

**COUNTRY REPORT:**

**PACIFIC ISLANDS COUNTRIES**

East Asia and Pacific Regional Consultation on Children and HIV/AIDS  
Hanoi, Viet Nam 22 – 24 March 2006

# Children and AIDS in the Pacific Islands Countries

March 2006



### **Acknowledgements:**

This report was prepared in view of the Asia Pacific Children and AIDS consultations, Hanoi, Vietnam from 22 to 24 March 2006. Although there are 22 small island countries and territories within the Pacific region, this report focuses mainly on the following 14 independent states: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. The report was compiled by UNICEF Pacific in consultation with the following delegates: Dr Lisi Tikoduadua from Fiji, Dr Teatao Tiira from Kiribati, Dr George Malefoasi from the Solomon Islands, Dr Maliesi Latasi from Tuvalu and Ratu Epeli Nailatikau, UNAIDS Special Representative for the Pacific and Speaker of Fiji Parliament. This report would not have been possible without the close collaboration of UNFPA Advisors: Dr Wame Baravilala and Dr Annette Sachs Robertson; Dr Sopheap Seng from the World Health Organisation, Stuart Watson, Steven Vete and Jone Vakalalabure from UNAIDS, Dr Rob Condon, Dr Tamara Kwarteng from the Pacific Regional HIV Project, Dr Dennie Iniakwala from the Secretariat of the Pacific Community.

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## Introduction

Throughout the world, HIV and AIDS is redefining the very meaning of childhood, depriving children and young people of the care, love and protection of their parents, of education and options for the future, and of protection against exploitation and abuse. The Pacific region is not spared, but it is currently in the advantageous position of being able to learn from 25 years of global experience in the fight against HIV and AIDS.

In the Pacific, as in other parts of the world, children are the missing face of AIDS, and failure to take account of their critical needs for prevention, protection, treatment and care will acutely undermine the region's chance of achieving other development objectives, including the Millennium Development Goals.

While it is generally accepted that HIV prevalence in Pacific Island Countries remains low, preliminary data from the recent second generation surveillance exercise calls for a rapid scaling up of interventions<sup>1</sup>. In fact, with nearly two-thirds of the new HIV cases aged between 20 and 35 and perinatal transmission accounting for nearly 5 percent of all cases, a "business as usual" approach can no longer be applied.

This report looks at the current HIV trends and attempts to project the potential impact an HIV epidemic could have on the children of the Pacific. It aims to shed light on the urgent actions that are needed both at country and regional levels to scale up prevention, care and support of children affected and infected by HIV. The report is divided in four sections:

- 1) An overview of the situation of children and HIV/AIDS in the Pacific region: Epidemic trends and the potential effect on children;
- 2) The region's progress towards achieving the goals set at the United Nations General Assembly Special Sessions on HIV/AIDS 2001 and Children 2002;
- 3) A review of national and regional HIV/AIDS strategic plans and interventions; and
- 4) Priorities and scale-up plans

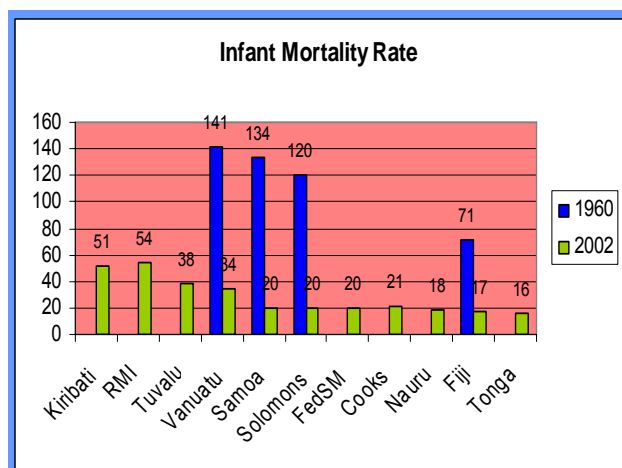
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<sup>1</sup> Data are still being analysed, report should be finalized in 2006

## Section 1- Epidemic trends and the potential effect on children as more women and children are infected

### 1.1 Background:

The Pacific<sup>2</sup> is a region of unique geography: the small island states which spread over the world's largest ocean have an estimated land mass equivalent to Great Britain and a total population of 2 million people- scattered over more than 1,500 islands<sup>3</sup>. There are three different ethnic groupings (Melanesians, Polynesians and Micronesians) and over 200 different languages more than half of which exist in one country alone. Located next door to Papua New-Guinea (which has a full-blown generalized epidemic), Pacific Island Countries are at a cross-road in their history. An accelerated HIV infection rate could annihilate many of the development achievements of the last 30 years.



**Table 1- Infant Mortality Rate 1960/2002<sup>4</sup>**

### 1.2 Epidemiology

The HIV epidemic has undergone a sharp increase in the Pacific and the potential for exponential growth is unquestioned. There are several reasons underlying the assumption that the HIV epidemic will spread further: ongoing political, social and economic changes; high mobility of the population; emergence of new patterns of sexual behaviours; increase in substance abuse; increase in the number of commercial and transactional sexual workers, all combined with a lack of health and sex education. Although the total number of HIV cases is still low compared to other countries in the region, the trend in new infections is a major cause for alarm.

<sup>2</sup> Reference to the Pacific, unless stated otherwise, in this report refers to the following fourteen island states: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu

<sup>3</sup> See Annex 3

<sup>4</sup> Dr Wame Baravilala, "Presentation: Introduction to Reproductive Health Manuals", Fiji School of Medicine-WHO-UNICEF-UNFPA Pacific Regional Workshop, 19 April 2004

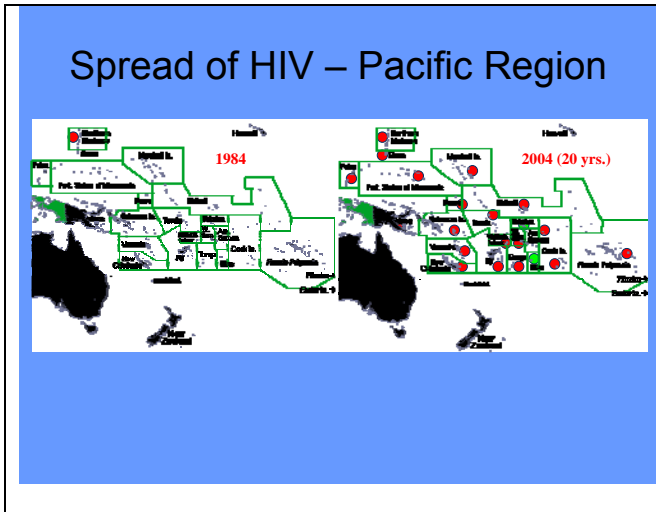


Figure 1- The raise of HIV cases in the Pacific Region<sup>5</sup>

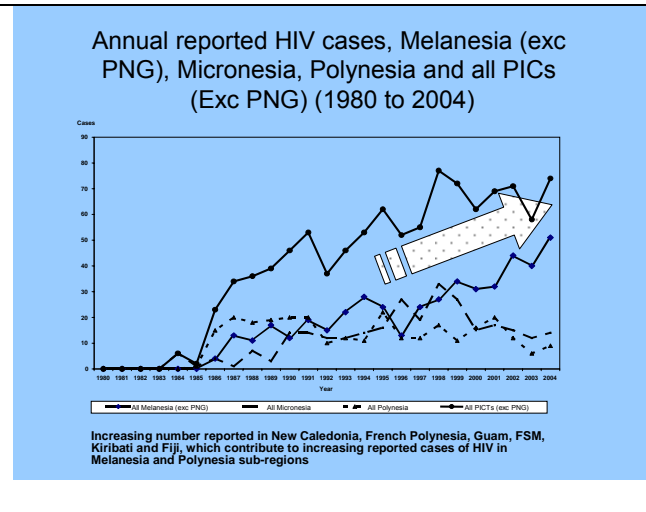


Table 2- Increase reported cases overtime<sup>6</sup>

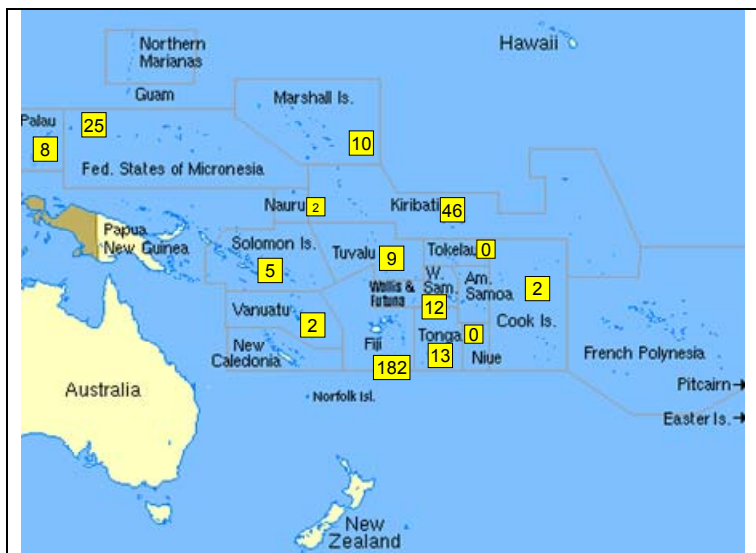


Figure 2- Map of the Pacific region and number of reported cases as per Table 4

Figure 2 shows the number of HIV and AIDS cases reported in 12 Pacific Island countries.

As shown in Table 4, over 316 HIV infections (including more than 78 AIDS cases, 25%) had been reported in 14 Pacific Island Countries by late 2004. The predominant mode of transmission to date has been heterosexual; however, there is evidence suggesting that homosexual transmission is under reported. Two countries/territories (Niue, Tokelau) have not as yet reported any HIV infections.

<sup>5</sup> Dr Dennie Iniakwala, "Presentation: HIV and AIDS, Current Trends and Status, Vulnerability Factors, Regional Response though Regional Strategy", 2005, Secretariat of the Pacific Community

<sup>6</sup> Ibid.

A closer look at the reported cases by ethnic groupings indicates that there are more cases in Melanesia and Micronesia. In Polynesia, 50 percent of the reported cumulative HIV and AIDS cases have already passed away and 33 percent of cases have been reported among women. Melanesia, with its larger population size, has also recorded the highest number of cases and 44 percent of these are among women. 45 percent of the reported cases in Micronesia have already passed away. Women account for 37 percent of all reported cases. The increasing number of infections among women is a serious concern as up to 45% of children born to HIV positive mothers can become infected with HIV in the absence of intervention.

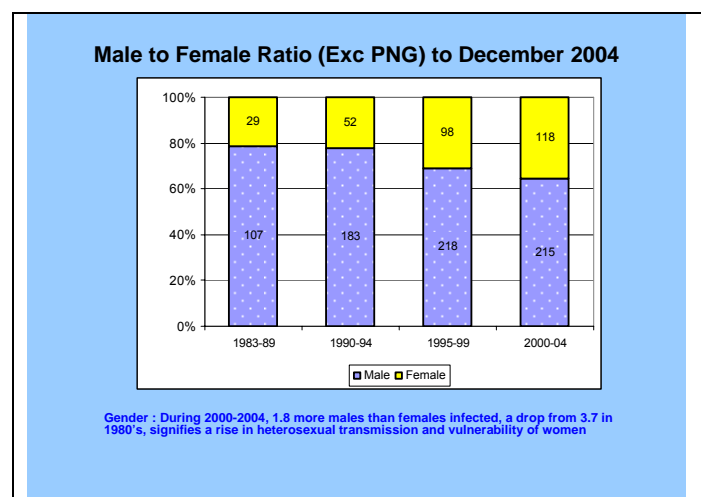


Table 3: Growing number of reported cases among women over time<sup>7</sup>

To gain a clearer picture of the HIV and AIDS situation in low prevalence countries, WHO recommends using a simple formula of multiplying the total number of reported cases of HIV and AIDS by ten. Tuvalu and Kiribati, have the highest prevalence rates. Tuvalu reported 9 cases of HIV/AIDS while Kiribati reported 46 cases of HIV/AIDS. Using this formula, Tuvalu, with a potential number of 90 cases would have a prevalence rate of 0.9% while Kiribati, with 460 cases, could have a prevalence rate of 0.5%. Tuvalu could therefore be very close to a generalized epidemic. These figures reveal the rapidly devastating impact that HIV and AIDS could have in the small communities of the Pacific and highlight the need for a real sense of urgency to ensure rapid measures are taken towards halting the spread of HIV and AIDS in the region.

If nothing is done to reverse the current trends, unique cultures and languages of some Pacific island nations could be wiped out. For a generalized epidemic to occur in the Pacific it would only need 20,000 People Living with HIV/AIDS. This is equivalent to the size of Nuku'alofa, the capital of Tonga or the entire population of Palau or the student population enrolled at the University of the South Pacific.

	HIV/AIDS Cum	AIDS Death	Male	Fem.	Est. # (10x)	Pop.	1% = Gen.
<b>Polynesia</b>							
Tonga	13	8	7	6	130	98,300	983
Niue	0	0	0	0		1,600	16
Cook Islands	2	0	1	1	20	14,000	140
Samoa	12	8	8	4	120	182,700	1,827
Tuvalu	9	2	8	1	90	9,600	96
Tokelau	0	0	0	0		1,500	15

<sup>7</sup> Dr Dennie Iniakwala, "Presentation: HIV and AIDS, Current Trends and Status, Vulnerability Factors, Regional Response through Regional Strategy", 2005, Secretariat of the Pacific Community

	HIV/AIDS Cum	AIDS Death	Male	Fem.	Est. # (10x)	Pop.	1% = Gen.
	<b>36</b>	<b>18</b>	<b>24</b>	<b>12</b>	<b>360</b>	<b>307,700</b>	<b>3,077</b>
<b>Melanesia</b>							
Solomon	5	2	2	3	50	460,100	4,601
Vanuatu	2	0	0	2	20	215,800	2,158
Fiji	182	17	109	73	1,820	836,000	8,360
	<b>189</b>	<b>19</b>	<b>111</b>	<b>78</b>	<b>1,890</b>	<b>1,511,900</b>	<b>15,129</b>
<b>Micronesia</b>							
Palau	8	3	5	3	80	20,700	207
Marshall	10	2	3	3	100	55,400	554
FSM	25	12	14	11	250	112,700	1,127
Nauru	2	1	2	0	20	10,100	101
Kiribati	46	23	30	16	460	93,100	931
	<b>91</b>	<b>41</b>	<b>54</b>	<b>33</b>	<b>910</b>	<b>292,000</b>	<b>2,920</b>
	<b>316</b>	<b>78</b>	<b>189</b>	<b>123</b>	<b>3,160</b>	<b>2,111,600</b>	<b>21,116</b>

Table 4- HIV and AIDS Reported Cases in 14 Pacific Island Countries: Cumulative total from pre-1997 to 2004

### 1.3 High Risk Behaviours

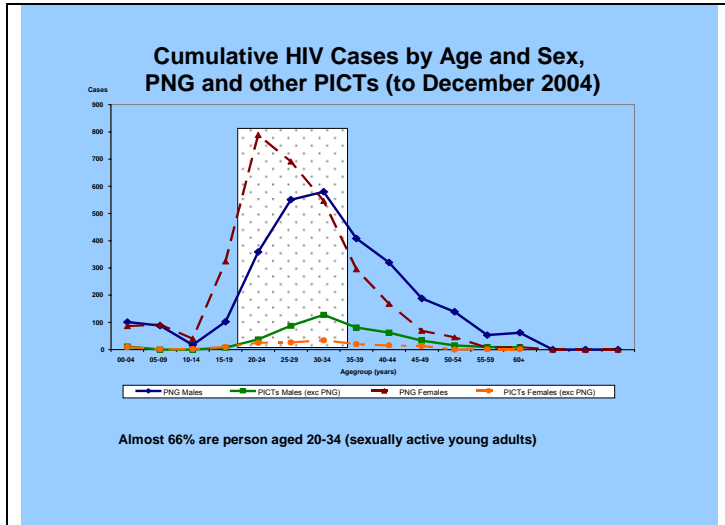


Table 5- HIV Cases by Age and Sex<sup>8</sup>

As in other parts of the world, HIV is most prevalent in the productive segment of the population. In fact 65% of HIV cases are reported among the 20-35 years old.<sup>9</sup> In the Pacific, populations particularly vulnerable to HIV infection are as follows<sup>10</sup>:

- In some countries, seafarers have far higher rates of HIV infection than the general population. **Seafaring** carries a specific occupational risk due to extended periods away from families and opportunities for increased sexual interaction with sex workers. The risk of HIV infection is also heightened for seafarers' wives and partners.
- People involved in **transactional sex** – either formal sex work, or less organised sex for money or favours – are particularly vulnerable to HIV. This has been reported to be a significant source of vulnerability in Palau, Marshall Islands, FSM, Solomon Islands, Vanuatu, Fiji, Kiribati and Samoa.
- **Foreign sex workers** (predominantly Chinese/Korean women) have been reported in Fiji, Marshall Islands and Palau. These women are particularly vulnerable, as are their partners/clients.
- **Students** at the University of the South Pacific are mobile, away from family, and sexually active. They are also often ill informed on HIV and have limited access to preventive services and information.
- **Men who have sex with men** have varying access to information and services in the region – stigma and discrimination increase vulnerability in many countries.
- Other mobile populations<sup>11</sup> including uniform services, overseas workers and nationals travelling aboard for business, education, sport and other activities.

A risk behaviour study among 257 male military personnel and policemen carried out in 2004-2005 in Fiji showed a low level of knowledge of HIV protection methods: Only 32 percent of the participants had correct knowledge of HIV protection. A slightly higher proportion, 47 percent had the correct knowledge about HIV transmission. Only 19 percent of men had both correct HIV protection knowledge and HIV transmission knowledge. Also,

<sup>8</sup> Dr Dennie Iniakwala, "Presentation: HIV and AIDS, Current Trends and Status, Vulnerability Factors, Regional Response through Regional Strategy", 2005, Secretariat of the Pacific Community

<sup>9</sup> Secretariat of the Pacific Community, 2005

<sup>10</sup> Pacific Regional HIV/AIDS Project, HIV/AIDS Situation and Responses in Seven Pacific Island Countries, January 2005, p.9

<sup>11</sup> Also referred as Mobile Men with Money

only a quarter of participants had accepting attitudes to People Living with HIV.<sup>12</sup> This study also highlighted that among the participants who had reported having had sex with a commercial sex worker; only 8 percent had used a condom. Among men who reported to have had casual sex partners in the last 12 months, only 13 percent reported using a condom at last sex, while only one respondent reported consistent condom use.

#### **1.4 Gender and HIV**

The status of women and girls, and the issues they face, vary across PICs. However, key indicators (literacy, education, representation in decision making and poverty) point to inequality between women and men throughout the Pacific region. Consequently, women's reduced access to resources, opportunities and ability to make decisions about their own lives and reproductive health, increases their vulnerability to HIV infection. As with other parts of the world, Pacific women are the primary care givers in the home. They therefore face a triple HIV burden – vulnerability to infection themselves; and if infected, the risk of transmission to their child; and responsibility to care for others in the family who are infected.

It is commonplace in the Pacific that the conventional morality throughout the region prescribes different codes of sexual conduct for men and women. Cultural values of pre-marital chastity and post-marital fidelity for women contrast sharply with a tacit license for sexual promiscuity granted to Pacific men.<sup>13</sup> These gender-related social norms increase women's vulnerability to HIV/AIDS. The steady increase of reported cases among married women calls for interventions aimed at raising women's awareness and empowerment. Unless the cultural systems that allow women little control over their sexuality and place them in a subordinate position within marriage are challenged, the HIV-prevention initiatives cannot reverse current trends.

Women in the Pacific confront a number of gender-based challenges which put them at risk of HIV infection, and to eventually transmit HIV to their infants:

- Many Pacific women have difficulty negotiating the use of contraceptives because control over their fertility is usually asserted by their husbands;
- Women may be unable to access pre-natal health services as their partners often control the household financial or transportation resources, as they cannot take time off work, or because they cannot leave their dependents to travel to clinic or hospital;
- Fear of rejection, stigmatization, violence or abuse may prevent women from utilizing HIV voluntary and confidential counseling and testing services (if available), disclosing their HIV status, accessing HIV prevention programmes targeting pregnant women, mothers and their children, or engaging in safer infant feeding practices (if provided with infant feeding counseling).
- General attitudes that women have to submit to their husbands- a situation often reinforced by religious teachings.

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<sup>12</sup> UNGASS Report 2006, Ministry of Health Fiji

<sup>13</sup> Draft UNIFEM, Women, Gender and HIV and AIDS in the Pacific, Advocacy kit: Women and HIV and AIDS in the Pacific, 2006

The number of HIV reported cases among pregnant women continues to rise.

Outcomes of Known HIV Positive Pregnancies					
Selected PICs. to September 2005					
COUNTRY	CUMULATIVE No OF KNOWN HIV+ PREGNANCIES	INFANT'S OUTCOME			CRUDE VERTICAL TRANSMISSION RATE (EST)
		POS	NEG	UNK	
Fiji	17	8	4	5**	47(-76)%
Kiribati	7	7	-	-	100%
Samoa	2	2	-	-	100%
FSM	2	2	-	-	100%
Tuvalu	1	1	-	-	100%
Vanuatu	1	1	-	-	100%
RMI	1	-	-	1**	(100%)
<b>TOTAL</b>	<b>31</b>	<b>21</b>	<b>4</b>	<b>6</b>	<b>68%</b>

\*6 have died, 2 on treatment  
 \*\* 2 awaiting confirmatory tests, 3 less than 6 months of age

Table 6- Mother-to-Child Transmission of HIV<sup>14</sup>

Table 6 represents a crude MTCT rate of between 47 and 76 percent and clearly highlights the need to scale up PMTCT in Fiji, but also in the other Pacific Island Countries. In the last two years, Fiji has made great strides to integrate prevention of mother-to-child transmission programming into its antenatal care services. Although these are currently only available in Suva and Lautoka, UNICEF Pacific is working closely with Fiji and other Governments to increase coverage.

In 2004, four women of the 17,714 women who delivered a baby, tested HIV positive.<sup>15</sup> Only one received anti-retroviral therapy to reduce the risk of mother-to-child transmission of HIV. The first Pediatric ARV procured in the region arrived for 5 children in Fiji in 2004. These were procured by UNICEF Pacific following a request from the Ministry of Health. More remains to be done to strengthen procurement services, through the regional hub, the Fiji Pharmaceutical Services and to ensure treatment protocols are administrated by committed care and support teams.

There is no doubt that ARV procurement in a region with more 1,500 islands is and will be a challenge, especially when it comes to Pediatric ARV formulations, which often require storage in a refrigerator, an important element often missing in our outer islands.

A recent survey on the Knowledge, Attitude and Practices on HIV among Health Care Providers in Fiji, Kiribati, Samoa, Solomon Islands Tonga, Tuvalu and Vanuatu, reveals the urgent need to increase the level of knowledge of Mother-to-Child Transmission among services providers as shown in Table 7:

<sup>14</sup> UNICEF Pacific 2004

<sup>15</sup> UNGASS Report Fiji 2006

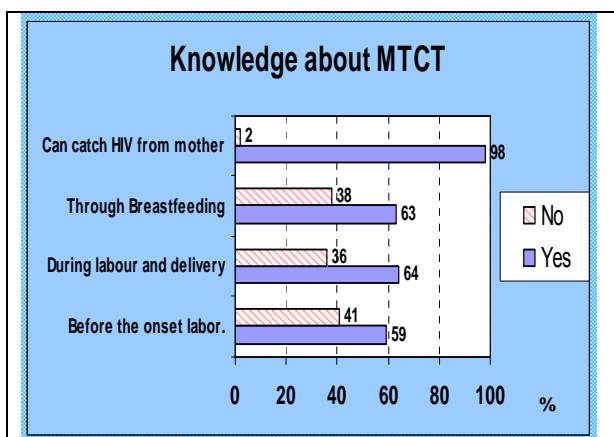


Table 7- Knowledge about Mother-to-Child Transmission of HIV, 2004<sup>16</sup>

### 1.5 HIV Impact on Children

As seen earlier, the high crude rates of Mother-to-Child transmission of HIV in the Pacific, show that HIV is already having a devastating impact among children. If nothing is done to reverse these trends, HIV and AIDS could roll back hard-won development gains. The region cannot afford to wait for a large cohort of Pediatric HIV cases to start addressing the issue. Complacency about Children and AIDS could endanger the very survival of unique cultures and peoples.

Preliminary estimates from the Asian Development Bank provide numbers of orphans associated with high and low growth epidemic scenarios in Fiji and PNG. Given the generalized nature of the epidemic in PNG, orphan numbers are calculated to be greatest for this country. It is estimated that 210,000 children would be orphaned by 2020 in PNG under the high growth scenario, while 56,000 would be orphaned under the low growth scenario. Orphan children as a result of HIV and AIDS are estimated to be lower for Fiji, but still substantial. It is estimated that 2,060 and 570 children respectively will be orphaned as a result of HIV and AIDS in Fiji by 2020 under the high and low growth scenarios<sup>17</sup>.

<sup>16</sup> UNICEF Pacific, Knowledge, Attitude and Practice on HIV among Health Care Providers in seven countries, June-September 2004

<sup>17</sup> Draft, Asian Development Bank, Socio Economic Implications of HIV in the Pacific, January 2006

Country	PNG (Current population of 5,695,300)	Fiji (Current population of 836,000)
<b>2020 (High Growth Scenario)</b>		
HIV/AIDS Dual Orphans (thousands)	96.41	0.29
HIV/AIDS All Orphans (thousands)	210.46	2.06
<b>2020 (Low Scenario)</b>		
HIV/AIDS Dual Orphans (thousands)	18.97	0.08
HIV/AIDS All Orphans (thousands)	55.87	0.57

**Table 8: HIV and AIDS Orphans in PNG and Fiji<sup>18</sup>**

It is important to point out that Pacific countries currently do not have any policies or strategies to address the additional needs of potentially increasing cohort of orphans due to HIV and AIDS. The ADB study describes two scenarios for which Fiji would be ill prepared. Of course, these scenarios could still be averted, provided that actions are immediately taken to scale up HIV interventions.

### 1.6 High Rates of Sexually Transmitted Infections

Many of the Pacific countries also report high rates of sexually transmitted infections – a proxy to HIV infections as Sexually Transmitted Infections can increase the risk of HIV transmission by three to five times. Surveys in 1987, 1997, 1999 and 2000 show very high rates in the “general population” (Antenatal Clinic attendees) in three countries (see Table 9 below)

In Vanuatu’s capital, Port Vila, 6 percent of pregnant women were infected with Gonorrhoea, 21 percent with Chlamydia and 27 percent with Trichomonas.<sup>19</sup> The numbers are even more startling in Samoa: 43 percent of pregnant women in the Samoan capital Apia were found to have at least one sexually transmitted infection.<sup>20</sup> The Suva STI Clinic in the Fijian capital has reported that more than 70 percent of its STI cases were young people between the ages of 15-25; 90 percent of whom said they had more than one sexual partner.<sup>21</sup> A 2003 study of seafarers in Kiribati showed more than 9 percent had Chlamydia.<sup>22</sup> These rates point to the urgent need for health professionals in the Pacific to diagnose and treat STIs early, before they become conduits for HIV infections. Preliminary data from the Second Generation Surveillance survey 2004-2005 also confirms high rates of STIs among antenatal women. Data from the Ministry of Health in Fiji highlighted that cervical cancer, which is generally caused by untreated STIs, accounted for 37 percent of all cancers in women in the mid-1990s with an incidence rate of 114.6 per 100,000 women, a very high rate by international standards.<sup>23</sup> STI prevention and control are urgently needed in region.

<sup>18</sup> UNAIDS, UNICEF, USAID (2004) Children on the Brink 2004, A Joint Report of New Orphan Estimates and a Framework for Action. UNAIDS

<sup>19</sup> WHO, STI Surveys, Samoa, Vanuatu and Fiji, 2000

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> WHO, Kiribati’s Ministry of Health, University of New South Wales, Prevalence Survey of STIs among Seafarers and Women Attending Antenatal Clinics, 2002-2003.

<sup>23</sup> Fiji UNGASS Report 2006

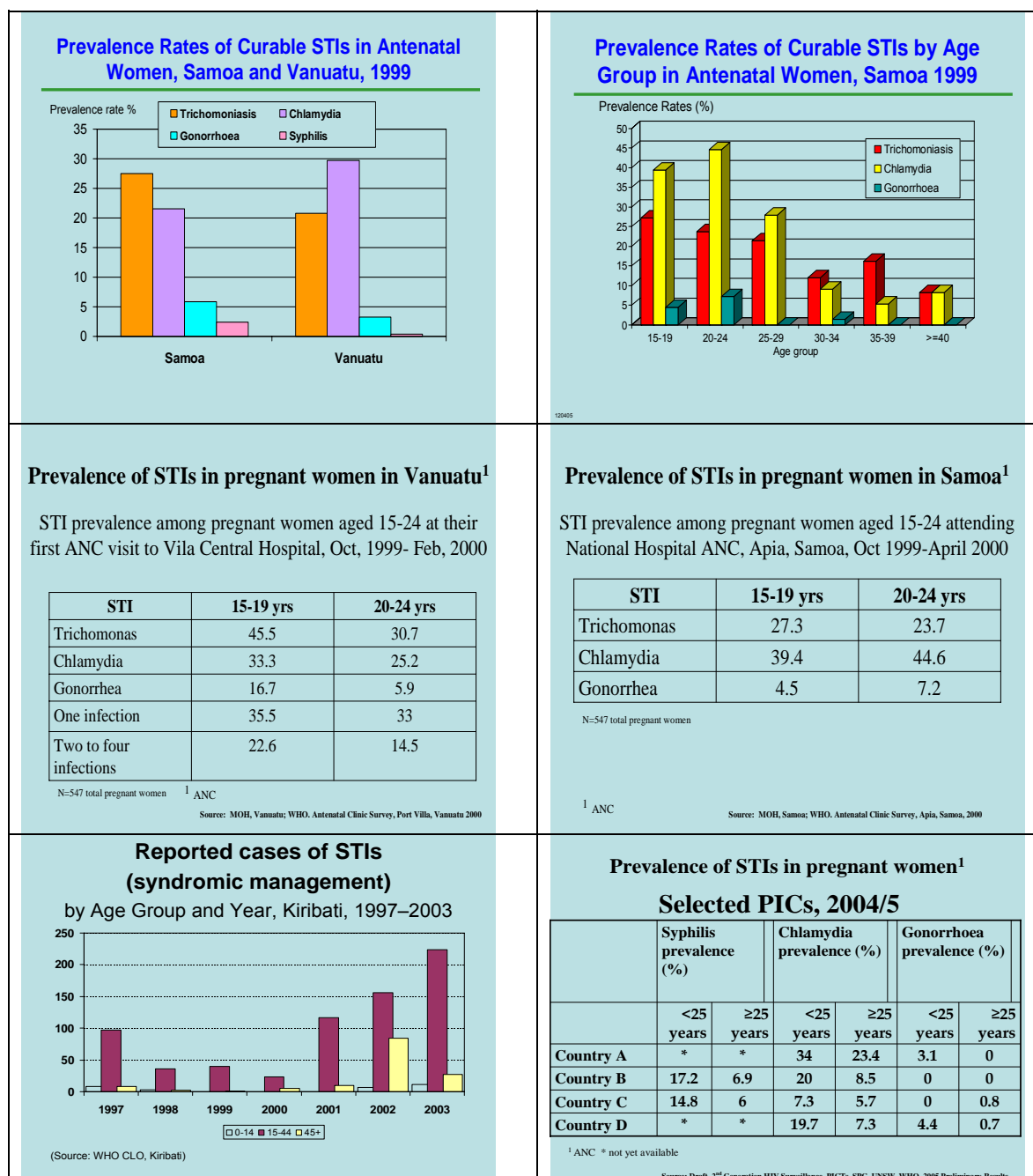
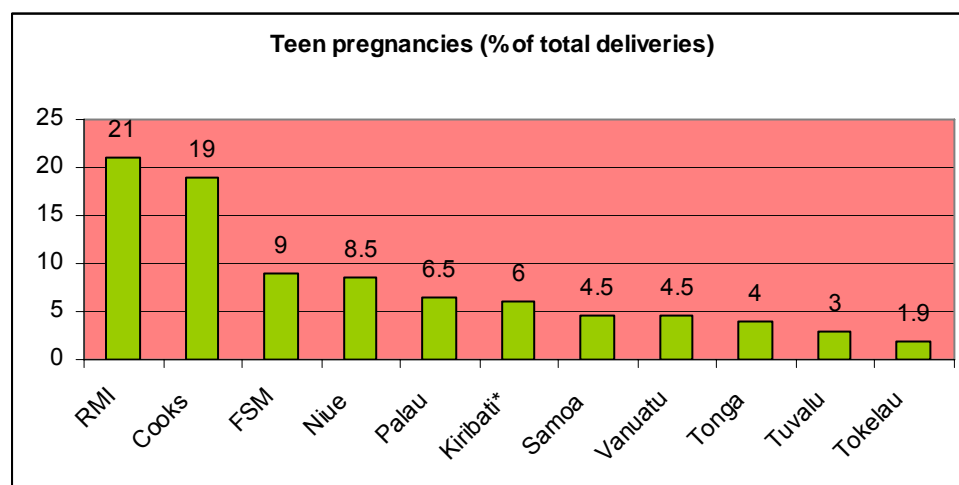


Table 9- Results from various STI studies<sup>24</sup>

<sup>24</sup> See WHO, Kiribati's Ministry of Health, University of New South Wales, Prevalence Survey of STIs among Seafarers and Women Attending Antenatal Clinics, 2002-2003; WHO, STI Surveys, Samoa, Vanuatu and Fiji, 2000, also Dr Annette Sachs Robertson, "Presentation on STI Control among young people in the context of the Pacific", Joint UNFPA-UNICEF-WHO Meeting on Prevention and Control of STI in the Pacific, 8-11 November 2005

## 1.7 Teenage Pregnancy

Many Pacific nations are also recording alarming rates of unwanted teenage pregnancies – signs of unprotected sex and shortfalls in basic sex education. Although early marriage is now discouraged in most Pacific countries and more information on safe sex is becoming available, teenage pregnancy rates remain a concern.<sup>25</sup>



**Table 10- Rates of teenage pregnancy in selected Pacific Island Countries<sup>26</sup>**

As there are often constraints in Pacific societies that restrict discussion about sexuality, the main sources of sex education for youth are adolescent reproductive health clinics, peer education programmes and the high school biology curriculum. It is clear, however, that not all young people come into contact with health services or peer educators, and sex education is often avoided or not well taught by teachers (as they are uncomfortable to teach this topic and fear parents' resentment). Many who rely on their friends for information, are likely to be poorly informed about reproduction and conception. Moreover, girls tend to be unprepared to deal with peer pressure and lack the social skills to refuse intimacy. As shown in the SPC study on teenage pregnancy in Tonga, most of the teenage mothers interviewed had intended to abstain from sexual activity until marriage as they had been taught, and became pregnant because they had not anticipated the risk of becoming sexually active and were not prepared to deal with that risk.<sup>27</sup> Other studies carried out in Samoa, Cook Islands and Kiribati also found evidence of misinformation about conception and pregnancy among both boys and girls, including a belief that pregnancy could not occur at first intercourse.<sup>28</sup>

<sup>25</sup> UNICEF Pacific, *The State of Pacific Youth*, 2005, p.7

<sup>26</sup> UNICEF Pacific, *The State of the Pacific Youth*, 1998, p.43

<sup>27</sup> Secretariat of the Pacific Community, *Teenage Pregnancy in Tonga*, 2005

<sup>28</sup> UNFPA, *Sexual Knowledge and Attitudes of Adolescents in Samoa, Cook Islands and Kiribati*, UNFPA Research Papers in Population and Reproductive Health, No2, No3, No5, 2002

## 1.8 Surveillance

There is a real dearth of accurate epidemiological information on HIV in the region. In the 14 Pacific Island countries covered by UNICEF, HIV surveillance remains very weak. The scarceness of accurate data generates an apathy at a time when evidence-based interventions are most urgently needed. To date there is no operating centralized data collection system for close epidemiologic monitoring in the region.

It is interesting to note, in parallel to this, that the region continues to battle with a number of other communicable diseases, which are adding an extra burden on health programmes. These include Malaria in the Solomon Islands and Vanuatu<sup>29</sup>, Leprosy, which has recently reemerged in the Solomon Islands, and Tuberculosis in Marshall Islands, Tuvalu, Fiji and Kiribati (see table below). Non-communicable diseases such as diabetes are also adding extra pressure on health budgets.

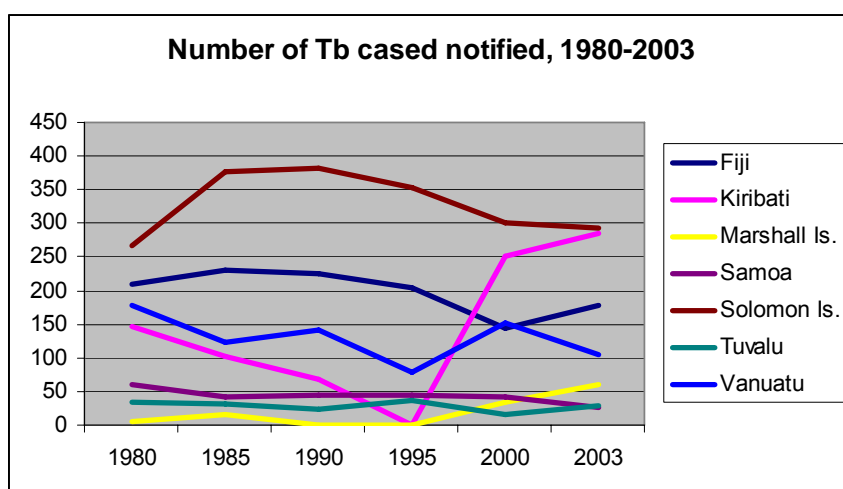


Table 11- Resurgence of Tuberculosis<sup>30</sup>

There are also no closely monitored operating sentinel groups in the Pacific. In fact, HIV prevalence is not monitored among groups with high risk behaviours. HIV is currently not routinely screened at Antenatal Clinics. Blood safety is also of major concern as the current system of blood supply is mainly based on family or replacement donors and drawn blood is not systematically screened for HIV. It should be noted that the small population size of some countries makes it impractical to maintain a blood bank because of the inconsistent and low demand for blood donations- a situation that further complicates HIV screening, especially during emergencies.<sup>31</sup>

It is recognised that the number of reported cases of HIV and AIDS represents a small proportion of the true number of people infected in each country. There are several reasons for under-reporting of HIV infection, including: limited testing and surveillance facilities, poor accessibility of populations at risk to HIV testing services, public perception of no risk and consequently no testing, improper diagnosis of opportunistic infections and AIDS, alternative diagnosis entered on death certificates, variable quality of reporting systems, diagnosis/treatment sought overseas, private doctors do not always report HIV/AIDS diagnosis.<sup>32</sup>

There is hope however, as the Pacific Islands Regional Multi-Country Coordinating Mechanism-GFATM project (2002-2007- Round II) covering 11 countries (except Marshall Islands, Niue and Tokelau)

<sup>29</sup> See Tables in the Annex 2

<sup>30</sup> World Health Organisation, Country Data for the Western Pacific and East Asia Regions: Number of Tb cases notified 1980-2003

<sup>31</sup> UNGASS report 2006 Tuvalu

<sup>32</sup> Pacific Regional HIV/AIDS Project, HIV/AIDS Situation and Responses in Seven Pacific Island Countries, January 2005

embarked on Second Generation Surveillance activities, including the establishment of a regional reference laboratory based in Fiji.<sup>33</sup> Data from this exercise is still being analysed in 2006.

Testing is based on rapid tests- Determine or Serodia- (Elisa test and Western blot are currently unavailable- although there is some provisions with the Global Fund project to upgrade the main laboratory in Fiji and develop a reference laboratory for the South Pacific). This means that countries from the South Pacific need to send blood samples for confirmatory tests to Australia or New Zealand, while Palau, Federated States of Micronesia and Marshall Islands send theirs to Guam or Hawaii. There are only a handful of testing sites, and in these, confidential counseling is far from the norm. Few people use the testing services. For example, it is reported that in Tonga only 2,500 tests were undertaken since the service commenced (only 2.5 % of the population).<sup>34</sup> This situation could be indicative of what is happening in other countries of the region. In fact in many cases tests have only been undertaken when people had started developing AIDS, were in-patients, health clinic attendees or were known contacts of HIV positive people. As quite a number of AIDS cases have first been picked up clinically, and then confirmed by blood test, this scenario might indicate a large under-reported number of People Living with HIV/AIDS.

### 1.9 Care and Support

The Pacific, unlike other parts of the world, is still at an early stage in developing its capacity to deliver comprehensive care, treatment and support for PLWHA. Treatment is currently limited to 15 people living with HIV/AIDS living in Suva, Fiji (see Table below for gender breakdown). Treatment was first made available in 2004 through the support of the New Zealand government. The Global Fund project (Round II), which is due to finish in 2008 is currently supporting treatment costs for Fiji with the view to extending coverage to other countries. People Living with HIV/AIDS in other countries like Vanuatu, Kiribati, the Solomon Islands and Samoa have access to treatment, through various ad hoc arrangements without a clear care and treatment system in place, including strong procurement services that could avoid breaks in supplies, thus reducing the chances of drug resistance. Follow up to the first regional Care and Support Workshop held in February 2005 is urgently needed to ensure that Care and Support Teams are in place in each country. These teams, comprising doctors, nurses, NGOs/FBOs, pharmacists, midwives and PLWHA, are the first attempt to establish a continuum of care.

Number receiving ART	
Female	Male
7	8

**Table 12- Patients with advanced HIV infection receiving Anti-Retroviral Therapy in Fiji 2004-2005<sup>35</sup>**

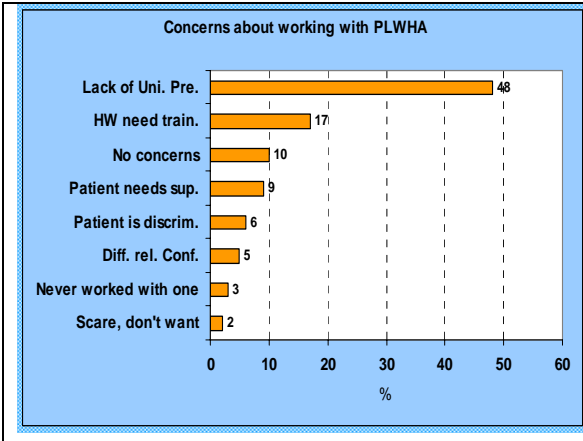
### 1.10 Stigma and Discrimination

It is generally acknowledged that stigma and discrimination conspire to prevent people from seeking testing even when services are available. This is no exception in the Pacific. The recent KAP study on HIV among health care providers in seven countries clearly highlights that health staff are not ready to face an impending epidemic. As shown in Table 13, stigma and discrimination faced by PLWHA in health care settings is deeply rooted in the lack of adequate knowledge about HIV transmission, lack of protective equipment and unaddressed fears.

<sup>33</sup> The Principal Recipient of the Global Fund for AIDS, TB and Malaria, the Secretariat of Pacific Community, manages the US\$6 million dollar allocation for HIV responses.

<sup>34</sup> Unverified source

<sup>35</sup> UNGASS Report Fiji 2006



*“I am scared and the government should be prepared to give danger/risk allowance to all health workers”*

*“Government should publish a list of names of all PLWHA”*

*“I have the right to refuse to look after a case.”*

Table 13- Concerns of Health Care Providers<sup>36</sup>

<sup>36</sup> UNICEF Pacific, Knowledge, Attitude and Practice on HIV among Health Care Providers in seven countries, June-September 2004

## Section 2- Account of the region’s progress towards achieving the goals set at the United Nations General Assembly Special Sessions on HIV/AIDS 2001 and Children 2002

Through successive major international conferences and summits of the 1990s, the international community has committed itself to a common development agenda with measurable goals and targets, culminating in the Millennium Development Goals. In making sure Pacific children do not become the hidden face of an impending HIV epidemic, it is essential to keep these goals in mind.

Pacific Islands Countries can celebrate the progress made over the past decades to improve the quality of life of children, but with an HIV epidemic looming in the region, it is important to take stock of the regional progress towards achieving the goals set at the United Nations General Assembly Special Sessions on HIV/AIDS in 2001 and Children in 2002.

As not all countries have completed and submitted their UNGASS reports, it is difficult to portray the situation in the region using the core indicators set in 2001.

<b>UNGASS on HIV: Indicators for low prevalence countries (percentage)</b>
Most-at-risk population(s) who received HIV testing in the last 12 months and who know the results
Most-at-risk populations reached by prevention programmes
Most-at-risk population(s) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
Female and male sex workers reporting the use of a condom with their most recent client
Men reporting the use of a condom the last time they had anal sex with a male partner
Most-at-risk population(s) who are HIV infected
HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission
Women and men with advanced HIV infection receiving antiretroviral combination therapy
Transfused blood units screened for HIV
Young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner
Infected infants born to HIV infected mothers

**Table 14: Core UNGASS Indicators**

As the region is only beginning to grapple with the first cases of HIV, very few countries have allocated budgets for care and support of People Living with HIV/ADS (see Table 15). On-going support will be critical to maximize returns for these investments and ensure quality programme delivery.

Budget allocation for care and support		
COUNTRY	BUDGET	AMOUNT (USD)
Fiji	YES	\$ 290,000
Kiribati	(YES)	–
Samoa	(YES)	–
Solomon Islands	(YES)	\$72,000
Tonga	(NO)	–
Tuvalu	YES	\$ 5,200
Vanuatu	(NO)	–

**Table 15- Budget Allocation for Care and Support by Country<sup>37</sup>**

The Special Session for Children held in 2002 at the United Nations, adopted the “World Fit for Children” agenda, which called for increased attention on children in the combat against

<sup>37</sup> UNICEF 2005

HIV and AIDS. Promoting healthy lives, providing quality basic education, protecting against abuse, exploitation and violence, and combating HIV and AIDS, are the four key pillars of the World Fit for Children agenda. The Siem Reap Declaration: "Towards a Region where every Child counts" adopted in 2005, signaled the importance of addressing disparity and inequality. These issues are also embedded into the Pacific Plan.

### Section 3- A description of the extent to which children are integrated into existing national and regional policies and HIV/AIDS strategic plans.

#### 3.1 National responses

Most countries have developed National Strategic Plans (NSPs) to address HIV and AIDS, as outlined in Table 16.<sup>38</sup> Most of these NSPs were developed in 2000 and need to be updated to reflect changes in HIV situation. For example, only one of the NSPs incorporated the commitments made by PICs to UNGASS and/or Millennium Development Goals (MDGs). Furthermore, few of the NSPs included a budget or a monitoring and evaluation plan (Fiji being the exception).

Most PICs have a national AIDS Committee (NAC) or equivalent. NACs are typically multi-sectoral with representation from government, NGO, Churches and academic institutions. The private sector is not represented in any of these coordination mechanisms.

For varying reasons, the NACs in most countries are not meeting regularly. In all countries, the MOH undertakes the coordination of the national HIV response. The partnership with the NGO sector varies significantly from one country to another. Christian churches are a major provider of care and support services in most countries.

Country	Current NSP		National Coordination Mechanism (NCM)	
	Y/N	Duration	Y/N	Name
Cook Islands	Y	2004 - 2008	Y	CCM
Fiji	Y	2004 - 2006	Y	National Advisory Council on AIDS (NACA)
Kiribati	Y	2006 - 2010	Y	Kiribati HIV/AIDS & TB Task Force (also CCM for GFATM)
FSM	N	N/A	Y	Community Planning Group
Marshall Is	Y	2005 - 2009	N	Community Planning Group
Nauru	Y	2000 - ??	N	Health Promotion Council has role of coordinating HIV response
Niue	Y	2003 - ??	Y	National Health Council (also CCM for GFATM)
Palau	Y	2000 - 2005	Y	Community Planning Group. MOH is decision maker on HIV issues
Samoa	N		Y	National AIDS Coordinating Committee (NACC)
Solomon Islands	Y	2005 - 2010	Y	Solomon Islands National AIDS Committee (SINAC)
Tokelau	N	N/A	N	N/A
Tonga	Y	2000 - 2005	Y	Tonga CCM
Tuvalu	Y	2006 - 2010?	Y	Tuvalu National AIDS Committee, TUNAC (also CCM for GFATM)
Vanuatu	Y	2003 - 2007	Y	NAC & CCM

Table 16- Status of Development of HIV National Strategic Plan by Country<sup>39</sup>

Prevention education and provision of youth-friendly health services are already stipulated in national strategies and are being implemented at various levels. Country-specific PMTCT

<sup>38</sup> PRHP Pacific Regional HIV/AIDS Project, HIV/AIDS Situation and Responses in Seven Pacific Island Countries, January 2005

<sup>39</sup> PRHP 2006

policies and programmes are still at an early stage of development. Only Fiji and Tonga have developed PMTCT guidelines, which still have to be translated into national programmes. As assistance from the Pacific Regional HIV Project evolves, there will be a chance to ensure PMTCT policy is integrated into National HIV responses.

Interventions focused on the most vulnerable young people are often said to be the key to slowing or halting the epidemic. The main challenges ahead are mostly related to human and financial resources, especially in terms of conducting Rapid Assessment and Responses studies.

### 3.2 Regional initiatives

A Pacific Regional HIV/AIDS Strategy has recently been developed and endorsed by the Pacific Forum Leaders in August 2004. This strategy provides the following framework for action to support national and community responses to the HIV epidemic:

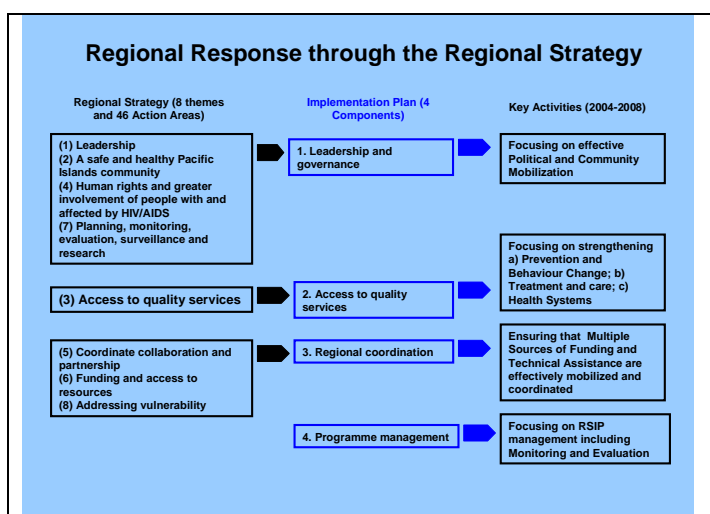
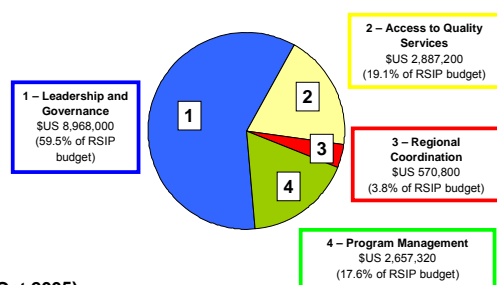


Table 17- Pacific Regional Strategy HIV and AIDS strategy<sup>40</sup>

Following the endorsement of the Regional Strategy, leaders called for an implementation plan. The Secretariat of the Pacific Community (SPC), led the process which culminated with the development of a joint-annual work plan with regional agencies in September 2005. Each component was then revised according to current plans of activities, identifying a funding gap of USD 8,539,100. Since then, ADB and NZAID have pledged support to the implementation of the Regional Strategy. The UN has also developed a Joint Programme from 2006-2011 which should be used to complement resource mobilization in the region.

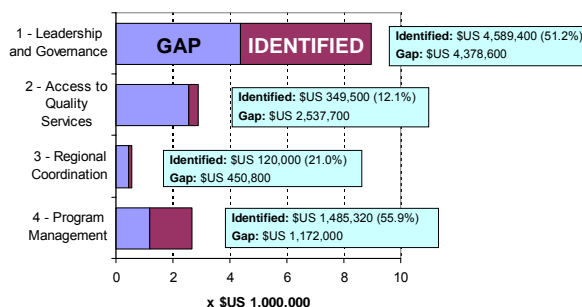
<sup>40</sup> Dr Dennie Iniakwala, "Presentation: Funding Gap PRSIP and UN Joint Programming", 2006, Secretariat of the Pacific Community

The Four Components of the Draft RSIP and their Indicative Budgets (\$US) as a proportion of the overall RSIP Budget (\$US 15.08 million)



(Oct 2005)

The Four Components of the Draft RSIP showing "Identified" Resources and Estimated Funding Gap (\$US)



(Oct 2005)

Table 18- Budget of Regional Strategy and Funding Gaps<sup>41</sup>

## Section 4- A description of plans and initiatives, including gaps in the response, related to children and HIV/AIDS in 2006 and beyond

The issue of children and AIDS cannot be isolated from the HIV interventions at both national and regional levels, and this is especially in the context of small nation states, where the national governmental response often relies on a handful of competent personnel who are also dealing with many other pressing health problems like Diabetes, Immunization and Reproductive Health. There is an urgent need to develop a practical and comprehensive multi-sectoral approach putting community at heart of the HIV response. For this to happen, it will be essential to develop evidence-based advocacy messages to alert leaders at all levels to the urgency of averting the HIV epidemic in the region.

In addition to this, it will be important to strengthen health systems, continue to develop human capacity and expand community involvement. It is urgent to strengthen HIV epidemiology in the region, not only by focusing on laboratory equipment, but also monitor behaviour development and change through regular sentinel and behaviour surveillance surveys. Timely diagnosis of HIV infection should be made through effective Voluntary and Confidential Counselling and Testing services, followed by increased access to antiretroviral drug prophylaxis and treatment for women and newborns, as well as early recognition and treatment of opportunistic infections. There is an urgent need to be scaled up and include treatment for both women and their infants into a larger continuum of care and support package.

In the context where 99.9 percent of the population are suspected to be HIV-negative,<sup>42</sup> prevention and early action remains the key. HIV responses related to children should adopt a life-cycle approach where:

- Gender relations between men and women are assessed and analysed to encourage a debate about the different standards for men and women in relation to their access to accurate information, their ability to negotiate safer sex and the social norms related to number of sexual partners. Without support from men, particularly husbands, women are less likely to access testing, counseling and treatment services, or to adhere to treatment regimes for themselves and their children;
- STI prevention and control is strengthened;
- Voluntary and Confidential Counselling and Testing are promoted and expended for both young people and antenatal women.

<sup>41</sup> Dr Dennie Iniakwala, "Presentation: Funding Gap PRSIP and UN Joint Programming", 2006, Secretariat of the Pacific Community

<sup>42</sup> Based on epidemiological data, as discussed earlier in section 1

- Education sector ensures teachers are ready and equipped to provide life saving information to their pupils, and are using methodologies conducive to the development of life skills; and
- Condoms acceptability, access and use are scaled up especially among young people who are engaging in high risk behaviours

Leaders at all levels need to shatter the silence surrounding HIV and AIDS; together they should ensure that Pacific children are not the missing face of HIV interventions.

## Conclusion

Whereas the international community is currently focusing its attention on the social and economic impact of HIV and AIDS in high prevalence countries, it is urgent to underline that HIV has the potential to seriously ravage the already fragile Pacific Islands States. A silent and rapid HIV epidemic could jeopardize the very survival of peoples, cultures, languages, and nations.

It is universally accepted that HIV thrives on poverty. Current poverty incidence rates as shown in Table 19 could rapidly increase throughout the region, as more breadwinners (and possibly their dependents) would be contracting the virus. It could be also extrapolated that general social and economic conditions could worsen in the five Least Developed Countries of the region: Kiribati, Samoa, Solomon Islands, Tuvalu and Vanuatu.

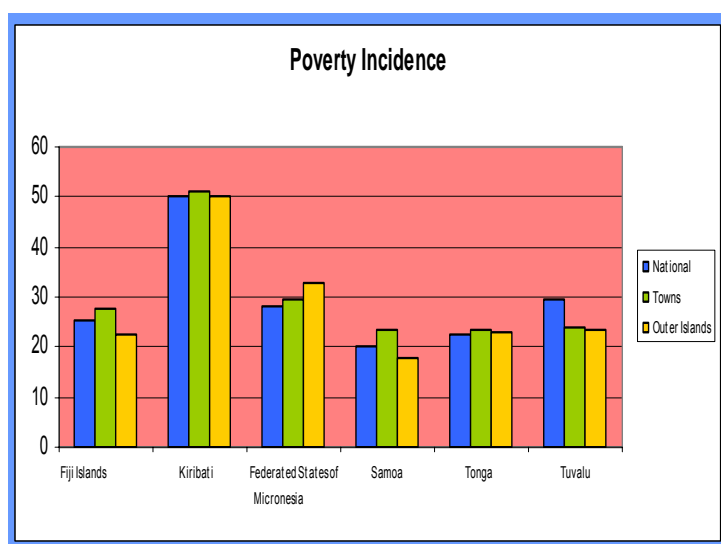


Table 19- Poverty Incidence in Selected Countries<sup>43</sup>

The Pacific Islands Countries are at a stage where “shattering the silence” is urgently needed to make sure that issues related to children and AIDS are brought up and discussed openly. The Pacific needs to learn from the PNG experience and other parts of the world to avert future HIV infections among Pacific children.

The Pacific is different from other low prevalence region. The scatteredness of its population over thousands of kilometers of ocean, cannot afford a fragmented and complacent response while the virus continues its deadly toll among men and women, among fathers, mothers and children.

There is a need for greater empowerment and capacity among governments, health professionals and communities if the goal set at the United Nations General Assembly Special Session on HIV to make services for the prevention of mother to child transmission of HIV available to 80 percent of pregnant women by 2010 is to be met.

<sup>43</sup> Asian Development Bank, Hardship and Poverty in the Pacific, 2005

Every political, traditional, religious and community leader is required in this “life saving” campaign where social norms are actively challenged and addressed. Individuals should be equipped to assess their personal risks and encouraged to practice protective behaviours. Children and AIDS issues should be discussed widely during traditional communication strategies such as *fono* or *talanoa*<sup>44</sup> sessions as well as in religious gatherings, effectively empowering communities to avert an impending HIV epidemic.

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<sup>44</sup> Polynesian word describing community discussions.

## Annex 1

**Cumulative reported HIV, AIDS and AIDS death cases, crude incidence rates, gender & cases with missing details:  
All Pacific Islands Countries and Territories, New Zealand & Australia to 31<sup>st</sup> December 2004 (or date specified)\***

Country / Region	Mid year population (2004)	Cumulative Cases			Cumulative HIV incidence		Gender (HIV)		Missing details (HIV)		
		HIV (including AIDS)	AIDS (incl. deaths)	AIDS related deaths	Crude rate per 100,000 (99% CIs)	Age-adjusted rate per 100,000 (99% CIs)	M	F	Sex	Age <sup>†</sup>	Exposure
<b>MELANESIA</b>	<b>7,444,100</b>	<b>11,600</b>	<b>2,061</b>	<b>422</b>	<b>155.8 (152.1 to 159.6)</b>	<b>151.1 (147.4 to 154.8)</b>	<b>5,674</b>	<b>5,276</b>	<b>650</b>	<b>4,436</b>	<b>8,693</b>
<b>MELANESIA (excluding PNG)</b>	<b>1,748,800</b>	<b>461</b>	<b>135</b>	<b>69</b>	<b>26.4 (23.2 to 29.5)</b>	<b>25.3 (22.2 to 28.4)</b>	<b>311</b>	<b>147</b>	<b>3</b>	<b>12</b>	<b>26</b>
Fiji Islands	836,000	182	30	17*	21.8 (17.6 to 25.9)	19.9 (16.1 to 23.7)	109	73	0	1	2
New Caledonia	236,900	272	101	50	114.8 (96.9 to 132.7)	100.9 (84.9 to 117.0)	200	69	3	11	24
Papua New Guinea	5,695,300	11,139	1,926	353	195.6 (190.8 to 200.4)	191.2 (186.4 to 196.0)	5,363	5,129	647	4,424	8,667
Solomon Islands	460,100	5	2	2	1.1 (0.2 to 3.1)	1.2 (0.3 to 3.3)	2	3	0	0	0
Vanuatu	215,800	2	2	0	0.9 (0.0 to 4.3)	0.8 (0.0 to 3.5)	0	2	0	0	0
<b>MICRONESIA</b>	<b>536,100</b>	<b>286</b>	<b>159</b>	<b>116</b>	<b>53.3 (45.2 to 61.5)</b>	<b>47.9 (40.4 to 55.3)</b>	<b>213</b>	<b>69</b>	<b>4</b>	<b>18</b>	<b>59</b>
Federated States of Micronesia	112,700	25	15	12	22.2 (12.4 to 36.4)	21.4 (12.0 to 35.2)	14	11	0	6	8
Guam	166,100	168	97	67	101.1 (81.1 to 121.2)	89.5 (71.5 to 107.4)	145	23	0	0	34
Kiribati	93,100	46	28	23	49.4 (32.7 to 71.5)	49.3 (32.6 to 71.3)	30	16	0	8	8
Marshall Islands	55,400	10	2	2	18.1 (6.7 to 38.6)	16.5 (6.1 to 35.2)	3	3	4	4	4
Nauru	10,100	2	1	1	19.8 (1.0 to 91.8)	16.6 (0.9 to 76.8)	2	0	0	0	1
Northern Mariana Islands	78,000	27	12	8	34.6 (19.9 to 55.8)	24.8 (14.2 to 39.9)	14	13	0	0	4
Palau	20,700	8	4	3	38.6 (12.4 to 89.7)	27.2 (8.7 to 63.1)	5	3	0	0	0
<b>POLYNESIA</b>	<b>635,750</b>	<b>283</b>	<b>115</b>	<b>79</b>	<b>44.5 (37.7 to 51.3)</b>	<b>44.6 (37.7 to 51.6)</b>	<b>202</b>	<b>81</b>	<b>0</b>	<b>1</b>	<b>5</b>
American Samoa	62,600	3	1	0	4.8 (0.5 to 17.5)	4.2 (0.5 to 15.3)	2	1	0	0	0
Cook Islands	14,000	2	0	0	14.3 (0.7 to 66.2)	12.7 (0.7 to 58.7)	1	1	0	0	0
French Polynesia	250,500	243	94	61	97.0 (81.0 to 113.0)	89.9 (74.8 to 104.9)	175	68	0	0	4
Niue	1,600	0	0	0	-	-	0	0	0	0	0
Pitcairn Islands	50	0	0	0	-	-	0	0	0	0	0
Samoa	182,700	12	8	8	6.6 (2.7 to 13.2)	7.2 (3.0 to 14.5)	8	4	0	0	0
Tokelau Islands	1,500	0	0	0	-	-	0	0	0	0	0
Tonga	98,300	13	9	8	13.2 (5.7 to 25.9)	14.5 (6.2 to 28.4)	7	6	0	1	1
Tuvalu	9,600	9	2	2	93.8 (32.6 to 208.3)	102.7 (35.7 to 228.1)	8	1	0	0	0
Wallis and Futuna	14,900	1	1	0	6.7 (0.0 to 49.9)	5.3 (0.0 to 39.6)	1	0	0	0	0

Country / Region	Mid year population (2004)	Cumulative Cases			Cumulative HIV incidence		Gender (HIV)		Missing details (HIV)		
		HIV (including AIDS)	AIDS (incl. deaths)	AIDS related deaths	Crude rate per 100,000 (99% CIs)	Age-adjusted rate per 100,000 (99% CIs)	M	F	Sex	Age <sup>†</sup>	Exposure
<b>All PICTs</b>	<b>8,615,950</b>	<b>12,169</b>	<b>2,335</b>	<b>617</b>	<b>141.2 (137.9 to 144.5)</b>	<b>136.5 (133.2 to 139.7)</b>	<b>6,089</b>	<b>5,426</b>	<b>654</b>	<b>4,455</b>	<b>8,757</b>
<b>All PICTs (excluding PNG)</b>	<b>2,920,650</b>	<b>1,030</b>	<b>409</b>	<b>264</b>	<b>35.3 (32.4 to 38.1)</b>	<b>33.6 (30.9 to 36.3)</b>	<b>726</b>	<b>297</b>	<b>7</b>	<b>31</b>	<b>90</b>
New Zealand	3,993,817	1,975	845	607	49.5 (46.6 to 52.3)	44.5 (41.9 to 47.1)	1,657	300	18	98	343
Australia*	19,731,984	23,306	9,260	4,521	118.1 (116.1 to 120.1)	110.7 (108.8 to 112.6)	21,476	1,510	260	213	3,716

\*Reporting period: to 31<sup>st</sup> December 2004 except for: Australia (December 2003); Fiji – AIDS related deaths (December 2001).

<sup>†</sup>Numbers of cases for whom age was estimated for inclusion within age-adjusted HIV rates.

All data are supplied by official country reporting authorities. All data are subject to revision.

Reported cases do not reflect total disease burden. Case numbers are influenced by access to testing, testing uptake & notification rates.

Source: AIDS Section, Public Health Programme, Secretariat of the Pacific Community ([www.spc.int/aids](http://www.spc.int/aids)) (Table date: 20<sup>th</sup> December 2005).

## Annex 2

### Solomon Islands : Notified Malaria cases (annual)

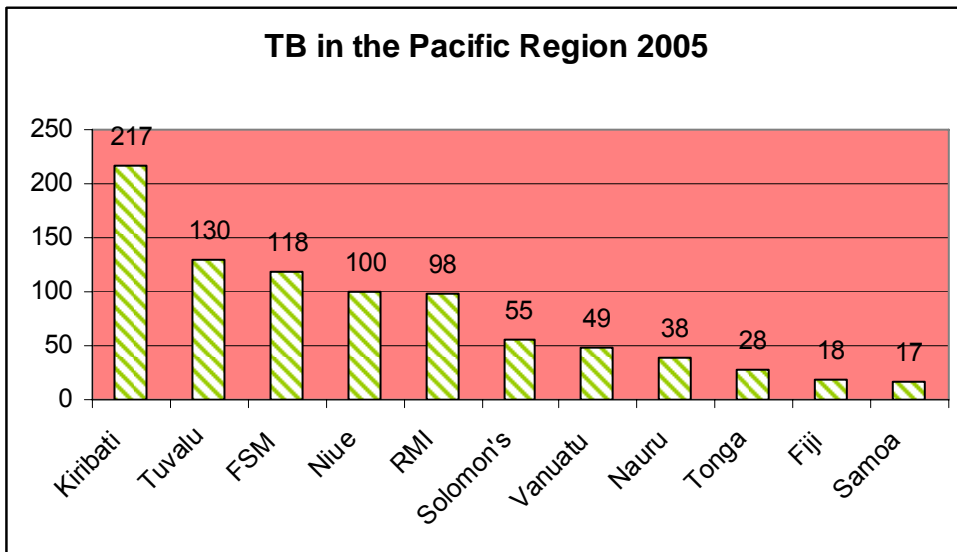
Year	Number
1990	28,805
1991	19,466
1992	12,842
1993	11,483
1994	5,765
1995	11,954
1996	5,740
1997	6,103
1998	6,181
1999	5,180
2000	6,422
2001	7,647
2002	14,339
2003	15,240

[Source: WHO, Solomon Islands Country Liaison Office Report, 2005]

### Vanuatu : Reported Malaria cases (annual)

Year	Number
1990	116,500
1991	141,400
1992	153,359
1993	126,123
1994	131,687
1995	118,521
1996	84,795
1997	68,125
1998	72,808
1999	63,169
2000	67,884
2001	76,417
2002	74,865
2003	90,606

[Source: WHO, Vanuatu Country Liaison Office Report, 2005]



Rate per 100,000 population: Please note that Kiribati ranks first among the Western Pacific Region before Cambodia and the Philippines.

Source: World Health Organisation, Western Pacific Region, 2005

### Annex 3- Pacific Islands Country (2004)

	Cook	Fiji	FSM	Kiribati	RMI	Nauru	Niue	Palau	Samoa	Solomon	Tokelau	Tonga	Tuvalu	Vanuatu
Population ('000)	18	831	108	87	52	10	1	20	176	464	2	103	11	202
Land mass Km <sup>2</sup>	240	18,272	700	726	181	21	259	487	2,934	28,000	12	688	26	12,190
# of islands	15	332	607	33	34	1	1	200	5	105	3	170	9	80
Growth Rate	0	1.2	1	1.6	1.4	2.5	-3.8	2.3	0.8	2.8	-0.9	0.3	1.4	2.8
Total fertility Rate	3.7	2.9	3.8	4.5	5.7	4.4	3	2.6	4.2	4.8	5.6	3.8	4.1	4.4
Number of birth	0.4	19	3	2	1.2	0.3	0.05	0.5	5	15	-	2	0.2	6
% of Central government Expenditure on Health	16	9	11	18	14	-	8	15	9.1	12	-	7	9.4	11
% of Central government Expenditure on Education	13	18	4	18	30	7	-	20	13.3	15.4	-	17.8	16.8	17.4
IMR	21	17	20	51	54	17.8	12	24	20	20	19	16	38	34
Under 5 Mortality	26	21	24	69	66	22	12	29	25	24	30	20	52	42
MM ratio	6	75	120	225	109	-	-	-	130	130	170	160	-	130

#### IMR, U5MR

While IMR has steadily declined in the region over the past decade, it is still high (between 37-63) in some countries. While it remains difficult to accurately assess trends in U5MR due to insufficient and/or unreliable data, the leading causes of death in children under the age of five include acute respiratory infection, diarrhea, other infectious and vector-borne disease including malaria (Vanuatu and Solomon Islands), peri-natal complications, and injuries.

#### MMR

Maternal mortality rates continue to be high in some PICs. Contributing factors include inadequate child spacing, anemia, malaria, lack of access to safe delivery systems.

#### Education

The proportion of children enrolling in primary school is high in most Pacific island countries; but a number of children are missing out through non-enrolment or by dropping out. The quality of education in the Pacific island countries is a major problem, characterized by rote learning methodologies, lack of resources and untrained/unmotivated teachers. For the young child, there is a lack of effort by Governments and non-governmental organizations (NGOs) to address the need for early stimulation and psychosocial development of those under the age of two years. Households are being required to assume the increasing, and often unmanageable, costs associated with schooling. In many areas, discrimination exists, with access to basic education limited by distance, poverty and/or disability. The gender gap in primary and secondary school enrolment is closing, although gender issues such as early female dropouts, the lack of gender sensitivity in the school curriculum, and patterns of violence against girls and women require attention.

### **Adolescents**

The spread of HIV/AIDS is increasing, and the prevalence of sexually transmitted infections (STIs) remains high, especially for young people. Pacific migration, the population's youthful age structure, limited economic opportunities, increasing poverty, low status of women, increasing substance abuse, lack of treatment for STIs, and the growing conflict between traditional and modern values are some of the factors contributing to the spread of HIV/AIDS. While there are relatively few recorded cases of HIV infection in Pacific island countries, there is the potential for a major crisis in these small island States. There are also increasing numbers of children and young people living on the street, involved in pornography and prostitution. Legislation to protect children is inadequate in most countries, although some improvements have been made in areas such as adoption and juvenile justice.