Governments are freed from daily management of some services and can concentrate on service delivery in other areas and on policy development.

- Regional integration: Lowering market barriers between countries. These barriers may be physical (e.g. borders) or technical (e.g. quarantine measures, import taxes, passport requirements). Regional integration can improve access for Pacific businesses to consumers, increasing economies of scale and therefore reducing prices and making more goods available.

The Health and Population Working Group of the Pacific Islands Forum Secretariat invited all donors and institutions involved in the health sector to meet irregularly to share information and concerns. Suva-based UNHG, proposed by WHO, was established in 2004. The heads of UNICEF, UNFPA and WHO meet every three months to share information and to identify common interests and joint activities. At operational level, staff from these three agencies meet frequently to implement agreed joint activities.

3.4 Challenges in aid coordination

The increasing number of international and subregional agencies with interest in the health sector brings both opportunities and challenges to the work of WHO in the Pacific. WHO's position as the key technical agency for health is being undermined in some programmes in the current uncoordinated, highly political and donor-dominated environment. Donors and partners are sometimes equating technical expertise with funding streams. This is not necessarily so for countries. Donor funding is increasingly going to regional organizations such as SPC, FSMed, SOPAC and Economic and Social Commission for Asia and the Pacific. The technical advice provided by donors and partners is not uniform and sometimes needs to be corrected by WHO technical guidance. WHO's role could be strengthened through improved clarity and better coordination as regard to the role and expertise of each agency.

Countries are often unable to absorb multiple-donor projects and funding effectively, in part due to limited staff numbers within countries. This results in ministry of health staff taking on multiple tasks and obligations for different donor organizations concurrently. Ministry of health staff often direct their input and attention to those donors with the most funding (and to off-island opportunities to attend meetings). The burden of implementing donor programmes and reporting is frequently placed on WHO staff. Projects funded by GFATM, particularly for HIV/AIDS, are requiring increasing amounts of WHO technical input in some countries.

The key challenges for donor support in the Pacific is ensuring that aid flows to where it is most needed and appropriate, and that it is not duplicated by multiple donors. Often, it is the donor that decides where and how the money is spent, which frequently reflects community and political norms within the donor nation and not that of the recipient country. WHO's influence in advocating for the technical needs and sound and appropriate development of health services within this context needs to be strengthened.

3.5 Summary of key challenges and opportunities

- WHO needs to focus on areas in which it has special strengths or in which other partners are not working.
- WHO needs to maintain its leadership role by offering strong technical expertise (though WHO's financial inputs may be low in certain areas).
- Subregional collaboration among the 15 countries and areas needs to be strengthened.
    - Many of these countries are too small to be self-sufficient in skills and services.
    - Closer collaboration is needed among all or smaller groups of countries; WHO can play an important role in advocating and facilitating this collaboration and in pursuing the Pacific Plan strategies, as delineated under section 3.3.
    - There is both a need and opportunity for pooling of expertise, experiences and skills, by creating an observatory or clearinghouse among the countries (e.g. to review health policies and legislations and experiences from implementation and evaluation of programmes and interventions).
- Health priorities need to be set by countries rather than donors.
- In-country capacity to coordinate projects needs to be strengthened.
- Donor requirements for planning, implementation procedures and reporting need to be less burdensome.
- Roles of regional institutions are changing.

4 REVIEW OF PAST AND CURRENT WHO COOPERATION

4.1 Brief historical perspective

The WHO Representative Office for the South Pacific was established on 1 January 1970. This office provides support to the following South Pacific countries and areas: Fiji, French Polynesia, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, New Caledonia, New Zealand, the Commonwealth of the Northern Mariana Islands, Palau, Solomon Islands, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna. In addition to the WHO Representative Office for the South Pacific, WHO country liaison offices are present in Kiribati (established on 26 July 1984), Tonga (established on 14 August 1975), Solomon Islands (established on 4 April 1983) and Vanuatu (established on 7 March 1983). The Country Liaison Officers report to the WHO Representative Office in Fiji. The size of the offices ranges from 30 staff (Fiji office) to two staff (some of the country liaison offices).

Five other Pacific island countries and areas are covered by the WHO Representative Office in Samoa, but are not considered to be part of the South Pacific: American Samoa, Cook Islands, Niue, Samoa and Tokelau.

4.2 Key areas of work

The primary role of the WHO Representative Office and the four country liaison offices is to prepare and execute the WHO Regional Office's plans for technical cooperation with countries and areas in the Pacific.

The government is WHO's primary partner for health and development, and the ministry of health is the direct counterpart for both planning and implementation. The four country liaison offices (Kiribati, Solomon Islands, Tonga and Vanuatu) in the South Pacific are all physically located within the ministry of health building, and office space is provided free of charge. Direct collaboration with other government ministries is limited and all country budget resources are allocated to the ministry of health. However, there are a number of areas where WHO supports cross-cutting, health-related issues. Country participation at regional capacity-building events often includes delegates from outside of the health sector. So, although formal collaboration outside of the ministry of health remains limited, provision of technical advice and guidelines will often influence decisions by other government sectors.

The WHO Representative and the four Country Liaison Officers respond to requests from country health officials, including requests for subregional health situational analysis and ad hoc disease outbreak response. Through close collaboration with government health officials, WHO facilitates and promotes coordinated health programme development. The WHO South Pacific office and four country liaison offices therefore have multiple functions with several levels of delivery among governments, development partners and regional institutions. Coordination of country support by the WHO Representative, Country Liaison Officers, and by the technical and support staff is increasingly challenging.

4.3 Financial resources

Table 8 shows the approved programme budget of WHO and actual obligations incurred for regular budget funds and "other sources" of funds for three bienniums. The data indicate that the bulk of the resources for the South Pacific come from the regular budget rather than from extrabudgetary sources.

The approved programme budget for technical support provided by the WHO Representative Office (and four country liaison offices) for the 2006-2007 biennium was about US$ 6.6 million. The WHO regular budget allocations (excluding intercountry programme [ICP] funds) to the countries and areas under the WHO Representative Office have remained nearly the same during last three bienniums.

Table 8: Programme budget figures (US$) for countries and areas covered by the WHO Representative Office for the South Pacific, 2002–2007

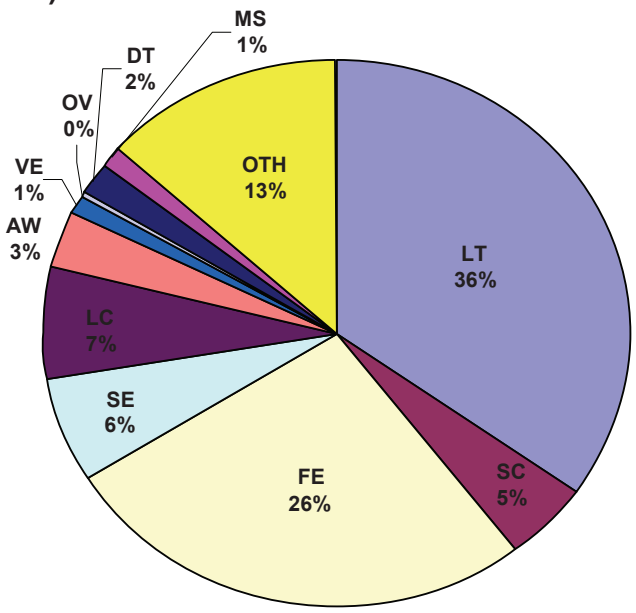
Country or area	2002–2003				2004–2005				2006-2007	
	RB		EB		RB		EB		RB	EB
	Approved	Obligated[a]	Allotted	Obligated[a]	Approved	Obligated[a]	Allotted	Obligated[a]	Approved	Allotted
Fiji	1 088 000	2 408 136	154 285	28 409	970 000	935 523	364 992	358 316	985 000	218 765
French Polynesia	50 000	53 633	0	0	45 000	47 629	0	0	45 000	0
Kiribati	286 000	635 489	55 025	53 935	366 000	330 339	1389	1389	390 000	47 000
Marshall Islands	220 000	192 863	52 300	52 300	264 160	258 598	0	0	285 000	0
Micronesia, Federated States of	522 000	463 668	0	0	475 000	468 761	3286	3134	485 000	0
Nauru	96 000	102 660	70 056	32 441	95 000	87 487	38 235	26 664	96 000	0
New Caledonia	50 000	18 650	0	0	45 000	34 338	0	0	45 000	0
New Zealand	40 000	33 854	0	0	36 000	32 146	0	0	36 000	0
Northern Mariana Islands, Commonwealth of the	50 000	37 628	0	0	45 000	48 672	0	0	45 000	0
Palau	119 000	130 353	0	0	114 000	100 227	0	0	115 000	0
Solomon Islands	1 164 000	1 046 237	255 450	251 942	1 260 437	1 039 801	1 683 443	1 288 599	1 263 000	51 442
Tonga	826 000	990 682	136 613	117 069	772 000	665 604	3179	3119	780 000	34 000
Tuvalu	115 000	107 391	100 710	100 710	114 000	92 637	12 594	12 593	120 000	10 000
Vanuatu	844 000	1 121 135	93 985	87 730	982 229	841 016	280 149	62 939	960 000	77 256
Wallis and Futuna	ND	ND	ND	ND	ND	ND	ND	ND	ND	n/a
ICP	ND	ND	ND	ND	ND	ND	ND	ND	980 850	2 907 454
Total	5 470 000	7 342 379	918 424	724 536	5 583 826	4 982 778	2 387 267	1 756 753	6 630 850	3 345 917

EB, extrabudgetary sources; ICP, intercountry programme; ND, not determined; RB, regular budget
[a] Obligated figures include ICP-funded activities.
Source: Programme Development and Operations, Western Pacific Regional Office

As shown in Figure 3, five of the top components of the total country approved budget are long-term staff (36%), fellowships (26%), local costs (7%), supplies and equipment (6%) and short-term staff (5%).

Approximately 42% of the total approved country budget for 2004–2005 was for WHO country presence (almost equally divided between the South Pacific office and the four country offices). These figures do not include the salaries of technical and general service staff who were paid through ICP and other funds.

Figure 3: Components of approved country budget for 2004–2005 (including WHO country presence)



AW, agreement for performance of work; DT, duty travel; FE, fellowships; LC, local costs; LT, long-term staff; MS, miscellaneous; OTH, other; OV, study tours; SC, short-term staff; SE, supplies and equipment; VE, vehicles
Source: Plan of Action/Regional Information System, WHO Regional Office for the Western Pacific, May 2006.

4.4 Human resources

The WHO Representative Office and country liaison offices have managed their country programmes in close relationship with the respective governments to achieve the objectives set by the Regional Office. In 2005, the WHO South Pacific team comprised 16 international staff and 31 local staff (Table 9).

Table 9: WHO staff in the South Pacific in 2005

Office	Technical staff		General services staff	
	Country regular budget	Regular budget ICP and other funds	Country regular budget	Regular budget ICP
Representative Office	WHO Representative PMO PAO	MVP NCD (MO) HRH EPI (STP) CSR HSI (STP) HSE NCD (SSA, data management) STB (JICA) PHA (EU)	Secretary Administrative assistants (2) Drivers (2) Registry clerk Receptionist Equipment operator Cleaner	Secretaries (9)
Tonga	Country Liaison Officer		Secretary Driver	
Kiribati	Country Liaison Officer		Secretary Driver	
Vanuatu	Country Liaison Officer	MVP	Secretary Clerk typist Driver Cleaner	
Solomon Islands	Country Liaison Officer	MVP	Administrative assistant Secretary Driver	

CSR, Communicable Disease Surveillance and Response; EPI, Expanded Programme on Immunization; EU, European Union; HRH, Human Resources for Health; HSE, Healthy Settings and Environment; HSI, HIV/AIDS and Sexually Transmitted Infections; JICA, Japan International Cooperation Agency; MO, medical officer; MVP, Malaria, Other Vectorborne and Parasitic Diseases; NCD, Noncommunicable Diseases; PAO, Programme and Administrative Officer; PHA, Pharmaceuticals; PMO, Progamme Management Officer; SSA, special services agreement; STB, Stop TB ; STP, short-term professional.

Two technical officers in the South Pacific office were funded in the 2004-2005 biennium through voluntary contributions from the EU and JICA. WHO Headquarters also funded one person.

WHO's presence in small country offices in isolated islands brings special additional costs. For example, travelling outside the region and using e-mail and Internet are very expensive (and slow) as compared to bigger countries.

4.5 WHO partnerships with other agencies

In addition to working with government ministries, WHO cooperates with multilateral and bilateral development partners in several projects based in the South Pacific. These partners include the Joint United Nations Programme on HIV/AIDS (UNAIDS), GFATM, FAO and SPC. The areas of cooperation are based on the WHO priority areas:

(1) *Combating Communicable Diseases.* Includes Expanded Programme on Immunization, Malaria, other Vectorborne and Parasitic Diseases, HIV/AIDS and STI, Stop TB and Leprosy Elimination, Communicable Diseases Surveillance and Response, Food safety, and Emergency and Humanitarian Action.
(2) *Building Healthy Communities and Populations.* Includes Environment Health, Maternal and Child Health and Nutrition, Noncommunicable Diseases and Mental Health, and Tobacco Free Initiative and Health Promotion.
(3) *Health Sector Development.* Includes Health Services Development, Health Care Financing, Human Resources for Health, Essential Medicines and Technologies, and Health Information, Evidence and Research.

Churches and faith-based organizations play an important role in development in many Pacific island countries, and many of them are involved in the health sector. Collaboration with church organizations is similar to that with NGOs. Many ministries of health work with churches when the opinion of church leaders influences decision-making and opportunities for implementation. Areas of importance are adolescent reproductive health, HIV and human rights.

Collaboration with NGOs often takes the form of agreements for performance of work, whereby an NGO is contracted for a specific product such as developing a material or implementing an intervention. Funding can come from country budget allocations, but more often it comes from intercountry funds. This is a common way for WHO to channel support to the organization by other stakeholders. WHO actively promotes the involvement of national NGOs in the planning and implementation of national and regional health development activities. WHO also works with professional organizations such as medical associations, nursing associations, and other organizations that make use of WHO technical support and guidelines.

ODA partners include United Nations organizations, bilateral and multilateral organizations and development banks. Bilateral organizations include AusAID, NZAID and JICA.

WHO collaborating centres are important partners for WHO in the Pacific region because they complement WHO's efforts to provide technical support, training and education and to conduct research. In May 2006, there were 48 WHO collaborating centres in Australia, five in New Zealand, and one in Papua New Guinea. Some of them contribute substantially to WHO's work in the Pacific, including the Pacific Paramedical Training Centre in Wellington, New Zealand, which supports the Regional External Quality Control Scheme, and the National Reference Laboratory in Melbourne, Australia, which supports second-level laboratories of LabNet. In the future, other collaborating centres in Australia and New

Zealand should be more active in supporting Pacific island countries, and such support should be outlined in their terms of reference and workplans. There is no WHO collaborating centre in any of the Pacific island countries.

4.6 Subregional, intergovernmental partners and other partners

WHO works closely with SPC, its most important partner in the Pacific, in the areas of planning and implementation of health programmes. This partnership has grown over the years. Often, WHO and SPC share responsibilities based on geographical access, staff presence and technical competencies. The most successful areas of cooperation include control of vectorborne diseases (e.g. malaria, lymphatic filariasis and dengue fever), tuberculosis and HIV/AIDS and surveillance of infectious diseases.

The meetings of Pacific health ministers, which began in 1995 with the landmark Yanuca Island Declaration on Healthy Islands, is a biennial event of WHO and SPC that has produced key strategic health policy options and directions on priority health matters for Pacific island countries, with the underlying theme of "Achieving Healthy Islands". So far, six meetings have been held to address three main areas: (1) the growing burden of noncommunicable diseases; (2) the lingering burden of infectious diseases and the dangers of their re-emergence as well as the threat of new emerging ones; and (3) the need to support health systems so that they can cope with the double burden of communicable and noncommunicable diseases. The 2005 meeting in Samoa, with the theme "Healthy Lifestyles and Supportive Environments", produced a series of recommendations (Samoa Commitment: Achieving Healthy Islands) on key areas of communicable and noncommunicable diseases, surveillance and response as well as on migration of skilled health personnel and POLHN.

WHO's partnerships with SPC and others have facilitated the provision of specific health interventions such as immunizations and control or reduction of some diseases. However, the challenges posed to health systems by globalization, HIV/AIDS and the migration of health personnel require more extensive partnerships beyond WHO and SPC. Such partnerships could include the Pacific Islands Forum as well as bilateral and multilateral partners to support the Pacific island countries in their efforts to achieve their Healthy Islands goals.

In 2005, the Pacific Islands Forum Secretariat prepared the Pacific Plan for Strengthening Regional Cooperation and Integration, which was endorsed by the Leaders at the Pacific Islands Forum meeting in October 2005. One of the strategic objectives in the Pacific Plan was to improve health. An initiative was agreed for the years 2006–2008 to harmonize approaches in the health sector under the Samoa Commitment, including: implementing the HIV/AIDS and STI strategy; a stronger focus on noncommunicable diseases; and agreement on health worker recruitment. The Pacific Islands Forum Secretariat and WHO are also in the process of establishing an agreement on strengthening food legislation in the Pacific, to be implemented in conjunction with FAO.

There is also close collaboration with regional educational and training institutions, including FSMed, FSN, University of South Pacific and University of Papua New Guinea. WHO fellows from the region are often placed at FSMed and at FSN.

4.7 Main strengths, weaknesses, opportunities and threats

Table 10: SWOT analysis of the WHO Representative Office for the South Pacific

Strengths	Weaknesses
Long-term physical presence in countries and good relationships with governments	Present in only a small number of countries
Strong technical capacity for WHO as a whole	Limited capacity in some aspects of health sector and system support
Timely and flexible response to governments' urgent requests and emergencies	Thinly spread resources, need to concentrate on selected priority areas of work
Recognition of WHO as leading technical agency in health	Increasing complexity of demands from countries requires strengthening of field office capacity
Good knowledge of the region and the countries	Bypassing of country office by Regional Office and Headquarters
Programmes focused on national priorities and integrated into the regional plan of action	Inadequate involvement of field officers in the planning of regional and global initiatives
Strong team work	Decentralization of work without adequate resources and authority
Opportunities	**Threats**
Results-based planning; able to focus on priority areas	Lack of national capacity and migration of health professionals
Engagement strategy with agencies and donors [a]	Donor-driven health agenda that does not reflect key country needs
Increasing interest by international and regional organizations	More partners in health makes coordination efforts more complex
More partners in health-related areas [b]	Political instability in some countries
WHO leadership in regional networks [c]	Natural disasters

a Includes United Nations agencies, Australian Agency for International Development, New Zealand Agency for International Development, Japan International Cooperation Agency, and Secretariat of the Pacific Community.
b Includes United Nations Health Group.
c Includes Pacific Programme to Eliminate Lymphatic Filariasis, Pacific Public Health Surveillance Network, Pacific Immunization Programme Strengthening, Pacific Open Learning Health Network, and Mobilization of Allies in Noncommunicable Disease Action

4.8 Summary of key challenges and opportunities

Optimization of WHO support to the Pacific

- WHO's presence in Pacific island countries – matching WHO's support to the countries' needs.
- "Subregional ICP" to further delegate authority from the WHO Regional Office for the Western Pacific to the subregional office in the South Pacific.
- Strong capacity for technical advice by long-term staff in the main programme areas .
- Reorienting gradually WHO's resources and inputs according to the subregional changing needs.

5 WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

The real centre of WHO's work is countries, and countries have to be placed at the heart of WHO's work. The targets identified by WHO included management and expenditure of 70% of overall WHO resources in countries and regions for the 2004-2005 biennium and 75% for the 2006-2007 biennium.

The majority of countries in the Western Pacific Region with a WHO presence now have a CCS or are developing a CCS that reflects the medium-term vision of WHO for its cooperation with a country and defines a strategic framework for working with a country. The CCS clarifies WHO's roles and functions in supporting national health plans and other national health and development frameworks. The CCS is an Organization-wide reference for country work, guiding planning, budgeting, and resource allocation. It is the basis for developing the "WHO one country plan and budget" and is used for mobilizing human and financial resources for strengthening WHO support to countries, in order to contribute optimally to national health development. In a two-way process, it feeds into, and takes into consideration, both the WHO General Programme of Work and the Programme Budget.

In developing its programme of work, WHO is guided by the principles of results-based management. Priorities are identified based on recent WHA and Regional Committee resolutions. Translation of global and regional collective mandates such as the MDGs to country level is important. The highest priority is given to identifying country needs and priorities in close collaboration with countries. Priorities expressed in recent WHA resolutions include the need to enhance global health security, accelerate progress towards achieving the MDGs, responding to the burden of noncommunicable diseases, promoting equity in health and ensuring accountability. Under recent programme budgets, the following areas have been identified for greater emphasis:

- epidemic alert and response;
- making pregnancy safer;
- child and adolescent health;
- surveillance, prevention and management of chronic noncommunicable diseases;
- tobacco; and
- planning, resource coordination and oversight.

The fiftieth session of the Regional Committee for the Western Pacific endorsed the document *WHO in the Western Pacific Region: A Framework for Action* as a set of guiding principles for WHO's work in the Western Pacific Region in the early years of the 21st century. The Regional Committee requested Member States to work with WHO to implement the Organization's programme of technical cooperation in line with the approaches described in the *Framework for Action*. The Regional Director was asked to implement the approaches outlined in the *Framework for Action*, with particular attention to least developed countries.

The *Framework for Action* identified four main challenges for WHO and the tasks associated with them:

(1) improve our understanding of the changing needs of Member States;
(2) reform WHO;
(3) strengthen partnerships; and
(4) achieve more with fewer resources.

In order to meet these challenges, the WHO Regional Office for the Western Pacific identified the three major themes listed below, each of which has action and outcome oriented strategic focuses:

(1) combating communicable diseases;
(2) building healthy communities and populations; and
(3) health sector development.

In line with Regional Office's desire for WHO to become more focused on priority problems at the country level, dialogue with the Member States and other international partners has increased and their involvement in policy making and evaluation of WHO's performance has grown. In addition, WHO has undergone a process of reform and restructuring as outlined in the *Framework for Action*. This process has included cultural and orientation reforms, changes in the management framework and organizational structure, strengthening of country presence and operations and reforms in personnel management and staff development.

Achieving better health for all by promoting the development and implementation of appropriate pro-poor health policies and interventions is therefore central to WHO's work. However, the capacity of key ministries of Member States to address poverty in health remains weak. Therefore, a major objective of WHO's support to countries and areas is the strengthening of both the capacity and commitment to develop and implement pro-poor health policies and interventions across a range of sectors, in the context of recent global initiatives. Strengthened commitment and capacity will catalyze action and contribute significantly to the development and implementation of appropriate pro-poor health policies and interventions in Member States.

The MDGs have focused the efforts of the world community on achieving significant, measurable improvements in people's lives, with the elimination of poverty as the overarching priority. Targeting health interventions will promote progress towards the MDGs, particularly among the least developed countries in the region. WHO supports Member States to create an enabling environment for poverty alleviation and to strengthen health systems, as prerequisites for ensuring equitable access to efficient and good quality health services for all. If the number of people in extreme poverty is to be halved by 2015 (the target of the MDG on poverty), health policy development and systems implementation must be more effective in achieving greater equality of health outcomes and greater equity in health financing.

As well as supporting Member States in the implementation of activities to achieve the MDGs, the future support of WHO will focus on: conducting advocacy and strengthening awareness; building national capacity for MDG monitoring and reporting; providing guidance on standard definitions, means of verification, data sources, and methods of estimation; and assessing the extent to which progress is pro-poor and equitable.

Many developing countries in the region face common challenges in developing and implementing policies to address poverty, health and equity, and in incorporating them into their national agendas for socioeconomic development. There is growing awareness that the achievement of national goals depends to a large extent on health improvements among the poor and disadvantaged. If these are to be achieved, investments in health to strengthen health systems, particularly those providing essential health services, need to be increased, and the financial burden associated with health care needs to be reduced. In addition, there is a need to integrate technical and financial resources to strengthen sustainable development of health systems. The Regional Office and country offices already work closely with governments to support national efforts to address these concerns and this work will be intensified.

WHO provides technical assistance to support pro-poor health policies in many areas. This includes work to promote universal access to cost-effective PHC services and essential drugs; improve social protection, especially against catastrophic health expenditures,

through pro-poor health care financing mechanisms; strengthen understanding on resource flows through implementing national health account systems, cost-effectiveness analysis and other operational research; and make services accessible to all, including the poor and marginalized.

6 STRATEGIC AGENDA FOR WHO COOPERATION

6.1 Introduction

The Pacific island countries and areas will be places where:

- children are nurtured in body and mind and develop to their full potential;
- the health of people is protected and fostered;
- individuals and communities practise healthy lifestyles;
- all islanders celebrate their diversity and enjoy equity of opportunities for health;
- ecological balance is a source of pride;
- culture invites learning and leisure; and
- people work and age with dignity.

The WHO Representative Office for the South Pacific works collaboratively with governments and other partners, individually and collectively, to provide timely, responsive and effective technical cooperation to these island countries in their pursuit of national and international health development goals.

The WHO Representative Office for the South Pacific will be guided by the following strategic principles in implementing the strategic directions outlined below:

- Critically analyse needs and promote evidence-based technical approaches.
- Cooperate in a way that is action oriented, country focused and results driven.
- Work towards a common vision for health in the subregion, guided by both collective priorities, as identified by Pacific health ministers meetings, and by national health priorities.
- Promote technical cooperation among countries and areas for sustainable programmes, with recognition of the diversity in the level of health development and commonalities among groups of countries and areas.
- Explore innovative ways of working with an increasing number of partners.

6.2 Strategic agenda

Priorities for the WHO Representative Office for the South Pacific were identified with the view of the overall health and development needs and priorities in the Pacific island countries, within the framework of WHO's 36 areas of work, and the larger Millennium Development Goals framework. Consequently, four main overarching strategic directions for WHO support under the 2006–2011 Country Cooperation Strategy were articulated, namely: to support governments' efforts towards (1) reducing risk factors to human health arising from environmental factors, including natural and manmade hazards; (2) strengthening public health and enabling equitable access to primary heath care-based systems providing good-quality services, with particular attention given to the needs of people in outer islands; (3) reducing morbidity, mortality and disability from priority illnesses (or conditions) including elimination of selected diseases; and (4) supporting public health leadership and nurturing partnerships. Each strategic direction comprises several strategic foci. Each focus delineates the key areas of work.

Strategic priority 1: Reducing risk factors to human health arising from the environment, including natural and manmade hazards

Safe water and food, and adequate sanitation and waste management are among the most important determinants of health. The WHO Regional Office for the South Pacific will aim at increasing access to safe drinking-water, adequate sanitation and waste management based on sustainable community-based solutions and strengthening government's role in regulating and monitoring water quality and protecting vulnerable groups. The fragile ecosystems, fisheries and vulnerable freshwater resources in the Pacific island countries need to be protected from increasing urbanization and development (including tourism), which pose a threat to people's health and livelihood.

Main focus 1: Environmentally and economically sustainable safe water, sanitation and waste management

Key areas of work include:

(1) improve access to safe water and sanitation; and
(2) improve waste management, including health care waste.

The WHO Representative Office for the South Pacific, together with countries, will identify key environmental health problems at country level. Improving access to safe water and sanitation based on sustainable community-based solutions will be an important goal. Efforts will also be focused on improving solid and health care waste management. Technical support will be provided directly to countries and areas and also through subregional mechanisms and partnerships. For example, WHO's links with the South Pacific Applied Geoscience Commission (SOPAC) and the Secretariat of the Pacific Regional Environment Programme (SPREP) are two relevant partnerships for water/sanitation and environment/waste management issues, respectively. These partnerships offer the opportunity for 'Pacific-owned' institutions and mechanisms to complement WHO's normative and technical functions. Support, often in cooperation with Pacific partnerships such as these, will focus on the transfer of appropriate technologies, the setting of standards and the establishment of monitoring systems.

Main focus 2: Disaster response and management

Key areas of work include:

(1) support development of mechanisms for disaster management (including preparedness and response) with emphasis on protecting health; and
(2) strengthen national capacity on health emergency management.

Activities will focus on providing support to strengthen national capacity on health emergency management. Key partners will include relevant United Nations agencies, such as the Pacific Sub-regional Centre and the Office for Coordination of Humanitarian Affairs (OCHA), both based in Suva. The United Nations Resident Coordinator's Disaster Management Team provides a valuable coordinating mechanism that is particularly suited to emergency and disaster response. Meanwhile, SOPAC is a key regional partner for WHO initiatives in the area of disaster mitigation and preparedness. In coordination with relevant regional partners and disaster networks, Member States will be assisted in reviewing and updating national health sector disaster plans and developing the needed capacities for disaster preparedness and response. When emergencies occur, the WHO Representative Office for the South Pacific will respond quickly by providing technical support and facilitating provision of emergency supplies and equipment.

Main focus 3: Food safety

Key areas of work include:

(1) strengthen food safety systems including support for policy development, legislation reform, risk assessment, inspection, monitoring, foodborne disease surveillance, analysis and food safety education.

Addressing current problems in relation to food safety control in the Pacific requires action on several fronts. Effective food safety control requires sound structures, relevant legislation and effective enforcement, surveillance and monitoring, as well as the delivery of information, education and advice to stakeholders across the farm-to-table continuum. This requires a multisectoral approach to food safety and calls for closer and more effective communication between all stakeholders (e.g. between veterinary public health, agriculture and food regulatory officials, and legal officials). Furthermore, the Pacific island countries and areas would benefit from a regional approach to the review of food legislation and development of standards; to surveillance; to the collection of data on food contamination; and to training of inspectors and education and training of industry and consumers.

Consequently, efforts to enhance food safety in the Pacific will be focused on sharing information on food safety; supporting legislative reform in the Pacific; supporting a coordinated and regional approach to strengthening food and water analysis laboratories and obtaining data on food and water contamination; assessing dietary exposure to hazards; building foodborne disease surveillance capacity together with the foodborne disease surveillance technical working group of the Pacific Public Health Surveillance Network (PPHSN); recognizing the importance of having adequate and competent food inspectors and establishing regional training standards for the training of food inspectors; and integrating *WHO's five keys to safer food* into school policies and curricula and in the delivery of information, education and advice to consumers and industry. The WHO Representative Office for the South Pacific will build on the collaboration with FAO in the area of food safety and focus on interventions that have the potential to improve food safety at community level.

Strategic priority 2: Strengthening public health and enabling equitable access to a primary health care-based health system providing good-quality services, with particular attention given to the needs of people in the outer islands

Weaknesses of health systems, including health policy-making and strategic planning, are causing serious difficulties for implementation of key preventive and curative public health interventions and for achievement of MDGs in the Pacific island countries. Health systems development is an essential strategic direction as the primary health care based health system is the necessity for all the preventive and curative public health programmes.

Main focus 1: Strengthening governance for public health

Key areas of work include:

(1) strengthen government capacity to develop public health policies and support legislation, using up-to-date strategies and frameworks;
(2) strengthen government capacity in strategic national health sector planning;
(3) strengthen the mechanisms and capacity for participatory policy development, with greater involvement from local communities, other ministries and agencies, partners, NGOs, private sector, and professional associations;
(4) enhance capacity for effective implementation of policies and legislation; and
(5) improve country capacity for development of health information systems.

Strong policy-making capacity is essential for strengthening health systems in the Pacific. Realistically, however, the size of the policy workforce will remain small, and it is therefore difficult for ministries to develop in-house, in-depth policy expertise in many areas of health policy. Much of the older legislation is based on out-of-date policy approaches, in some cases 'imported' from jurisdictions that do not match the needs, resources or social context of the Pacific. In addition, policy development is now much more complex, affected by broader public sector administrative and economic reforms, and involving many more stakeholders (other ministries, increasing responsibilities being devolved to local governments, private sector players, NGOs, a more vocal and active community, etc).

Ministries will therefore remain dependent on accessing specialized advice, either engaged specifically to assist the ministry directly, or through other ministries (such as the justice/attorney-general's/solicitor-general's office in the case of legislation). While planning and management capacities have often been strengthened within specific programme areas, less attention has been given to strengthening the overall policy and planning capacity of ministries of health and to ensuring that the policy frameworks (and supporting legislation) are based on modern principles and frameworks tailored to be relevant in each country setting. WHO will increase its commitment and involvement in the national strategic health planning processes.

It is also critical that ministries are able to access good information sources and examples of policies and legislation developed elsewhere, but capacity must exist to adapt these examples to the local situation and analyse and incorporate other relevant evidence before such policies are signed off or implemented. One relevant effort to mention in this area is the Pacific Senior Health Officials Network, which was established to strengthen links between the Australian Department of Health and Ageing and Pacific ministries of health, with the aim of supporting good governance in the region.

In addition, there is a need to ensure a coordinated and comprehensive approach to public health, which could be helped by using the essential public health functions (EPHF) approach in conjunction with primary health care, and an increased focus on ensuring that the most cost-effective public health interventions are fully utilized. Essential public health functions are closely linked to governance for public health. The EPHF concept enables more systematic definition, planning and evaluation of all aspects of public health, while maintaining flexibility for different country contexts. Importantly, essential public health functions represent public goods and, in this respect, governments as a whole need to ensure they are provided, although actual provision of these activities can be undertaken through a mixture of public, private and nongovernmental organizations and community groups, depending on what is most relevant for the country. Essential public health functions are broad and act as a framework for all relevant parts of government that have jurisdiction for overseeing or implementing different public health activities or aspects, not just the department or ministry of health. Essential public health functions that need to be delivered at local levels are, in the Pacific, usually delivered through primary health care. Strengthening primary health care is therefore very important for strengthening public health. In addition, greater awareness is needed of the most cost-effective public health interventions and greater commitment is needed to increase resources for these important interventions.

Better information and better use of information are essential in health policy-making and planning as well as in management of health services. Many countries have deficiencies in their vital statistics of births and deaths, and communicable disease surveillance. Requests for information by many donors and international agencies make a heavy burden for small countries. Although some regional and international agencies assist Pacific island countries to strengthen their health information systems, this work is not well coordinated between the agencies.

Partners that can support efforts in these areas include AusAID, EU/EC, NZAID and the United States Agency for International Development (USAID) (often undertaken as part of health sector strengthening or public sector reform projects more generally). In the area of health information, the Health Metrics Network is a new partner providing support in the development of health information systems, offering assessment tools and a health metrics framework for all interested countries.

WHO is able to provide policy frameworks and advice on all areas of public health, as well as engage expertise for drafting legislation. In addition, many of the guidelines and standards developed by WHO in policy and information areas (including a health information system strategic plan for the Western Pacific Region, 2006) are relevant to the Pacific. WHO will assist in identifying how/whether these might need to adjusted for use in particular countries and areas.

Main focus 2: Access to and quality of health services

Key areas of work include:

(1) strengthen community-based health services and capacities to enable more equitable and efficient provision of health care services at local levels, using primary health care approaches;
(2) improve access to, and coverage by, health services in the outer islands;
(3) study feasibility and possible benefits of telemedicine and e-health in general;
(4) assess and improve in-country and intercountry referral systems;
(5) supply pharmaceuticals and equipment; and
(6) improve quality of primary, secondary and tertiary health services.

Good quality PHC services, accessible to all, are essential in the Pacific, and form a fundamental part of all health systems in the Pacific. Special emphasis is placed on activities at the first or primary care level—in addition to basic diagnostic and treatment services—to promote and maintain health with good community participation and empowerment. However, there are gaps and weaknesses in these PHC services, primarily relating to sufficiency and competence of the workforce, particularly on remote islands where it is difficult to attract and retain suitably qualified staff, and to provide the means for maintaining and upgrading the knowledge and skills of all staff. At times, the availability of drugs and equipment, particularly in more remote settings, causes problems for service delivery, and greater attention is needed to manage these more effectively. In addition, systems for providing more effective support, communications and referral systems that can be utilized when needed by more distant workers is an ongoing challenge, and the possible benefits of telemedicine and e-health to assist workers in this situation in the Pacific need to be explored.

The quality of services also remains a key issue throughout the Pacific. Modern approaches to quality take a systems perspective, utilizing a complex array of different tools and approaches to examine the issues involved and identify improvements that should be made to current systems and procedures. Not only does this require leadership and management commitment and understanding of the complex issues involved in quality and quality improvement, but clinical and support staff must also have this understanding and be given access to relevant up-to-date information and training so that they are in a position to examine what they do and how they do it. They also need to use local and international evidence to be able to improve their own performance and that of the system as a whole. Patient safety is a key component of quality, and all staff must be involved in efforts to improve patient safety in a constructive manner. There must be a supportive environment in which system errors, mistakes in practice, or near misses can be discussed. Where necessary, the issue of culpability for individual errors should be handled through separate

mechanisms. Up-to-date standards and guidelines are also needed to improve quality and the impact of resources.

Partners that can support efforts in these areas include AusAID, EU/EC, NZAID and USAID (often undertaken as part of health sector strengthening projects). In addition, the World Bank, JICA and ADB have from time to time supported projects to strengthen infrastructure and equipment. The World Alliance for Patient Safety can provide some support or advice related to patient safety.

With the exception of buildings and equipment, WHO is able to access expertise to provide advice on all of these issues, although any major project would need to secure specific additional funding from a donor. Human resources are further discussed in section 6.4.2.4.

Main focus 3: Health financing

Key areas of work include:

(1) advocate for increased and better planned investment for health;
(2) build capacity in planning and management of financial resources;
(3) set up national health account systems to monitor resource allocation and utilization; and
(4) assess the need for social health insurance.

Until now the funding for basic health services has been provided by the government in most of the Pacific island countries. However, both service provision and health financing are becoming more pluralistic with the increasing role to private service provision and financing, and at the same time sustainability of government-funded systems is in danger. Because of weak financial reporting systems, an increasing share of out-of-pocket and overseas spending on health, the amount and flow of financial resources is not well known. Some countries and areas have shown an interest in social health insurance, but before decisions are made on implementation it will be necessary for WHO to work with national counterparts to make careful assessments of the organizational and management aspects and to discuss how to ensure insurance coverage for the poor and marginalized groups.

Main focus 4: Human resources development and management

Key areas of work include:

(1) strengthen health workforce information system, needs analysis and planning, and performance management and supervision;
(2) conduct training needs analysis and improve access to and quality of basic health care training programmes in the countries and areas of the Pacific;
(3) enhance open and distance learning opportunities such as through the Pacific Open Learning Health Network (POLHN);
(4) develop guidelines and codes of practices to reduce and manage the migration of health workers; and
(5) facilitate effective partnerships among donors and stakeholders for creating a Pacific HRH alliance in order to strengthen the capacity of the countries and areas of the Pacific to train and retain adequate workforces that are skilled, motivated and supported so as to meet their national health goals.

Human resources are essential for functional health systems. However, in the countries and areas of the Pacific common health workforce issues include shortages, poor salaries, working conditions and workplace environments; limited or lack of monetary and non-financial incentives; skill mix and distribution imbalances, worsened by migration; inadequate numbers of trainees with variable quality and standards of education; weak workforce knowledge base; and lack of coordination across sectors and partners. Ensuring the

numerical and distributional balance of various categories of the workers, the relevance of training and technical skills and the efficient skill mix of the health workforce, coupled with good personnel management, appropriate career structures, effective staff supervision and development, presence of adequate support, and good working environment will be challenging for most, if not all countries. Concerted and systematic efforts by all stakeholders at all levels, including strong support and commitment from key sectors like finance, education, labour and infrastructure, to mount more innovative, comprehensive and sustained responses to overcome the health workforce challenges will be essential.

WHO support will be focused on strengthening national capacity in health workforce development and management, with core functions that include: technical and policy support; development of tools, norms, standards; policy and advocacy; development of guidelines and adaptation of these to suit country needs.

Strategic priority 3: Reducing morbidity, mortality and disability in priority health areas including elimination of selected diseases

The focus of this direction is in control of both noncommunicable and communicable diseases. Most countries and areas of the Pacific are challenged by the double burden of noncommunicable and communicable diseases characterized by a rapid epidemiological transition. The priorities in the Pacific island countries include better control of chronic diseases, promotion of healthy lifestyles and improvement of disease surveillance to meet the requirements of revised International Health Regulations, or IHR (2005).

Main focus 1: Strengthen prevention, control and management of noncommunicable diseases

Key areas of work include:

(1) reduce prevalence of the key noncommunicable diseases (diabetes, cardiovascular diseases, cancer) and their risk factors;
(2) reduce tobacco use and tobacco smoke exposure; and
(3) strengthen activities for mental health problems, and prevention of injuries.

Noncommunicable diseases, especially cardiovascular diseases and diabetes, are major public health issues in almost all Pacific island countries. Currently, only a few countries have a surveillance system for noncommunicable diseases and their risk factors (tobacco use, alcohol use, poor nutrition, physical inactivity, obesity, raised blood pressure, blood glucose and blood cholesterol). The implementation of STEPS and global tobacco surveys allows for further development of an increasingly comprehensive surveillance system for noncommunicable diseases and their risk factors. WHO will expand the use of STEPS, support the development of national strategies, support the implementation of the appropriate community-based interventions and endeavour to develop a broad participatory framework of partners on prevention and control of noncommunicable diseases.

There is an urgent need to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco use and exposure to tobacco smoke. This can be done in the Pacific through rapid implementation of the WHO Framework Convention on Tobacco

Control, which has been ratified and is now binding in all Pacific Member States, and the Regional Action Plan 2005–2009 for the Tobacco Free Initiative (TFI), endorsed by all Member States of the Western Pacific Region. Effective implementation of the WHO FCTC will be a critical factor in reducing NCD-related morbidity and mortality. Therefore, WHO will

- expand the Global Youth Tobacco Survey and related global surveys to better plan, implement and evaluate national tobacco control policy, legislation and programmes;
- provide technical assistance and capacity-building support to countries for the development and enforcement of tobacco control legislation and programmes; and
- provide technical assistance, capacity-building and other support for the implementation of the WHO FCTC.

The prevalence of mental health problems such as depression and suicide is on the rise in the Pacific. However, only a small number of countries have mental health programmes to tackle the growing problem. Support for efforts to initiate and strengthen national mental health programmes is needed. WHO will continue to support national efforts to prevent, diagnose and treat mental health problems. WHO will also undertake the development of a participatory network to address mental health.

In addition to self-inflicted injuries (e.g. suicide) and violence-induced injuries (including gender-based violence), road traffic injuries are an increasingly important cause of mortality and disability in the Pacific. Most of these injuries could be prevented through enforceable legislation and effective prevention programmes, which most countries in the Pacific do not have. WHO coordinates the activities of the United Nations Global Road Safety Collaboration, with a mandate from the United Nations General Assembly. A number of intergovernmental organizations, NGOs and bilateral donors are participating in this global collaboration. In particular, WHO and UNESCAP will organize the First United Nations Global Road Safety Week in April 2007, engaging all countries and areas in the Pacific. Further, WHO will assist countries in developing surveillance systems, undertaking surveys, identifying trends, advocating for appropriate interventions, and strengthening pre-hospital and hospital trauma care. It will also collaborate with countries and areas in improving road safety through developing legislation, advocating for upgrading road infrastructure and signage, enforcing seatbelt and helmet use, controlling driving under influence of alcohol, and organizing safety awareness programmes.

Main focus 2: Strengthen communicable disease surveillance and response and implementation of the International Health Regulations (2005)

Key areas of work include:

(1) strengthen communicable diseases surveillance and response;
(2) support implementation of the revised International Health Regulations (2005); and
(3) support implementation of the Asia Pacific Strategy for Emerging Diseases.

Communicable diseases remain among the leading causes of morbidity and mortality in many Pacific island countries. While outbreaks of known communicable diseases such as typhoid fever, influenza, dengue, leptospirosis, measles and cholera continue to occur in the Pacific, the region also potentially faces public health threats arising from newly emerging diseases, including a pandemic influenza.

Although the Pacific island countries and areas have not experienced outbreaks of SARS or avian influenza A(H5N1), the lessons learnt from these diseases demonstrate that infectious diseases can continue to emerge in the world, spread rapidly cross national borders and adversely affect economic growth, trade, tourism and social stability. As many Pacific island countries are currently experiencing rapid social and environmental changes (migration, urbanization and globalization), the risk of cross-border transmission of infectious diseases is significantly increasing in the Pacific. National and local capacity for surveillance and

response, especially early warning functions and laboratory capacity for diagnostic confirmation and verification of outbreaks is still limited in most Pacific island countries. These countries will need to strengthen their core public health surveillance and response capacities and be prepared for potential disease threats, including an influenza pandemic, in order to minimize the health and socioeconomic impact of future outbreaks.

The revised International Health Regulations, or IHR (2005), require all Member States to assess, develop, strengthen and maintain capacity at each level to meet the minimum core capacity requirements for surveillance and response, and for designated points of entry, and to notify WHO of all events that may constitute a public health emergency of international concern within 24 hours of assessment by using the agreed decision instrument.

Within the global framework of IHR (2005), the Asia Pacific Strategy for Emerging Diseases was drawn up by the WHO Regional Offices for South-East Asia and the Western Pacific. The strategy aims to:

(1) reduce the risk of emerging diseases;
(2) strengthen early detection of outbreaks of emerging diseases;
(3) strengthen early response to emerging diseases;
(4) strengthen preparedness for emerging diseases; and
(5) develop sustainable technological collaboration within the Asia Pacific region.

The Regional Committee for the Western Pacific at its fifth-sixth session in September 2005 urged Member States to implement the strategy, as an important stepping stone to meet the core capacity requirements for surveillance and response under IHR (2005). Therefore, the strategic direction for future communicable disease surveillance and response programmes in the Pacific is to strengthen capacity to prevent, detect and respond rapidly to public health threats arising from infectious diseases of both known and unknown aetiology. Individual country needs should be addressed and a combination of subregional, integrated, multisectoral and comprehensive approaches for communicable disease surveillance and response programmes are needed to maximize utilization of limited resources and to improve the effectiveness of the programme. Under IHR (2005), WHO is mandated to receive alerts of cases and outbreaks or public health events of potential international concern, and to coordinate the verification, assessment of and response to these events. In the Pacific, WHO has undertaken this task with collaboration and support from SPC.

Pursuant to the above, WHO will:

- continue to be the primary recipient of disease outbreak or event alerts and notification and will continue to support countries in the detection, verification, assessment of and response to these events;
- support strengthening of hospital based surveillance;
- formulate and implement policies and strategies in the field prevention and control of emerging and other infectious diseases, including implementation of the Asia Pacific Strategy for Emerging Diseases;
- formulate guidelines and provide technical advice to Pacific island countries in the field of emerging and other infectious disease preparedness, prevention, detection, and control;
- support Pacific island countries in the implementation of IHR (2005), when possible fully utilizing their existing public health systems and structure;
- continue to collaborate and coordinate with SPC in the field of influenza pandemic preparedness in Pacific island countries; and
- in collaboration with SPC, work closely with governments and other partners to support countries in their efforts to strengthen their surveillance and response capacity for emerging diseases as well as their core capacities required for dealing with other public health emergencies of international concern, in accordance with IHR (2005).

Main focus 3: Strengthen prevention and control of high priority communicable diseases, including elimination of selected diseases.

Key areas of work include:

(1) elimination of selected communicable diseases;
(2) communicable diseases with MDG targets: TB, malaria and HIV/AIDS;
(3) universal access for HIV prevention, treatment and care;
(4) management of common childhood illnesses;
(5) vaccine-preventable diseases; and
(6) sexually transmitted infections.

Elimination of selected communicable diseases

Diseases such as lymphatic filariasis, measles, leprosy and yaws can be potentially eliminated or eradicated in the Pacific. The Pacific has interrupted measles virus transmission since 1997; however, measles outbreaks in 2004 indicate that the level of immunity in the communities is not sufficient. All but three out of 15 Pacific island countries and areas have eliminated leprosy as a public health problem. The Pacific region has set a target for lymphatic filariasis elimination of 2010 and measles elimination (as part of the Western Pacific Region) of 2012.

WHO will support countries to meet and certify the subregional, regional and global disease elimination targets.

Communicable diseases with MDG targets: TB, malaria and HIV/AIDS

Tuberculosis remains an important public health issue in the region. Partners in the area of tuberculosis control include: SPC, which supports implementation of GFATM-funded TB control programmes in 10 Pacific island countries; and the United States Centers for Disease Control and Prevention, which supports countries and territories affiliated with the United States. In addition, Australia and New Zealand provide technical support, mainly related to TB laboratory services.

Malaria is highly endemic in Solomon Islands and Vanuatu. While the incidence of HIV is currently low, HIV/AIDS programmes in the Pacific will need to continue to focus on prevention, and to strengthen the second generation surveillance. As HIV infections and AIDS cases are increasing in a number of countries, care and treatment including antiretroviral therapy need to be put in place.

Consequently, WHO will support countries to strengthen TB control activities, to eliminate the burden of malaria, to maintain low prevalence of HIV/AIDS, and to implement GFATM-funded activities.

Universal access for HIV prevention, treatment and care by 2010

Pacific island countries, although categorized as "low prevalence countries", will also benefit from the new goal of universal access. The five key strategic directions of universal access are:

(1) enabling individuals to know their HIV status through HIV testing and counselling;
(2) accelerating the momentum of HIV/AIDS treatment and care scale-up;
(3) maximizing the health sector's contribution to HIV prevention;
(4) investing in strategic information to guide a more effective HIV response; and
(5) taking urgent action to strengthen and expand health systems.

WHO will pursue the strategies of the universal access approach, with focus on the development of surveillance and treatment guidelines.

Management of common childhood illnesses

Child and infant mortality are declining in most countries of the region, but significant regional and subnational disparities remain. A continuing emphasis is needed on primary health care, including provision of immunization, as well as more effective education regarding nutrition. Currently, leading causes of death in children under five years of age include acute respiratory infections, diarrhoea, malaria and injuries. WHO will support Pacific island countries to increase Integrated Management of Childhood Illness (IMCI) activities and assist Pacific island countries to mobilize resources to target actions towards children and mothers in greatest need.

Vaccine-preventable diseases

Pacific island countries have made significant achievements in protecting their populations, particularly children, from vaccine-preventable diseases since the establishment of EPI in the early 1980s. However, significant challenges remain for EPI in many Pacific nations, and in recent years, immunization coverage has declined in some countries. Scattered island populations make accessing children difficult and expensive, and continued support and focus from both governments and donors will be required. Priority should be given to measles elimination, expanding the range of vaccines to children, maintaining high coverage and reducing hepatitis B carriage within the region. Strong EPI programmes have a positive effect on reducing infant and child mortality. Therefore, WHO will continue to support countries towards self-sufficient immunization programmes, including the ability to reach every child and woman of reproductive age with an expanding package of essential life-saving vaccines. In close collaboration with all other partners, targeted levels of immunization coverage must be achieved.

Sexually transmitted infections

Sexually transmitted infections are prevalent in the Pacific and play a critical role in facilitating HIV transmission. They also cause serious complications for women of reproductive age, including pelvic inflammatory disease, ectopic pregnancy, infertility and even cancer. In order to lower STI prevalence, WHO will support Pacific island countries in the prevention and control of treatable infections through the provision of effective and user-friendly comprehensive STI case management, and through the monitoring of drug resistance and strengthening of laboratory capacity.

Strategic priority 4: Supporting public health leadership and nurturing partnerships

As the health sector increasingly becomes an important development agenda, and as the number of partners in this area continues to climb, WHO will need to take the lead in coordinating efforts. In most Pacific island countries, the capacity of ministries of health needs to be strengthened to engage in the new environment. Considering the new global initiatives and the evolving role of SPC, there is an opportunity for WHO to reaffirm a leadership role in health in the Pacific.

Main focus 1: Strengthen the leadership of ministries of health to engage in multisectoral and international activities and opportunities, and to take an active lead in coordination of international aid.

Key areas of work include:

(1) strengthen the capacity of ministries of health in policy-making and planning;
(2) support ministries of health to work with the global health initiatives;
(3) support ministries of health in intersectoral collaboration in health-related issues; and
(4) support ministries of health in coordination of health sector development aid.

The overall responsibility of country's health system lies with the government. In addition to the government's role as steward of health resources, government's stewardship makes possible the attainment of health system goals such as: improving health, responding to the legitimate expectations among the population, and fairness of financial contributions. Most of the stewardship role falls to health ministry, but some aspects of stewardship in health must be assumed by the government as a whole (for example health issues that require multisectoral approach). Increasing number of global health initiatives and other bilateral and multilateral partners in health make it difficult for small island countries to take advantage of new potential partnerships. Within this area, WHO will:

- support capacity development of ministries of health in policy development and planning;
- support countries to participate in and take advantage of the new global and subregional initiatives. WHO will inform countries on new initiatives, assist in proposal development, and provide technical support in the implementation and evaluation of projects and programmes supported by international partners;
- support planning of health related development initiatives and provide necessary evidence to promote positive and equitable health impact; and
- assist the government to monitor and coordinate international aid to health sector with other agencies of the United Nations.

Main focus 2: Strengthening WHO's leading role in coordination of partners in health sector

Key areas of work include:

(1) promote and facilitate technical cooperation among countries and areas, in accordance with the strategies outlined in the Pacific Plan;
(2) support coordination of international aid; and
(3) provide evidence and share best practices.

WHO will facilitate the collection, analysis and sharing of information on the health situation and trends, and also collate evidence on best practices and the most cost-effective interventions, using both international and local experience. WHO should be the lead international agency in collection of health-related statistical data to be shared with ministries of health, SPC and other partners. WHO also needs to work with other United Nations agencies and ministries of health to assess needs and priorities in the health sector, to allocate resources and to assist ministries of health in project and programme implementation and evaluation when necessary. Pursuant to the aforementioned areas of work, WHO will:

- improve the knowledge base of health development in the region, identify and share best practices, and support development and implementation of technical cooperation among countries and areas;
- strengthen its functions under the "Reaching out" theme through various mechanisms, such as establishment of WR-SP office website and production of briefing folders;

- increase its efficiency and effectiveness by early and speedy implementation of the forthcoming Global Management System (GSM), utilizing it to its full potential for transparency, responsibility accountability and monitoring;
- engage in joint programming under the umbrella of UNDAF and use the One UN Fund through the UN pass-through mechanism;
- undertake subregional analyses to inform partners about health situation, trends and the impact of public health interventions; and
- take part in United Nations and other thematic groups and build strategic alliances in the area of health information systems.

7 IMPLEMENTING THE STRATEGIC AGENDA – IMPLICATIONS FOR WHO SECRETARIAT

The proposed agenda for WHO cooperation in the South Pacific is based on a situation analysis in the 15 countries and areas under the WHO Regional Office, and of discussions and vision-sharing among WHO staff (mainly at the country and regional levels).

This CCS serves as an Organization-wide reference for WHO's cooperation with the 15 countries and areas under the WHO Representative Office for the South Pacific. It will guide WHO's planning, budgeting, programme implementation and resource mobilization over the next five to six years. The proposed shifts in strategic directions obviously would mean shifts in resource allocation, in staff profiles and in the development of new capacities.

The CCS, the Medium-Term Strategic Plan (MTSP) and the proposed programmes for collaboration with Pacific island countries and areas will have implications for WHO programme management and technical resources in the Pacific and at different levels of the Organization. They will also affect budgetary needs and relations with national and international partners.

7.1 Reorienting WHO's resources and inputs according to changing needs in the South Pacific

To implement this Country Cooperation Strategy, it will be necessary to do the following:

(1) Increase financial and technical support (including voluntary contributions from partner agencies) to the South Pacific, taking into account the high operational costs in the subregion. The WHO Regional Office for the South Pacific is working with 15 countries and areas scattered across the ocean, resulting in high travel and communication costs.

(2) Allocate resources within the subregion to countries and areas most in need, based on clearly defined criteria. These criteria include health status indicators, population size, disease burden, remoteness, capacity of the health ministry and presence of other partners. Until now, there have been no clear criteria to guide allocation of resources among the countries and areas of the Pacific.

(3) Rationalize WHO's country presence in the Pacific by analysing current country health situations and needs. WHO's current country presence is based on decisions made in the 1980s.

(4) Recognize the subregional nature of the WHO Representative Office for the South Pacific and establish an intercountry budget to be controlled and programmed by it (as agreed by senior management during the CCS process). Until recently, ICP funds have been mainly managed and controlled by regional advisers in the Regional Office for the Western Pacific.

(5) Use Country Liaison Officers and other staff more effectively for provision of technical advice for all the Pacific island countries and areas. Current practices do not allow full utilization of Country Liaison Officers as technical staff (e.g. in planning and policy development). Delegation of authority to the WHO Representative Office would allow utilization of Country Liaison Officers anywhere in the subregion.

(6) The WHO Representative Office for the South Pacific will need to ensure that the level and skill-mix of international staff are appropriate to the new roles proposed by this

strategy. Given the small size of the office, it is inevitable that all staff will work in a flexible manner in order to provide support in several areas. Such flexibility will be invaluable in the future.

(7) Recognize that all technical staff based at the WHO Representative Office for the South Pacific provide technical support and assistance to the five countries and areas under the responsibility of WHO Representative Office in Samoa. The relationship between these two offices should harmonize WHO's presence in the Pacific.

(8) Strengthen WHO's technical assistance to the Pacific island countries. The following long-term posts should be established in the next two to three years:
- Medical Officer for HIV/AIDS and STI.
- Technical Officer for EPI.
- Technical Officer for Health Service Development/Health Care Financing Information.

(9) Arrange regular visits by staff from the Regional Office and/or Headquarters for the purpose of monitoring and evaluating the strategic direction of the CCS and developing programmes in the following areas:
- essential medicines;
- reproductive health;
- health legislation and health financing;
- public communication and social marketing; and
- child and adolescent health.

The visits should be jointly planned with the Regional Office and Headquarters at least every two years.

7.2 Implications for different levels of WHO

While responsibility for implementing the CCS ultimately rests with the WHO country offices, there are many areas where support and assistance from other levels of the Organization will be required. This section considers the implications of the strategy for the WHO Representative Office, the Regional Office and Headquarters in order to ensure smooth implementation of this CCS.

To get better results at country level, the three WHO levels have to agree on joint support to the South Pacific. This should include a common understanding of the issues expressed in the CCS. It is essential that the Regional Office and Headquarters recognize and support the direction set by this Country Cooperation Strategy. They can assist implementation of this strategy by ensuring that any initiatives they seek to undertake in the South Pacific are consistent with the broad direction of this strategy. Below are indications on what is expected from each level.

Implications for the WHO Representative Office for the South Pacific

The WHO Representative Office for the South Pacific will provide technical assistance to country interventions that focus on sustainable solutions at the community level.

One of the core functions of the WHO Representative Office for the South Pacific is to promote and support the application of evidence-based norms and guidelines, developed by Headquarters and the Regional Office, in Pacific island countries and areas. Priority-setting will be based on the burden of disease, availability of feasible interventions and community demand. Solutions and interventions will be developed in close collaboration with the

countries and areas of the Pacific and these will include adaptation of standards and guidelines to the country situation.

The WHO Representative Office will sustain and develop partnerships, coordinate activities and mobilize resources for health and environment in the Pacific. Recognizing the current trend of strengthening subregional cooperation for Pacific island countries, the WHO Representative Office will play a critical role in promoting cooperation and collaboration, including implementation of the *Pacific Plan for Strengthening Regional Cooperation and Integration.* Closely working with the Pacific Forum Secretary, SPC and other United Nations agencies, the WHO Representative Office could play an active role within United Nations agencies to facilitate the implementation of the *Pacific Plan,* in particular of the strategic objective No. 6, i.e. Improved Health.

The office will work closely with SPC, the main Pacific subregional partner in health, to avoid duplication of activities and to develop partnerships through the Pacific ministers of health meetings.

Better aid coordination and harmonization by all United Nations agencies present in the Pacific will be pursued under the new generation UNDAF process with active WHO participation.

Because of the increasing importance of global health initiatives and multilateral funding sources, the WHO Representative Office for the South Pacific will support countries and areas of the subregion in their efforts to apply for funding from partner agencies. Appealing for money at country level means that more technical resource will be needed to hold discussions with potential funding agencies and to prepare proposals. It will also mean specialized reporting requirements if funds are designated to various projects. While the potential for resource mobilization at the country level is good, support for fundraising should also be provided by staff of all levels of the Organization.

The WHO Representative Office for the South Pacific will put more effort into resource mobilization, especially with major regional donors, such as AusAID and NZAID.
The other priority areas of work in the WHO Representative Office for the South Pacific will include the following:

- advise countries and areas (when requested) on the development of health policies, strategies, legislation, etc., and study possibilities for a repository of subregional analysis of health policies and health interventions in collaboration with other partners in health;
- advocate relevant policies and programmes for prevention and control of noncommunicable diseases, and assist countries in NCD surveillance, programme development and implementation;
- develop and implement subregional and national plans of action for surveillance and response, in accordance with IHR (2005);
- support strengthening and harmonization of management information systems;
- advise countries on issues related to globalization and health, and assist countries to adapt their policies to global health requirements;
- promote open learning;
- assist countries and areas to conduct feasibility studies, field trials and to pilot new technologies; and
- improve communication with media on health issues, and develop an informative website.

The next steps for the WHO Representative Office for the South Pacific include:

(1) revisiting existing plans for 2010–2011 to check whether any changes are needed to align the current workplans and budgets with the finalized CCS for the South Pacific;

(2) revisiting working methods and management in the Regional Office to confirm that the priority areas identified in the CCS will be approached as a team; and
(3) monitoring of CCS implementation by the WHO Representative every six months, followed by discussions with the staff in the WHO Representative Office and senior management in the Regional Office on necessary actions.

Implication for the WHO Regional Office

The Regional Office will provide technical support, guidance and backstopping for the South Pacific office in areas where it does not have capacity (such as health legislation, the quality control of laboratory and other services). Regional Office staff should consider the special needs and circumstances of the countries and areas of the Pacific.

The Regional Office will support the South Pacific office in resource mobilization and allocate regional resources to the countries and areas of the Pacific in consultation with ministries of health. The Regional Office will discuss with AusAID, NZAID, USAID and other bilateral and multilateral agencies with the objective of raising more support.
The Regional Office will also:

- conduct needs analysis, collate and synthesize country reports;
- adapt global WHO guidelines and standards to regional and subregional needs when necessary;
- adapt new technologies and tools to regional settings;
- manage fellowships (with increasing participation of the South Pacific office); and
- advocate policies and practices (relevant to the Pacific) related to migration and retention of health workforce.

The Regional Office, in consultation with Headquarters, will hold expert meetings to review and develop evidence-based policies and programmes relevant to the countries and areas of the Pacific (for example in the area of noncommunicable diseases). The Regional Office will also provide technical support and coordinate outbreak alert, response and pandemic preparedness for implementation of IHR (2005). The Regional Office will also provide timely updates to ministries of health on new global and regional initiatives and on changes in the donor environment.

Next steps in the Regional Office:

(1) Technical units need to review the approved CCS and agree with the WHO Representative on necessary actions for implementation of the CCS in the current and the next biennium.
(2) Support is needed to identify international experts in areas where the WHO Representative Office for the South Pacific does not have sufficient expertise, such as policy-making, legislation and governance. Such skills will be essential to support the process of institutional strengthening that lies at the heart of this strategy.

Implications for Headquarters

One of the key roles of Headquarters is to develop evidence-based norms, standards, tools and guidelines that notify the special needs and solutions for small island countries. Headquarters also needs to provide timely updates on new global and regional initiatives. The Representative Office for the South Pacific would benefit from the transfer of resources from Headquarters to the Regional Office and country offices; the WHO Representative Office for the South Pacific is functionally a subregional office.

Headquarters also needs to:

- advocate policies and practices relevant to the countries and areas of the Pacific (for example, in issues related to staff migration and retention, globalization and endorsement of IHR [2005]);
- continue to establish a pool of experts (with the Regional Office) who, through the subregional office, can provide high-level technical assistance and policy support on noncommunicable diseases and other areas for Member States;
- share information through WHO publications to the WHO Representative Office for the South Pacific and the countries and areas of the Pacific; and
- conduct research and develop innovative cost-effective tools applicable also in the Pacific countries.

This strategy has also identified some internal administrative changes that would greatly assist the WHO Representative Office for the South Pacific. They will be discussed independently of the CCS process.

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ANNEX A: SELECTED GENDER EQUITY INDICATORS IN 10 PACIFIC ISLAND COUNTRIES

		Fiji	Federated States of Micronesia	Kiribati	Marshall Islands	Nauru	Palau	Solomon Islands	Tonga	Tuvalu	Vanuatu
Ratios of girls to boys in primary, secondary and tertiary education	Primary 1990	0.94 (1992)	0.921 (1994)	0.979	0.851 (1988)	1.032 (1992)	0.89	0.795 (1986)		0.873 (1991)	0.876 (1991)
	Primary 2000	0.98	0.935	0.93	0.831 (2002/03)	1.15	0.972	0.861 (1999)	0.895 (2001)	0.932 (2002)	0.907 (1999)
	Secondary 1990	1.05 (1992)	0.976 (1994)	1.164	0.912 (1988)	0.754 (1992)	1.08	0.57 (1986)		1.053 (1991)	0.843 (1994)
	Secondary 2000	1.07	1.04	1.141	1.041 (2002/03)	0.839	0.88	0.696 (1999)	0.993 (2001)	0.864 (2002)	0.931 (1999)
	Tertiary 1990	0.8 (1995)	0.788 (1994)	1 (1995)	0.5 (1995)	0.6 (1995)	0.74	0.3 (1995)	0.8 (1995)	0.37 (1991)	0.4 (1995)
	Tertiary 2000	1	1.07	1	0.91 (2002/03)	2.2	1.3	0.3	0.9	0.923 (2002)	0.496 (1999)
Proportion of seats held by women in national parliament	1990	0			3 (1983)	6	3.7	2 (1995)	0	8	1.9 (2002)
	2000	15.5	7.1 (1998)	4.8 (1998)	3 (2003)	6	3.7	0 (2003)	0	0 (2002)	3.8 (2004)

Source: SPC/UNDP/Forum Secretariat. *Regional Millennium Development Goals Report, 2004*