

Pacific Sexual Health & Well-Being SHARED AGENDA

2015-2019



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Original text: English

Secretariat of the Pacific Community Cataloguing-in-publication data

Pacific Sexual Health and Well-Being shared agenda: 2015-2019 / compiled and published by the Secretariat of the Pacific Community

1. Sexual health – Prevention – Oceania.
2. Pacific Islanders – Sexual behavior.
3. Sex – Social aspects – Oceania.

I. Title II. Secretariat of the Pacific Community

306.70995
AACR2

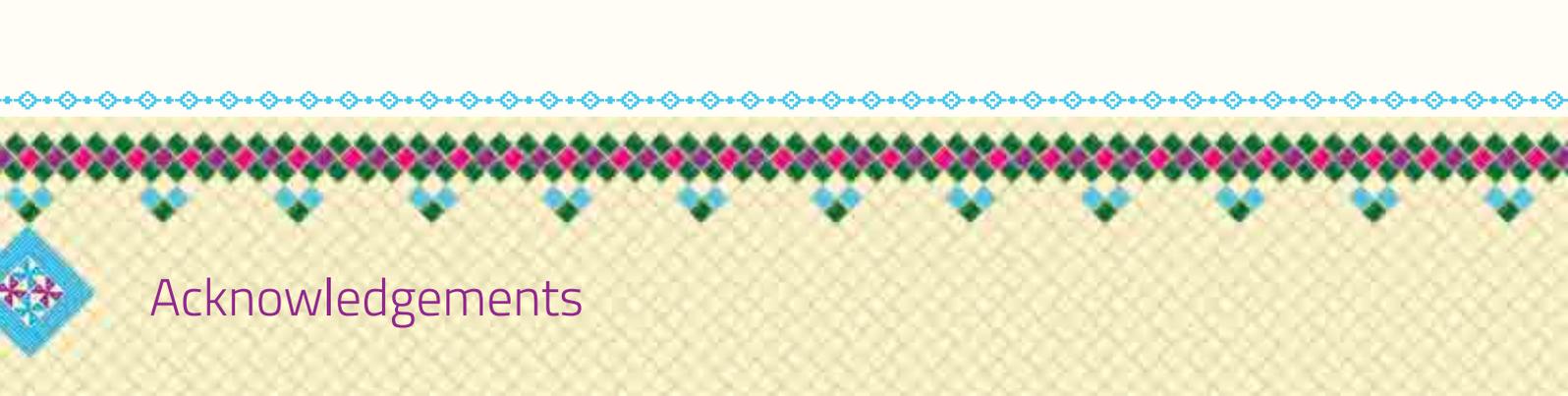
ISBN: 978-982-00-0741-3

Pacific Sexual Health & Well-Being SHARED AGENDA 2015-2019

Endorsed by Pacific Ministers of Health at the Pacific Health Ministers Meeting held in Honiara, Solomon Islands, 10th July 2014.



Compiled & Published by the Secretariat of the Pacific Community
Suva (Fiji), 2014



Acknowledgements

The *Pacific Sexual Health and Well-being Shared Agenda 2015–2019* (the Shared Agenda) is a collaborative venture of Pacific Island governments, civil society organisations, representatives of vulnerable and marginalised populations, and regional development partners. Many people were involved in shaping the Shared Agenda and deserve acknowledgement. Representatives of Pacific Island governments, civil society organisations and networks, and key populations provided invaluable perspectives, insights and directions in consultation meetings, seminars and ongoing discussions. The working group and task force both played key roles in driving the development and strategic direction of the Shared Agenda. The development was led by the Secretariat of the Pacific Community's Public Health Division, coordinated by the Sexual and Reproductive Health Policy and Planning Adviser, Ms Michelle O'Connor, and the HIV/STI Team Leader Dr Dennie Iniakwala. The process would not have been possible without the funding provided by the Australia and New Zealand Pacific Response Fund and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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Designed by Nicol Cave, Secretariat of the Pacific Community and Kautane Pene, Hatamara Graphics, Fiji.

Printed in Fiji by Star Printery.

Photos by the Secretariat of the Pacific Community (SPC).

Prepared and published by the
Secretariat of the Pacific Community (SPC)

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Despite their diverse social and cultural beliefs and values, and the various public health challenges they face, Pacific Island countries and territories are united in their goal of improving the sexual health and well-being of Pacific Islanders. This is reflected in the dedication of stakeholders, including governments, development partners, civil society and key populations, in the development of the *Pacific Sexual Health and Well-being Shared Agenda 2015–2019* (the Shared Agenda).

As we move into the post-2015 Millennium Development Goals era, the importance of sexual and reproductive health and rights is gaining greater recognition globally and will be a key feature of the post-2015 sustainable development goals. I am proud to say that the Pacific is leading in this approach through the Shared Agenda, which takes HIV services out of siloed programming and encourages a holistic approach to sexual health. Of particular importance is the integration of HIV and STIs into sexual and reproductive health services and programmes. It has become clear that there is no ‘one size fits all’ approach and no ‘quick fix solutions’ to issues such as HIV and other STIs, adolescent pregnancy, the unmet need for family planning, gender-based violence, sexual assault and related psycho-social issues, all of which impact on the well-being and sustainable development of Pacific Island nations. We need to look at the root causes, the social determinants of health, such as poverty, education and gender empowerment, and we need to strengthen our health service delivery systems so as to see long-lasting improved health and well-being outcomes.

I commend the Pacific region for the *Pacific Sexual Health and Wellbeing Shared Agenda* and encourage strong commitment and partnership to see it through to fruition. In the true Pacific spirit of sharing, may Pacific Island countries and territories set sail together on this endeavour to achieve the highest attainable standard of sexual health and well-being and ultimately healthy islands and healthy people.

Dr Colin Tukuitonga,
DIRECTOR-GENERAL,
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Fijian HIV advocate Apikali Waseilovoni and her children.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
CCM	Country Coordinating Mechanism
CEDAW	The Convention on the Elimination of All Forms of Discrimination against Women
CPR	Contraceptive prevalence rate
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSE	Comprehensive sexuality education
CSO	Civil society organisation
DHS	Demographic Health Survey
ESCAP	Economic and Social Commission for Asia and the Pacific
FPI	Family Planning International
GARPR	Global AIDS Response Progress Reporting
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IBBS	Integrated Biological and Behavioural Surveillance
ICPD	International Conference on Population Development
IPPF	International Planned Parenthood Federation
IFRC	International Federation of the Red Cross
KAP Survey	Knowledge, Attitudes and Practice Survey
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex
MDGs	Millennium Development Goals
MoH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Council
NGOs	Non-governmental organisations
OSSHMM	Oceania Society for Sexual Health and HIV Medicine
PICTs	Pacific Island countries and territories
PIFS	Pacific Islands Forum Secretariat
PIRMCCM	Pacific Islands Regional Multi-Country Coordinating Mechanism



PPF	The Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2009–2015
PRSIP I	Pacific Regional Strategy on HIV and Implementation Plan (2004 – 2008)
PRSIP II	Pacific Regional HIV and other STIs Strategy and Implementation Plan (2009 – 2013)
PSDN	Pacific Sexual Diversity Network
PYDF	The Pacific Youth Development Framework
RTI	Reproductive Tract Infection
SGSS	Second generation sentinel surveillance
SHC	Strategic Health Communication
SOGI	Sexual Orientation and Gender Identity
SPC	Secretariat of the Pacific Community
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nations Joint Programme for HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
UPR	Universal Periodic Review
WHO	World Health Organization



Executive summary

The *Pacific Sexual Health and Well-Being Shared Agenda 2015–2019* (the Shared Agenda) is a visionary document that provides guidance and strategic direction to strengthen the sexual health response in the Pacific region by shifting the focus from a single disease to a rights-based comprehensive approach to sexual health.

More precisely, the Shared Agenda aims to:

- ❖ set and build a vision for integrating HIV and other STIs into a broader sexual health agenda around the priority needs of the region;
- ❖ facilitate the delivery of accessible and equitable sexual and reproductive health services and programmes; and
- ❖ provide key strategic directions that work towards integration, and coordinate the action of stakeholders.

The Shared Agenda is grounded in the following principles: equality, equity and respect for diversity; ownership and commitment by all stakeholders; partnership and collaboration; rights- and evidence-based policy; and sustainability. The goal is: to attain the highest standards of sexual health and well-being, and realise sexual and reproductive rights are for all people in the Pacific.

Sexual health is fundamental to the physical and emotional health and well-being of all, and to the social and economic development of communities and countries (WHO). Of particular concern in the Pacific region are an increase in the number of reported HIV cases; high rates of STIs, gender-based violence and sexual assault; high rates of adolescent pregnancy; and low contraceptive prevalence.

The Shared Agenda recognises that there is a strong interrelationship between sexual and reproductive health and that reproductive health is an entry point for improved sexual health (WHO 2010a). A key focus of the Shared Agenda is to improve the reach of sexual health services and programmes through greater integration and linkages with related services and programmes. The main benefit of this will be the ability to improve multiple health outcomes simultaneously. Whilst the Shared Agenda is focused on sexual health, it is likely and desirable that it will strengthen efforts to improve reproductive health as well.



The *Pacific Sexual Health and Well-Being Shared Agenda 2015–2019* (the Shared Agenda) is a visionary document that provides guidance and strategic direction to strengthen the sexual health response in the Pacific region



Sexual health is fundamental to the physical and emotional health and well-being of all, and to the social and economic development of communities and countries (WHO 2010a).





The document was borne out of comprehensive consultations with government personnel, civil society organisations, vulnerable and marginalised populations and development partners across the region, following the expiration of the *Pacific Regional Strategy on HIV and other STIs* at the end of 2013.

The Shared Agenda supports engagement of Pacific nations in the implementation of agreed international commitments such as the *UN Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS* adopted in 2011, the commitments of the 1994 International Conference on Population and Development, and commitments to the *UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*, adopted in 1979.

In order to deliver effectively on the goal and long-term outcomes, five key approaches have been identified that will drive the work of stakeholders and be used as pillars to guide planning and programming.

The key approaches

1. Strengthen the generation of strategic information to inform policy, planning, and programming.
2. Establish, strengthen and expand integration and linkages between services for STIs/HIV, sexual and reproductive health and other related services.
3. Strengthen and roll out strategic health communication (SHC) and comprehensive sexuality education (CSE).
4. Empower key stakeholders to create inclusive environments through legal, social, structural, and policy reform.
5. Tailor services and programmes to meet the needs and rights of key populations.



Maximising the benefits of the Shared Agenda requires energetic partnerships



Maximising the benefits of the Shared Agenda requires energetic partnerships among multiple sectors to reach and advocate for vulnerable and marginalised populations, build on existing systems, develop effective policies and create a supportive and enabling environment.

A Governance body (Directors of Health) and Oversight Body shall oversee the implementation of the Shared Agenda. Implementation will take place through national planning processes and mechanisms. In this way, the Shared Agenda avoids the pitfalls of the 'one size fits all approach'. Development partners will play a supportive role through the provision of technical and financial assistance, capacity building and substitution, and the delivery of regional public goods (see Annex 2 for Division of Labour).



Young people play soccer on Bonriki International Airport runway between flights in Tarawa, Kiribati.



What is well-being?

‘There is no consensus around a single definition of well-being, but there is general agreement that at minimum, well-being includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfillment and positive functioning. In simple terms, well-being can be described as judging life positively and feeling good. For public health purposes, physical well-being (e.g., feeling very healthy and full of energy) is also viewed as critical to overall well-being.’

(United States Centers for Disease Control and Prevention 2013).

What is sexual health?

‘Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sex experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO 2006a)’.



Sexual health and well-being in the Pacific region

Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries (WHO 2010a). The achievement of sexual health and well-being is dependent on a person's ability to make good health choices by having the appropriate comprehensive knowledge and information about sexual health and related risks, access to high-quality health services and commodities and an enabling environment that promotes good sexual health and well-being for all without discrimination.

Pacific Island countries and territories (PICTs) show mixed results in terms of their progress towards achieving sexual health related Millennium Development Goals (MDGs). PICTs have low prevalence of HIV; all but Papua New Guinea are on track to achieving the goal of universal access to treatment for HIV and AIDS, and seven are on track to halting or have begun reversing the spread of HIV. However, factors such as high rates of sexually transmitted infections (STIs) and low condom use mean that acquiring HIV is still a serious risk for the region. Half of PICTs are on track to improving maternal health but progress towards ensuring universal access to reproductive health care has been slow, with contraceptive use averaging around 26% compared to the developing region average of 61% (PIFS 2011). The achievement of the MDGs is further hindered by the high prevalence and incidence of violence against women across PICTs (PIFS 2011, 2013).

The achievement of sexual health and well-being is dependent on a person's ability to make good health choices by having the appropriate comprehensive knowledge and information about sexual health

Concerns have been expressed throughout the region about the sexual and reproductive health and well-being of people living in the Pacific through a number of calls for action, declarations, meeting outcome statements and discussions instigated by governments and civil society. These include the Madang Commitment (2009), The Sixth Asian and Pacific Population Conference and corresponding Moana Declaration (2013), the outcome statement of the 12th Triennial Conference of Pacific Women and the outcome statement of the Pacific Feminist Coalition on Sexual and Reproductive Health Rights (2013) (WHO and SPC 2009; ESCAP 2013; SPC 2013b; Pacific Feminist Coalition on SRHR 2013). Of particular concern has been the risk of an increase in HIV cases; high rates of STIs, gender-based violence and sexual assault; high rates of adolescent pregnancy; unmet family planning needs and the achievement of sexual and reproductive rights without violence and discrimination. Further details are provided in Section B of this document.

Structural factors such as the economic, social, political and cultural context, and other aspects of the environment, contribute to the aforementioned poor health outcomes within the region and require greater attention. For example, gender inequality and existing gender roles, norms and expectations have adverse effects on women's sexual and reproductive health and contribute to gender-based violence and forced sex. Sexual and reproductive health rights are yet to be realised in many countries. Legislation continues to be in place that fails to protect people living with HIV, fails to promote women's right to make free and responsible sexual and reproductive health choices and discriminates against diverse sexual orientations and gender identities (SOGI).

In addition, PICTs are experiencing profound social changes characterised by the transition from subsistence to market-based capitalist economies, increasing mobility within and between countries, a large population of youth with few employment opportunities, rapid and often unplanned urbanisation, increased potential for conflicts due to intensified pressures over resource distribution, and environmental issues related to climate change. Such social changes can put a person at greater risk of poor sexual and reproductive health outcomes by reducing their access to services and information and increasing their risk taking behaviours.

A comprehensive approach to sexual health and well-being

Sexual health and well-being is determined by a complex mix of factors, and actions to improve it take place through a range of services – including primary health care, reproductive health services, TB treatment, social welfare services and adolescent health programmes – and in a variety of settings, including in schools and within the community. Therefore, a multi-sectoral approach is necessary. The World Health Organization (WHO) has identified the five domains that play a crucial role in determining sexual health and well-being as: laws, policies and human rights; education; society and culture; economics; and health systems (WHO 2010a). The Shared Agenda takes a multi-sectoral perspective by identifying five key approaches that encompass these five domains. This is further discussed in Section D of this document.

Sexual health and well-being is determined by a complex mix of factors, and actions to improve it take place through a range of services

WHO has identified the key elements of sexual health as (WHO 2010a):

- ❖ reproductive tract infections (RTIs) and STIs (including HIV)
- ❖ unintended pregnancy and safe abortion
- ❖ sexual dysfunction and infertility
- ❖ violence related to gender and sexuality
- ❖ young people's sexual health and sexual health education
- ❖ sexual orientation and gender identity
- ❖ mental health issues related to sexual health
- ❖ the impact of physical disabilities and chronic illnesses on sexual well-being
- ❖ the promotion of safe and satisfying sexual experiences.

Within the Pacific context there are opportunities for improving sexual health and well-being. Much work has already taken place to set a solid foundation. For example, a number of successes have been achieved over the past decade through the roll out of the two Pacific strategies on HIV and other STIs (*The Pacific Strategy on HIV 2004–2008* and *The Pacific Strategy on HIV and other STIs 2009–2013*). Legislative reform is beginning to take place; examples include Tonga’s *Family Protection Act* and Fiji’s *HIV/AIDS Decree 2011*. There is a strong social movement within the region advocating for the sexual and reproductive rights of all. Furthermore, the majority of PICTs have national strategies and plans that include elements of sexual health, such as STI/HIV national strategic plans or sexual and reproductive health national strategic plans. However, despite these achievements, it is also recognised that more progress has to be made. Many social, political, economic, legislative, structural and health system weaknesses and barriers remain and need to be overcome. This is further discussed in section B of this document.

Integration and linkages of sexual and reproductive health services

Sexual health encompasses more than reproduction; whilst sexual behaviour is central to both sexual and reproductive health, it does not always result in reproduction and is not always carried out for that purpose. Sexual health encompasses issues not necessarily linked to reproductive health, such as sexual assault and violence, as well as mental health. It is also not possible to achieve reproductive health and well-being without considering sexual health and well-being. Nevertheless, it is recognised that there is a strong interrelationship between sexual and reproductive health and that reproductive health is an entry point for improved sexual health (WHO 2010a).

Furthermore, it is recommended that steps be taken by PICTs to move towards an integrated sexual and reproductive health approach, with emphasis on both the sexual reproductive health components. The Shared Agenda is expected to set the foundations for this by improving sexual health and well-being within the region and by facilitating a shift towards a more comprehensive approach that recognises the links between sexual and reproductive health as well as sexual health issues in their own right.

A key focus of the Shared Agenda is to improve the reach of sexual health services and programmes through greater integration and linkages with reproductive health services and programmes. This is of particular importance for PICTs, where sexual and reproductive health services are not always available at the primary health care level where there is limited reach of services to vulnerable and marginalised populations such as women, youth, LGBTIQI and people living in remote areas.

A key focus of the Shared Agenda is to improve the reach of sexual health services and programmes through greater integration and linkages with reproductive health services and programmes.



Fijian seafarer, Mr Waqa spends quality time with his family at his home in Lautoka. Programs that reach out to seafarers and their families can help prevent STIs, HIV and gender-based violence.

A number of benefits of integrating HIV and other STIs into sexual and reproductive health services and programmes has been identified by WHO/UNFPA/UNAIDS and IPPF (Kennedy et al. 2010)

- ❖ Improved access to and uptake of key HIV and sexual and reproductive health services
- ❖ Better access by people living with HIV to sexual and reproductive health services tailored to their needs
- ❖ Reduction in HIV-related stigma and discrimination
- ❖ Improved coverage of underserved/vulnerable/key populations
- ❖ Greater support for dual protection against STIs and unintended pregnancy
- ❖ Improved quality of care
- ❖ Decreased duplication of efforts and competition for resources
- ❖ Better understanding and protection of individuals' rights
- ❖ Mutually reinforcing complementarities in legal and policy frameworks
- ❖ Enhanced programme effectiveness and efficiency
- ❖ Better utilisation of scarce human resources for health

An integrated approach to sexual and reproductive health is further supported by a number of international instruments. Recognising that sexual and reproductive health and rights are inextricably linked to population and development, the 1994 International Conference on Population and Development (ICPD) called for an integrated response to sexual and reproductive health. This was reaffirmed at high-level meetings of ICPD in 1999, 2004 and 2009 (UNFPA 2013a). In addition, the benefits of integration are articulated in the UNAIDS policy position paper 'Intensifying HIV prevention', which identifies the promotion of linkage between HIV prevention and sexual and reproductive health as an 'essential policy action for HIV prevention' (UNAIDS 2005). It is also expected that sexual and reproductive health and rights will be a key component of the post-2015 development agenda (United Nations 2013).

It is anticipated that by strengthening sexual and reproductive health integration and linkages and by expanding services, particularly at the primary health care level, the aforementioned benefits will be realised. The main benefit of this would be the ability to address clients' multiple needs in one place and improve multiple health outcomes simultaneously. Integration also has the potential to strengthen health systems (Kennedy et al. 2010).

The purpose of the Pacific Sexual Health and Well-being Shared Agenda

The Pacific Sexual Health and Well-being Shared Agenda is a visionary document that provides guidance in strengthening the sexual health response in the Pacific region by shifting the focus from a single disease to that of a comprehensive approach to sexual and reproductive health through a rights-based lens. The cornerstone of the Shared Agenda is the delivery of comprehensive sexual health services and programmes through strengthening linkages and integration with other services and programmes (including those in reproductive health, social welfare, adolescent health, TB, etc.) that promote the sexual health and well-being of all people living in the Pacific. More precisely, the Shared Agenda aims to:

- ❖ set and build a vision for integrating HIV and other STIs into a broader sexual health agenda around the priority needs of the region;
- ❖ facilitate the delivery of accessible and equitable sexual and reproductive health services and programmes; and
- ❖ provide key strategic directions that work towards integration and coordinate the action of stakeholders.

Development of the Shared Agenda

With the Pacific Regional Strategy on HIV and other STIs 2009–2013 coming to an end, the Secretariat of the Pacific Community (SPC) sought guidance from PICTs in early 2013 to ascertain the desire and need for a future regional approach to HIV and other STIs. Ministry of health HIV/STI and several reproductive health programme managers, coordinators and clinicians from 17 of the invited 22 PICTs attended the 'Making Waves: sub-regional consultations on the Pacific STI and HIV Response beyond 2013' held in Nadi, Fiji, 18–21 March and in Tumon Bay, Guam, 25–28 March 2013. During the consultations, concerns were raised about a number of sexual health issues affecting the health and well-being of people living in the Pacific, including HIV and other STIs, HPV and cervical cancer, forced sex and sexual assault, and adolescent and unintended pregnancy. Participants said that more needed to be done to meet the needs of specific vulnerable populations – particularly youth – and advocated for the strengthening of linkages between HIV/STIs and sexual and reproductive health. Representatives from all PICTs expressed a desire for another regional approach, arguing that a long-term regional vision and guidance for leaders and decision-makers is of great value to addressing sexual health issues within the region.

The consultations were complemented by a desk review of regional data and national, regional and international sexual and reproductive health and rights commitments, approaches and strategies. The review included identifying recommendations from other key documents such as the PRSIP Mid-Term Review 2012, the PRSIP Gender Audit and Strategy 2011, the Pacific Moana Declaration 2013 and the outcomes statement from the 12th Triennial Conference of Pacific Women 2013.



Members of the Drodrolagi Movement at the CSO Consultation Workshop in Suva, Fiji in August 2013.

The consultations and subsequent development of the Shared Agenda has been led by SPC in partnership with the Shared Agenda Technical Working Group, which comprised of regional development partners, including UN agencies, IPPF and IFRC and the Task Force which comprised of government and civil society representatives.

A series of technical working group sessions took place between March 2013 and April 2014 to shape and design the Shared Agenda. Further consultation took place with the STI, HIV and Reproductive Health Programme Managers during the WHO/SPC-led Programme Managers' Meeting in June 2013, in which a mandate was given for the draft Shared Agenda.

In August 2013 a two-day consultation was held in Suva, Fiji, with civil society organisations representing vulnerable and marginalised groups, including people living with HIV, LGBTQI people, MSM, sex workers, people living with disabilities, women and youth¹. This was one of the first consultations within the Pacific bringing together different vulnerable and marginalised groups to discuss sexual and reproductive health and rights. The consultation provided valuable in-depth information on sexual health needs and lessons learnt from grassroots-led programmes. Key results of the consultation included support for the Shared Agenda from civil society and the establishment of the Shared Agenda task force whose role was to steer the direction and content of the Shared Agenda. (SPC 2013a).

To ensure gender was effectively and adequately addressed in the Shared Agenda, consultation was carried out during the 12th Triennial Conference of Pacific Women held in Cook Islands in October 2013. Input was also received by gender experts from SPC, UNFPA, UNWOMEN and regional CSOs. Further consultation took place with youth groups at the Youth and Sports Conference held in New Caledonia in December 2013. A key outcome from all consultations was a strong drive for the realisation of sexual and reproductive health and rights for all.

Between February and April 2014 the Shared Agenda was distributed to a wide audience of stakeholders for review. It was endorsed by the Pacific Directors of Health in Nadi on 30 April 2014 and final endorsement was provided on the 10th July 2014 by the Pacific Ministers of Health during the Pacific Health Ministers Meeting held in Honiara, Solomon Islands.

¹ Participants at the CSO consultation included: Fiji Network Plus, Survival Advocacy Network, Drodrolagi Movement, MENFiji, Reproductive Health Association of Fiji, Davuilevu Theological College, Empower Pacific, Wan Smol Bag Theatre, Fiji Women's Crisis Centre/Pacific Actions Against Violence Against Women group, Pacific Disability Forum, Pacific Sexual Diversity Network, Pacific Youth Council, South Pacific Association of Theological Schools, Pacific Council of Churches network, Ma'a Fafine mo e Famili Tonga, Pacific Positive Working Group, LGBT Working Group, Samoa Fa'afafine Association, OSSHHM, Methodist Young People's Department, Homes of Hope, Business Coalition on HIV & AIDS (Fiji), FemLINK pacific, Fiji Women's Rights Movement, Oceania Pride, Foundation of the People of the South Pacific International, Empower Pacific.

B Situation and response analysis

Situation analysis

The Pacific, due to a confluence of factors including both structural and social determinants, has poor sexual health outcomes in a number of areas, including rates of STI infection, sexual and gender-based violence, adolescent pregnancy and unintended pregnancy.

From 1984 to 2012, a cumulative total of 1,737 HIV cases were reported in the region, excluding Papua New Guinea. The estimated prevalence amongst adults aged 15 to 49 years in the 17 countries with HIV cases in the Pacific is less than 0.1%. The prevalence for Papua New Guinea is estimated to be 0.5% (UNAIDS 2013). The main path of transmission in the region is through heterosexual contact, with over half of all cases transmitted this way. This is followed by male to male sex, through which 27% of cases are transmitted (SPC 2012).

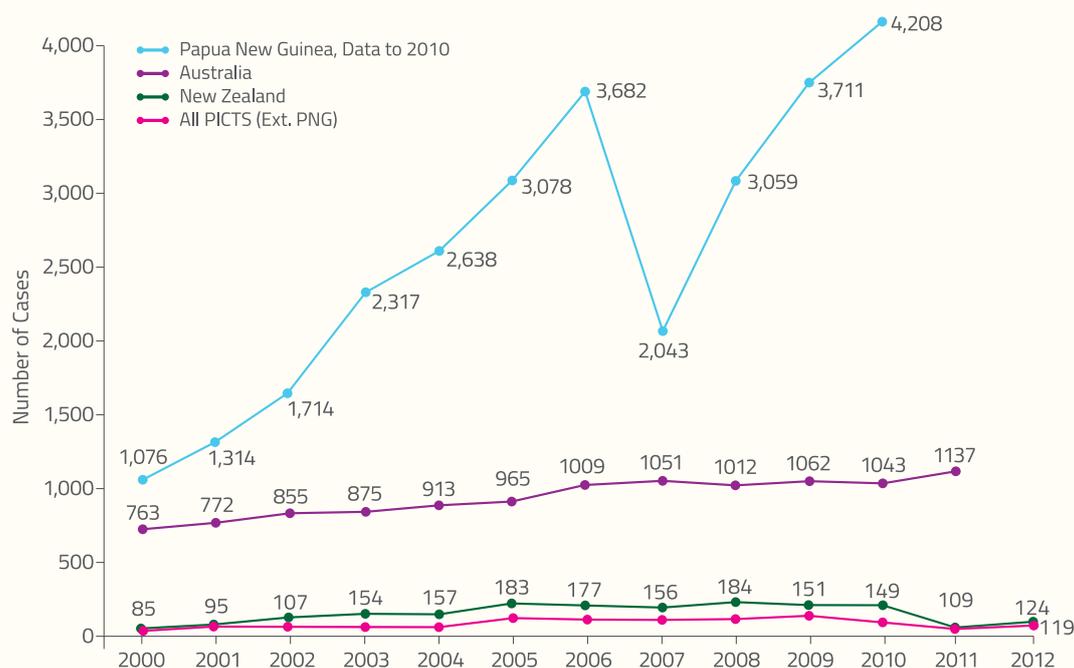


Figure 1: Newly detected HIV cases in the Pacific: 2000–2012 (SPC 2012)

STIs are hyper-endemic in the region. On average, 1 in 4 sexually active young people in the Pacific has a sexually transmitted infection and in some countries the figure is as high as 40% (Pacific STI Control Working Group. 2010). As shown in Figure 2, chlamydia, gonorrhoea and syphilis are present within the region, with chlamydia having the highest rate of infection. STI infections can have adverse effects on fertility and births and increase the risk of HIV transmission (WHO 2007).

On average, 1 in 4 sexually active young people in the Pacific has a sexually transmitted infection

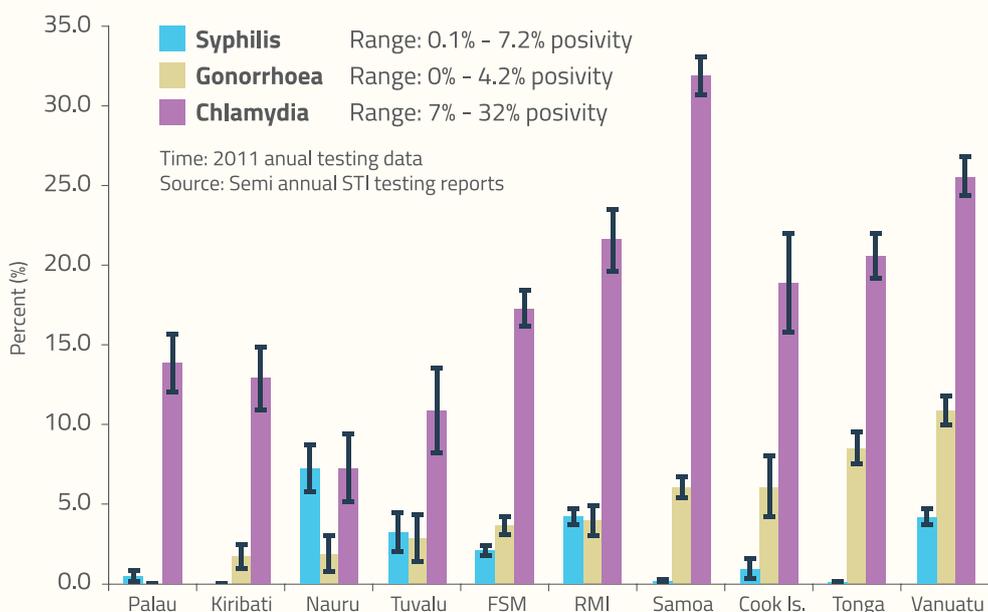


Figure 2: Rates of syphilis, gonorrhoea and chlamydia within 10 PICTs (SPC 2011)

The human papillomavirus (HPV), which can lead to reproductive cancers, is an emerging area of concern. There is limited data on the extent of HPV transmission within the region. However, a study in Fiji found that an average of 97 women a year are diagnosed with cancer of the cervix, and an average of 78 women a year die from this preventable disease (Kuehn et al. 2012). This is around three times higher than estimated global rates (Institute for Health Metrics and Evaluation 2013).

High STI rates are indicative of low condom use. Although condom use has increased in many PICTs, consistent condom use is low across the Pacific (Figure 3). Available data show a range of reasons for inconsistent condom use. In Kiribati, Solomon Islands and Vanuatu the most commonly cited reasons for not using a condom at last intercourse were: partner didn't want to; I didn't want to; not needed for sex with regular partner; embarrassed to use them; don't know how to use them; none easily available; sex doesn't feel as good (Solomon Islands Ministry of Health and Medical Services 2008; Vanuatu Ministry of Health 2008, UNICEF 2010a.b.c).

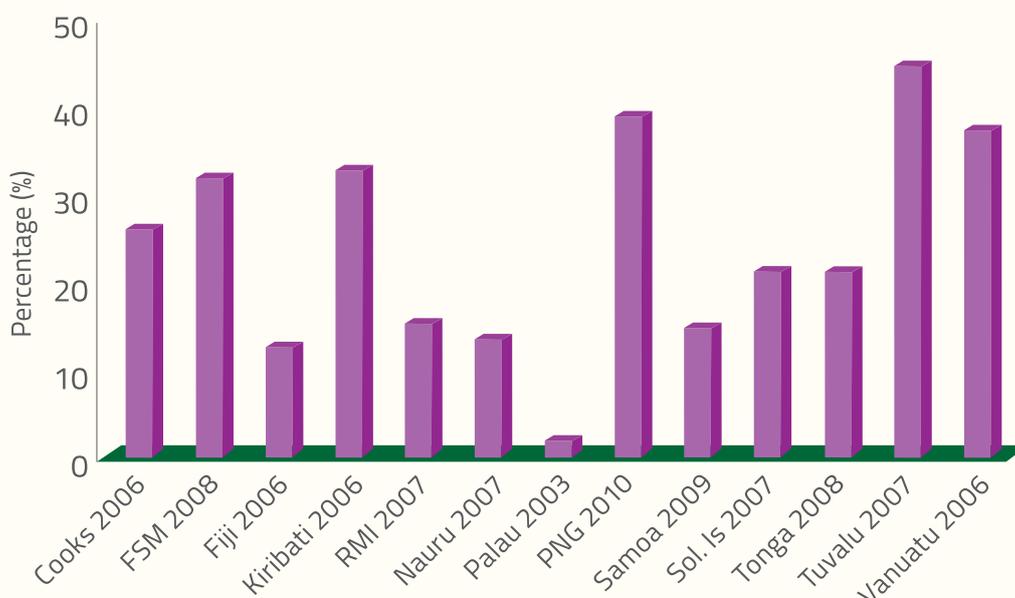


Figure 3: Condom use at high-risk sex in select PICTs (SPC 2014)

Table 1 shows that in Kiribati, Vanuatu and Tuvalu, a large percentage of youth interviewed know that condoms protect against HIV and other STIs. However, consistent condom use is still low.

Table 1: Condom knowledge and use in three PICTs.

Country	% 'Know a condom protects against HIV/STIs'	% Consistent condom use	Data source
Kiribati	94	30	Youth SGSS 2008
Vanuatu	87	11	Youth SGSS 2008
Tuvalu	85	30	Youth SGSS 2005

Sexuality and sexual relations are central to sexual and reproductive health (WHO 2010a). The inability to control family size impacts on mothers' and children's survival, health and well-being (WHO 2012a). As shown in Figure 4, unmet need for family planning is high in most PICTs, with between 8.1% and 45.6% of women expressing an unmet need to control family size using contraception.



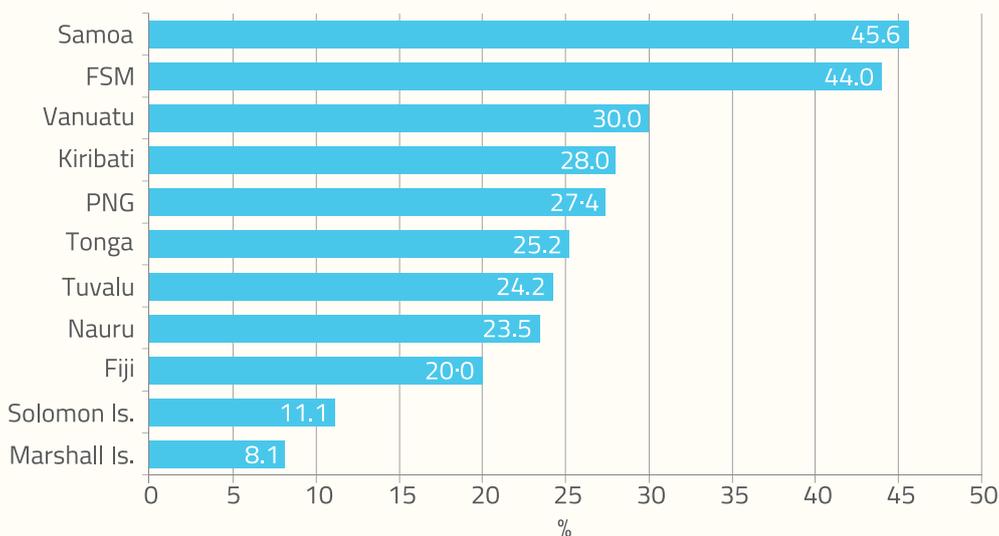


Figure 4: Unmet need amongst women aged 15–49 years for contraceptives in 11 PICTs (SPC 2014)

Contraceptive prevalence rates (CPR) have remained below 50% (Figure 5) – in some countries less than 22% – while preventable maternal deaths continue to occur (UNFPA2013b). There are a number of likely reasons for unmet need for contraceptives and low CPR in the region, including: weak health systems, limited access to contraception, lack of education regarding contraceptive choices, gender roles that prevent women from being able to make a decision about contraception use, and religious beliefs. Abortion is either illegal or available only under specific circumstances; making it very difficult for women to access a safe abortions.

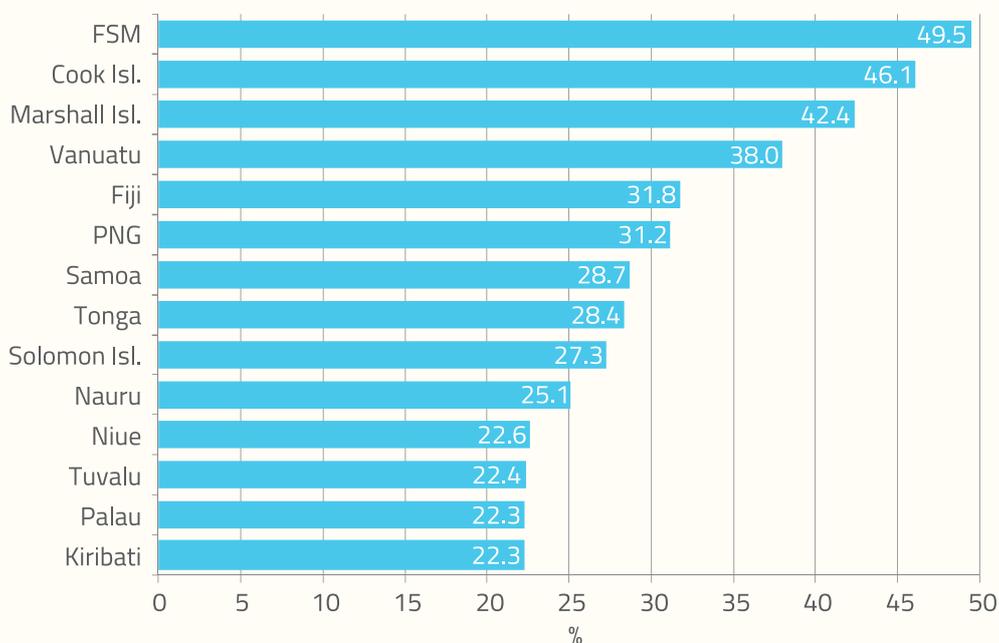


Figure 5: Contraceptive prevalence rates (%), females aged 15–49 years in 14 PICTs (SPC 2014)



A couple in Chuuk, FSM. Integrated service deliver points offer couples a range of family planning, sexual health and contraceptive services.

Some population groups are more vulnerable to poor sexual health and well-being than others. These are often populations who are marginalised and not afforded the same rights as others. In the Pacific context, these more vulnerable populations include women; young people; people living with disabilities; people living with HIV; and those who identify as lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI). Women, for example, are often deprived of the power to make decisions about their sexual and reproductive health through gendered norms and expectations grounded in tradition, culture, religion and social constructs of masculinity and often enshrined in law and the political economy of marriage and male–female relationships (UNIFEM, SPC and UNDP 2009). Men play a key role in both their own sexual health and that of their partners and should be engaged in sexual and reproductive health programmes.

Studies have found that young people are particularly at risk as they are more likely to lack control over their sexual and reproductive health. For example, studies conducted by UNICEF in Solomon Islands, Vanuatu and Kiribati found that between 38% and 45% of sexually active youth had experienced forced sex, with approximately 20% reporting that their first sexual encounter was forced (UNICEF 2010a,b,c). Sexual assault during childhood and adolescence has been linked to earlier sexual debut, sex with multiple partners, unprotected sex, transmission of STIs and early pregnancy (Women’s Health West 2011).

A 2012 open hearing on adolescent sexual and reproductive health in the Pacific found limited access to youth-friendly services, contraception and comprehensive sexuality education; a lack of meaningful engagement with young people; lack of access to safe abortion; and social, gender, cultural and religious norms that put young people at greater risk of poor sexual and reproductive health in the Pacific (New Zealand Parliamentarian’s Group on Population and Development 2012). A further study into condom use in Tonga and Vanuatu amongst 18–25 year olds attributed consistently low condom use to limited personal risk perception; numerous myths, misconceptions and misinformation about condoms; a lack of familiarity with condoms and inadequate supply.

People living with disabilities are vulnerable to poor sexual health and well-being as evidenced by a study by UNFPA and UNDP in Kiribati, Solomon Islands and Tonga. The study found that women with disabilities had experienced physical and sexual violence and *‘reported rape by strangers or acquaintances, including during the critical developmental years of adolescence’*. The study also found that *‘women with disabilities experience different forms of violence from women without disabilities,’* including *‘withholding of medication and assistance, denial of food or water, and forced sterilization and medical treatment’* (UNFPA and UNDP 2013).

A further vulnerable population are people living with HIV. Globally, people living with HIV have reported experiencing stigma and discrimination from friends, family, employers, health service providers and the wider community. Within the Pacific, a lack of confidentiality, stigmatisation and discrimination within health services are reported as key issues faced by people living with HIV (McMillian 2008). People living with HIV are often denied the rights afforded to people living without HIV, including restrictions on travel and work.

People who engage in ‘risk taking behaviours’ are also more vulnerable to poor sexual health and well-being. Traditionally, in relation to HIV and other STIs such populations include: sex workers and their clients, including those who engage in transactional sex; migrant and mobile men; men who have sex with men; people with multiple and concurrent sexual partners; and injecting drug users. Recent studies across PICTs note the existence of each of these more vulnerable populations, identify a range of socio-cultural and economic reasons why people participate in risk taking behaviours, and recommend further study into the specific vulnerabilities and needs of groups with higher risk behaviours. For example, a study on sex work within four PICTs notes that the form and conditions under which sex work takes place differ between and even within PICTs, illustrating that interventions to improve sexual health and well-being within these higher risk groups must be well targeted and evidence-based (McMillian 2013).



People’s sexual and reproductive health and well-being is shaped by social, legal, economic, cultural, religious and environmental conditions



People’s sexual and reproductive health and well-being is shaped by social, legal, economic, cultural, religious and environmental conditions, which impact behaviour, decision-making, choices and experiences. The diversity of culture, politics, religion and ideologies in the Pacific, both across and within countries, also leads to different social and structural determinants of sexual health that require different culturally and socially relevant approaches to respond to people’s needs.

Poverty and low socio-economic status can lead to risk-taking behaviours, such as engaging in commercial and transactional sex, whilst on a macro level, poverty within a country leads to reduced expenditure on sexual and reproductive health programmes (Women’s Health West 2011). PICTs ranked between 32 and 93 out of 187 (with 187 indicating the lowest level of deprivation) on the Multidimensional Poverty Index (MPI – the composite measure of the percentage of deprivations that the average person would experience if the deprivations of poor households were shared equally across the population) (UNDP 2012). This indicates that poverty differs greatly between the Pacific countries, with some countries enjoying relative wealth whilst others suffer from high levels of deprivation.



Socio-cultural norms, gender norms and religion contribute to a person’s health and well-being. For example, socio-cultural and religious values have an impact on contraceptive use. Studies outside of the Pacific have found that early marriage can have adverse health consequences, including unintended pregnancy, pregnancy-related complications, violence within marriage, higher risk of HIV transmission and higher neonatal, infant and early childhood mortality (Santhya 2011). As demonstrated in Table 2, in a select sample of PICTs, between 10% and 27% of women are married before the age of 18. However, data on the impact of early marriage in the Pacific are not available.

Table 2: Percentage of women (20–24) married before the age of 18 (select PICTs) (UNICEF 2013)

Country	Percent	Source
Vanuatu	27%	Multiple Indicator Cluster Surveys (2007)
Nauru	27%	Demographic and Health Surveys (2007)
RMI	26%	Demographic and Health Surveys (2007)
Solomon Islands	22%	Demographic and Health Surveys (2007)
PNG	21%	Demographic and Health Surveys (2006)
Kiribati	20%	Demographic and Health Surveys (2009)
Tuvalu	10%	Demographic and Health Surveys (2007)

Education, particularly for girls, is a key social determinant. Education amongst women is linked to a delay in child-bearing until a time a woman is physically, psychologically and financially prepared to have a child (UNFPA 2013c). In addition, comprehensive sexuality education within schools provides young people with the knowledge and skills to make responsible decisions about relationships and sexual and reproductive behaviours.

Discriminatory legislation, policy and social practices remain in place that act as barriers to sexual health and well-being and promote stigma and discrimination. For example, in the majority of PICTs same sex relations are illegal or the legal status is unclear (UNESCO 2013). In all Pacific states except Fiji, the human rights baseline in terms of legislation banning discrimination against people with diverse sexual orientation and gender identity has not yet been met (ILGA ANZAPI 2014).

Access to culturally appropriate, tailored, affordable health services is recognised as a key principle of effective sexual and reproductive health care (Women’s Health West 2011). The types of services available and their accessibility to subpopulations differ between and within PICTs.


Comprehensive sexuality education within schools provides young people with the knowledge and skills to make responsible decisions about relationships and sexual and reproductive behaviours.


Pacific people are mobile, and the region is expected to experience an increase in mobility between countries as a result of an increase in industries such as fishing, logging, mining and tourism. A study by UNDP documents the link between vulnerability to STI and HIV infection and mobility in the Pacific (UNDP and SPC 2010). In addition, one of the expected impacts of climate change on the Pacific region is increased migration. Migration, particularly in a humanitarian crisis that could be brought about by climate change, is likely to lead to difficulty in accessing sexual and reproductive health services, information and commodities.

Access to culturally appropriate, tailored, affordable health services is recognised as a key principle of effective sexual and reproductive health care

Response analysis

PICTs are committed to improving the sexual and reproductive health of people living in the region, as demonstrated by their commitment to the achievement of the Millennium Development Goals, ratification of the Convention to *Eliminate All Forms of Violence Against Women* (CEDAW) and active participation in and support for the outcomes of the International Conference on Population Development, the *United Nations Declaration of Commitment on HIV/AIDS*, the outcomes of Beijing Platform for Action, the *Suva Declaration on HIV/AIDS* (PPAPD 2004) and the *Auckland Consultation Statement on HIV and the Law, Ethics and Human Rights*, (Pacific High Level Statement on HIV and the Law, Ethics and Human Rights 2007).

There has also been a renewed drive to improve sexual and reproductive health in the region, as is evident by the Pacific Parliamentarians' Moana Declaration, which informed 6th Asian and Pacific Population Conference Outcome Document, 2013. The Moana Declaration advocates '[making] sexual and reproductive health (SRH) an integral part of national development strategies, health plans and public budgets, with clearly identifiable allocations and expenditures' and '[ensuring] access to sexual and reproductive health and rights (SRHR) for all our peoples, without discrimination' (UNFPA 2013d). This message was reiterated at the 12th Triennial Conference of Pacific Women and Ministerial Meeting 2013 which called for 'sexual and reproductive health and rights (SRHR) to be guaranteed, ensuring that women, young women, and girls, including those with disabilities, receive comprehensive and confidential SRHR services that respect their human rights throughout their life cycle' (SPC 2013b). The importance of adopting the *Pacific Sexual Health and Well-being Shared Agenda* was recognised at the Triennial as a vehicle for achieving this. In the same year a further call for action was made in a joint statement by Pacific Island feminists and activists who called for 'adoption of sexual rights as human rights and the protection and promotion of reproductive rights as human rights' (Pacific Feminist Coalition on SRHR 2013).

Regional policy and strategy documents have been utilised to guide and support the delivery of the regional response to HIV/STIs and sexual and reproductive health – most notably the *Pacific Regional Strategy on HIV 2004–2008* (PRSIP I) and the *Pacific Regional Strategy on HIV and other STIs 2009–2013* (PRSIP II). PRSIP II formed the cornerstone of the regional response to HIV and other STIs and attracted significant development partner support, particularly from the multi-donor Pacific Regional Response Fund (expired 2013) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.



A teacher demonstrates correct condom use to seafarers at the Marine Training Centre in Tarawa, Kiribati.

A number of achievements were made under PRSIP II, including wider reach of HIV and STI prevention and education programmes; strengthened regional and national laboratories; improved capacity to diagnose treat, and manage STIs including HIV; and improved monitoring and surveillance to enable evidence-informed policy and programmatic decisions on HIV and other STIs (O’Loughlin 2013; Wanyeki et al. 2012). The majority of PICTs have national HIV and STI strategic plans with corresponding operational plans and monitoring and evaluation frameworks. A small number of PICTs have sexual and reproductive health plans.

The Pacific response to HIV and other STIs has been largely disconnected from sexual and reproductive health. The *Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2009–2015* (PPF) was endorsed in 2008 by ministers and senior health representatives from 15 Pacific Island countries. The PPF includes specific areas such as policy and structure, services, supply chain management, and financing, and it sets out to ensure the achievement of universal access to reproductive health services and commodities in the region.

Furthermore, improving young people’s sexual and reproductive health and increasing their participation in this area is a key component of the Pacific Youth Development Framework (PYDF) endorsed by Youth Ministers in 2013. The *Pacific Sexual Health and Well-Being Shared Agenda* builds on the foundations set by PRSIP II, PPF and PYDF.

There has been significant progress made in understanding sexual health issues in the Pacific. However, there is still a great lack of knowledge and data regarding sexual health behaviours, risk factors and vulnerable populations within the region. Health information systems experience bottlenecks that impact the collation and analysis of data at the national and regional level. It is necessary to strengthen routine and active data collection as well as in-depth research and analysis to better equip decision-makers to deliver evidence-based policies, plans, services and programmes.

Currently in the Pacific, the legislative environment focuses on prohibiting behaviours, such as laws to criminalise homosexuality, prevent abortion and otherwise promote stigma and discrimination towards people living with HIV, including through travel restrictions related to HIV status. In the past five years, some countries have enacted legislation and policy reform to end discrimination, most notably Fiji through its *HIV/AIDS Decree 2011* and Tonga with its *Family Protection Act 2013* and other PICTs are beginning to follow suit. Such new legislative models take a more multi-disciplinary focus, which better enables a supportive link between legislation and policy. However, outdated criminal codes continue to exist that do not comprehensively address marital rape, sexual assault of children, trafficking and harmful traditional practices (SPC 2013c).

The establishment of LGBTQI networks in the region, such as the Pacific Sexual Diversity Network (PSDN), is a positive move towards political representation and acknowledgement of diverse sexual orientation and gender identity. However, legislation and policies remain in places that act as barriers to the achievement of sexual health and well-being for all. In the majority of PICTs, same sex relationships are illegal or the legal status is unclear (UNESCO 2013). Lessons learnt from past activities focusing on advancing HIV and domestic violence legislation include the importance of ensuring key information is available to decision-makers, technical support is available to shape legislative change, and civil society has the advocacy and lobbying tools required to bring about change.



Sexual and reproductive health services require greater integration at the primary health care level to ensure that services are accessible to all.



Health systems suffer from human and financial resource shortages. As a result, people in the Pacific, particularly on remote outer islands, are not able to access comprehensive sexual and reproductive health information, services and commodities. The majority of services and programmes in the region are vertically driven, focused on HIV and other STIs. This is most often evident when programmes are restricted by funding requirements or contractual agreements. A report by Family Planning International mapping integration of HIV and sexual and reproductive health in the Pacific found that *'integrated HIV and SRH services are not yet widely available and, where they are, they are commonly described as ad hoc and limited. In most instances, this is because they do not yet offer a comprehensive range of HIV and SRH services and because they are most commonly available only in urban areas'* (FPI 2010). Sexual and reproductive health services require greater integration at the primary health care level to ensure that services are accessible to all.

Services and programmes for vulnerable and marginalised populations are often provided by civil society organisations such as IPPF, IFRC and their networks; gender-based human rights groups; and faith-based organisations. Many services focus on married women and expecting mothers whereas the range of specifically designed services for single women, older women, men and transgender people is low. This leaves unmarried men and women, not pregnant women, youth, LGBTQI, and other marginalised populations often unable to access sexual health services. Access to psychosocial support services is also generally limited or nonexistent.



Access to information, education and services in the area of sexual and reproductive health is a critical component to enable all individuals, including young people and marginalised groups, to protect their health and exercise their sexual and reproductive health rights. Young people in the Pacific have many specific concerns and needs related to sexuality, yet few receive adequate preparation for their sexual lives, and they often face barriers that prevent them from accessing accurate information about sexuality and sexual and reproductive health. This means that young people often lack correct information, are exposed to misinformation, and have many questions but do not know where they can find reliable answers. PICTs are currently in different stages of implementing comprehensive sexuality education in schools. Youth friendly health services are available in few PICTs and reach remains low, with between 10% and 23% of young people utilising existing youth-friendly services (SPC 2014).

Resourcing and funding for sexual and reproductive health is for the most part funded by donors and development partners, not by national budgets. This potentially undermines national leadership and engagement and makes services and programmes vulnerable to external financial and political shifts and ‘siloed’ programming. PICTs also rely heavily on regional technical agencies and CSOs to provide technical assistance, with countries lacking the capacity to fully provide the necessary services and programmes.

The demonstrated strengths and weaknesses of the response to sexual and reproductive health and rights amongst PICTs offer experience that can be drawn upon and opportunities at the regional, national and grass roots level to improve the sexual health and well-being and advance the sexual and reproductive health and rights of all in the Pacific.

Lessons learnt

The following lessons were learnt from implementation of PRSIP II or were identified during the government and CSO Shared Agenda consultations.

- ❖ Involvement of communities and key populations such as people living with HIV is critical, at all levels of the programme, including advocacy, design, implementation and monitoring and evaluation, to deliver effect programmes.
- ❖ Given the varying levels of socio-economic development and the varying health priorities of PICTs, it is crucial to adapt global and international best practices to the national context.
- ❖ Strong leadership within a country’s ministry of health or programmes is essential, to ensure effective coordination of a multi-sectoral approach to the response to sexual and reproductive health.
- ❖ Testing and counselling are a critical part of HIV/STIs services but this has been an area of weakness. Under PRSIP I/PRSIP II, activities focused on strengthening the capacity of laboratories to do HIV/STI testing. It is critical that lab strengthening be continued and linked or integrated with efforts to control other diseases, such as TB.
- ❖ Effective planning, coordination and communication among partners prevents ad hoc programming and duplication of efforts and is greatly encouraged. Strong partnerships between government and civil society are especially important in ensuring that community needs are met.

C Guiding principles

The Shared Agenda is guided by the following principles:

- 1. Mutual ownership and commitment** – Stakeholders are committed to providing high-quality needs-based services and programmes, and are transparent in and accountable for their actions.
- 2. Promotion of well-being** – Stakeholders are committed to the promotion of positive psychological, social and physical sexual and reproduction health experiences and outcomes.
- 3. Evidence and rights-based policy** – Policies and practices are grounded in evidence and normative human rights agreement and their follow-up programmes of action, with the goal of achieving sexual and reproductive rights for all people living in the Pacific.
- 4. Promotion of equity, equality and respect for diversity** – All activities aim to ensure that appropriate services and programmes reach all people, especially under-served, vulnerable and marginalised populations, and promote gender equality and respect for diversity.
- 5. Multi-sectoral partnership and collaboration** – It is recognised that stakeholders possess different strengths; therefore, effective partnerships are encouraged and promoted to deliver the best possible outcomes utilising the knowledge and skills available. The populations the Shared Agenda aims to serve are key partners and are to be involved in decision-making, planning, policy and implementation.
- 6. Sustainability** – Work is performed in a manner that ensures sustainability, ownership and commitment to principles of aid effectiveness outlined in the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008), including the seven Pacific Aid Effectiveness Principles as adopted by the Pacific Islands Forum countries in 2007.



Male students at the Airahu Training Centre in Malaita, Solomon Islands engaged in group work on male reproductive anatomy during a training workshop on sexual health.

Overview and results framework

To improve sexual health and well-being in the Pacific, emphasis needs to be placed on the delivery of accessible, comprehensive and high-quality sexual and reproductive health services and programmes based on individual country needs. It is necessary for programmes to take a long-term view by aiming to remove conceptual, attitudinal, structural and other barriers that prevent good sexual health and well-being for all. Equity is to be achieved through increased focus on reaching key populations.

A comprehensive approach such as the one being put forward requires a shift in the way issues are addressed and a strong governance mechanism. The approach requires stronger partnerships among government departments, civil society organisations and networks, and local communities, and stronger partnerships between these agencies and organisations and the people they aim to serve, with regional development partners providing technical assistance and playing a capacity building role.

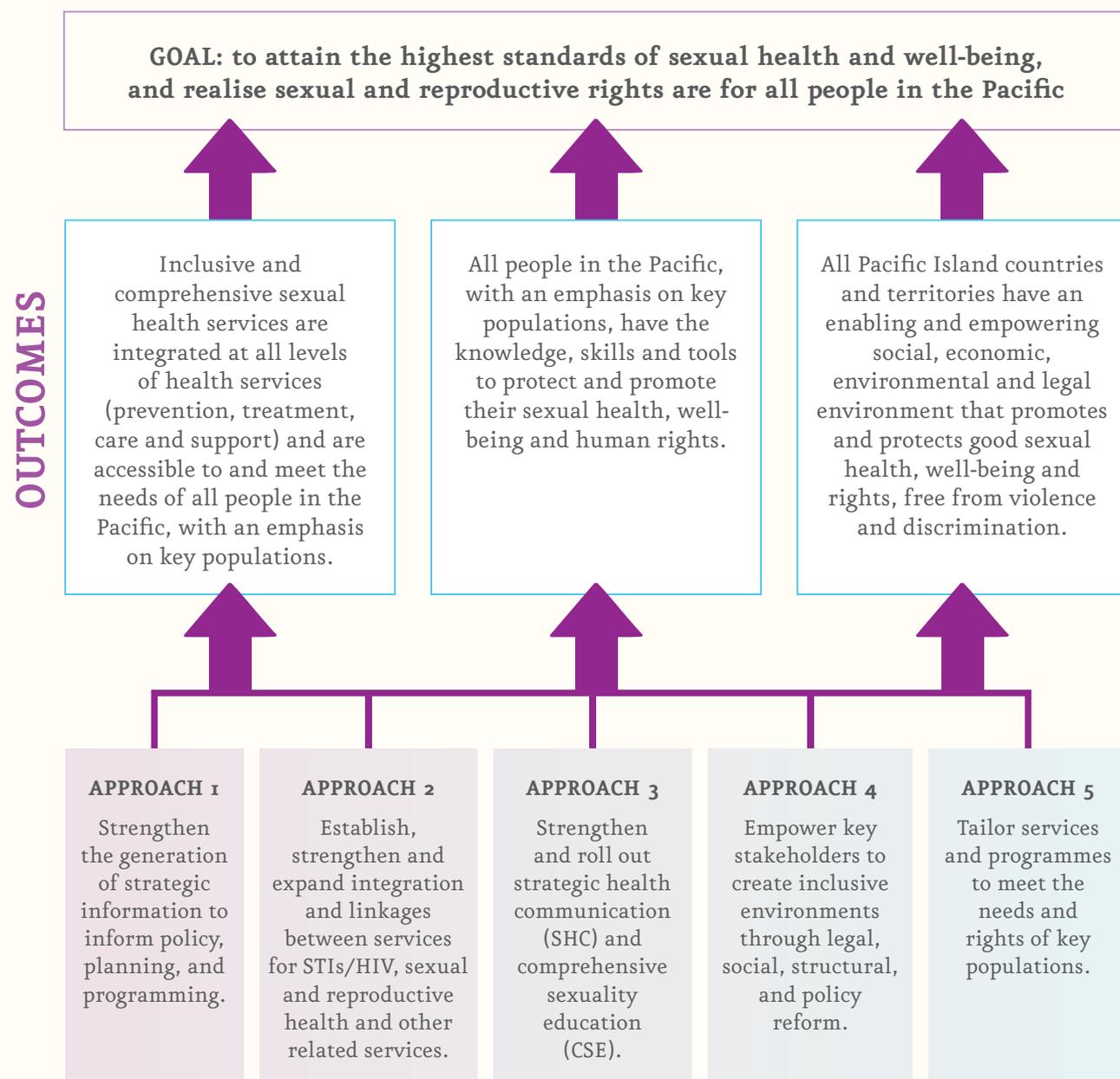
The Shared Agenda is a collective and collaborative initiative by governments, civil society organisations and their networks and development partners. Participants in the delivery of the Shared Agenda will be decision-makers in government, ; HIV/STI/Reproductive health/gender/youth programme managers and other coordinators;; civil society organisations; faith based and community based organisations, representatives of vulnerable and marginalized populations; the Pacific Islands Regional Multi-Country Coordinating Mechanism and national coordinating mechanisms; and development partners, including SPC, the UN family and donors.

The Shared Agenda is a collective and collaborative initiative by governments, civil society organisations and their networks and development partners.

The Shared Agenda serves as a visionary document, providing strategic direction for the region. The document is focused on long-term outcomes and agreed upon approaches, with the realisation that each PICT's context may be different. This provides the flexibility for national-level implementation plans that translate the Shared Agenda into action.

The results diagram on the following page illustrates the Shared Agenda's three key outcomes, which, if achieved, will contribute to the regional goal: *to attain the highest standards of sexual health and well-being, and realise sexual and reproductive rights are for all people in the Pacific*. Five key approaches are included in the diagram. By implementing these approaches, PICTs will work towards achieving the long-term outcomes and goal. Because the most appropriate and relevant methods of implementing each key approach will vary by PICT, specific activity, output, and short- and medium-term outcomes will need to be identified at the national level.

Sexual Health and Well-being Shared Agenda results diagram



GUIDING PRINCIPLES

- Mutual ownership and commitment
- Promotion of well-being
- Evidence-based and rights-based policy
- Promotion of equity, equality and respect for diversity
- Multi-sectoral partnership and collaboration
- Sustainability



Interactive group work during an outreach activity at a school in Raratonga, Cook Islands.

The goal and outcomes identified in the Shared Agenda are based on broad discussions held in the region. Impact- and outcome level indicators have been developed to monitor progress. The indicators chosen align with routine population surveys. Implementation is guided by five key approaches which are further explained, along with sample activities.

Implementation is guided by five key approaches

GOAL:

To attain the highest standards of sexual health and well-being, and realise sexual and reproductive rights for all people in the Pacific.

IMPACT INDICATORS:

- ❖ HIV prevalence rate amongst 15–24 years old/most at risk populations
- ❖ Syphilis rate among pregnant women
- ❖ Adolescent fertility rate (%)
- ❖ Proportion of ever-married or partnered women aged 15–49 who experienced physical or sexual violence by a male intimate partner in the past 12 months

LONG-TERM OUTCOMES:

1. Inclusive and comprehensive sexual health services are integrated at all levels of health services (prevention, treatment, care and support) and are accessible to and meet the needs of all people in the Pacific, with an emphasis on key populations.
2. All people in the Pacific, with an emphasis on key populations, have the knowledge, skills and tools to protect and promote their sexual health, well-being and human rights.
3. All Pacific Island countries and territories have an enabling and empowering social, economic, environmental and legal environment that promotes and protects good sexual health, well-being and rights, free from violence and discrimination.

The five key approaches described below are not in order of priority.

1 Strengthen the generation of strategic information to inform policy, planning, and programming

Knowledge and understanding of sexual health and well-being in the Pacific is essential for the delivery of cost-effective programmes and services and is aligned to the UNAIDS/WHO principle 'Know your epidemic'. Such knowledge includes a series of components that relate to knowing the impact of sexual health issues on the region, country and amongst communities, and the magnitude of the issues, such as the prevalence of HIV and other STIs, the rates of gender-based violence and number of unintended pregnancies, as well as knowledge on the determinants of health and what works best in a specific context. It is crucial to understand who is affected by poor sexual health and well-being and the reasons, root causes, risk factors and drivers, and the barriers preventing people from achieving good sexual health and well-being.. In order to gain this understanding, data should be, at a minimum, disaggregated by sex and age.

It is crucial to understand who is affected by poor sexual health and well-being

These data are collected in a number of ways, including routine surveillance, often recorded through clinic records, and active surveillance, such as through demographic and health surveys (DHSs), AIDS indicator cluster surveys, integrated biological behavioural surveillance (IBBS) and other research methods. In the Pacific, surveillance and research into sexual health has been largely 'stand alone' and not integrated into national health information systems. In-depth knowledge and understanding of sexual and reproductive health in the Pacific context is lacking. The current research gaps and limited understanding hinder interventions being grounded in local evidence. Where data does exist there a stronger focus on analysis and using the data is required.



A lab technician at Honiara's National referral Hospital in Solomon Islands prepares samples for HIV testing

Approach 1 aims to address these issues by strengthening the national monitoring systems through the integration of routine sexual health surveillance within existing national health information systems and building health information systems where necessary. It also emphasises strengthening data analysis, reporting and use. The approach proposes a greater focus on research and the use of existing research and data to enhance knowledge of the issues, risks and drivers associated with sexual health and well-being within the Pacific region. Special emphasis will be put on supporting operational research that provides information on efficiency and effectiveness of the activities being implemented. Recommended activities under this approach also include using data to advocate for increased awareness and resource allocation for sexual and reproductive health issues, as well as for policy-makers and implementers to develop evidence-based national sexual and reproductive health plans, policies and programmes. Further, data will be used to produce estimations and projections for planning purposes. Data will also be used to develop targeted, culturally appropriate social and behaviour change/strategic health communication interventions.



CASE STUDY 1: Behavioural surveillance survey amongst youth, Cook Islands



A trained youth surveyor administers a hand held galaxy tablet for collection and recording of SGS data.

The Cook Islands Ministry of Health, in collaboration with the Cook Islands Family Welfare Associations, SPC and WHO undertook a behavioural surveillance survey (BSS) in 2012 to assess the knowledge, attitudes and risk behaviours of youth related to sexual practices. Six peer educators from the Ministry of Health were trained in data collection and conducted the surveys, using hand held galaxy tablets. Tablets have been shown to reduce human error in data recording and improve confidentiality. The survey was conducted at places where young people are likely to be found, including sporting events, hostels and national celebrations. 674 young people (15–24 years) took part in the survey.

The results of the survey were used to inform development of the *Cook Islands Integrated National Strategic Plan for Sexual and Reproductive Health 2014–2018*; and to design interventions tailored to the needs of young people living in Cook Islands, including condom programming and comprehensive sexuality education in schools.

Lessons learnt

- ❖ Understanding key risk factors, behaviours and experiences of youth is crucial to delivering interventions that adequately address the needs of this often marginalised population.
- ❖ Using local youth as surveyors aided participants in translation of the questions; and being relatable to participants' ensured greater comfort and more honest answers.



Establish, strengthen and expand integration and linkages between services for STIs/HIV, sexual and reproductive health and other related services

Integration of sexual and reproductive health services, including HIV and other STIs, serves a number of purposes; most notably it increases the accessibility of services. In an integrated model of service delivery, a person is able access all services within one place within the same visit. Integrated services include antenatal care; STI and HIV prevention, testing, treatment, care and support; family planning and contraception distribution; counseling; sexual and gender-based violence services; men as partners programmes; and referrals to other specialised services. Some services are specialised, such as HIV treatment and psychosocial support, and it may not be feasible to include them within the same clinic. In these instances, linkages and referrals should be strengthened.



In an integrated model of service delivery, a person is able access all services within one place within the same visit.



A young person performing in a drama about sexual health and well-being. Connecting with NGO service providers allows greater reach and coverage of key populations.

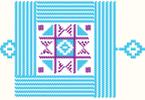
People living with HIV are around 30 times more likely to develop TB than those without HIV (WHO 2014). WHO recommends that TB and HIV plans and services be integrated to ensure coverage of TB testing and treatment for people living with HIV. TB services also provide an entry point for HIV testing, treatment, care and support. WHO recommends three collaborative TB/HIV activities: (i) establish and strengthen the mechanisms for delivering integrated TB and HIV services; (ii) reduce the burden of TB in people living with HIV and initiate early antiretroviral therapy; and (iii) reduce the burden of HIV in patients with presumptive and diagnosed TB (WHO 2012b). This approach is also

adopted in the Western Pacific TB Strategy, which identifies one of five key objectives of the strategy as ‘expanding TB/HIV collaborative activities’ (WHO 2011).

Civil society plays a key role in strategic health communication and service delivery. It is important that partnerships and linkages between civil society, including women’s crisis care centres, and the health system be maintained and strengthened where necessary to ensure appropriate and equitable service delivery, demand creation and uptake of integrated services.

There is no one size fits all approach to integration, and needs and feasibility will differ among PICTs. Before taking steps to integrate services, each country and territory should assess its current SRH services, identify where there are opportunities for integration and linkages, identify the resources required and the potential barriers, including in law, policy and practices. Engaging with the diverse members of the community in the process is also essential and strategies need to be identified to do so. A publication titled *Planning and implementing an essential package of sexual and reproductive health services*, by UNFPA and the Population Council (available at <http://www.unfpa.org/public/home/publications/pid/7287>), provides step by step guidance to developing such a package.





CASE STUDY 2: Integrating HIV and STIs into reproductive health services, Fiji



A nurse and pathologist at the Suva Hub clinic in Fiji. The clinic offers a wide range of sexual and reproductive health services and treatment, care and support for people living with HIV.

The Suva Hub Clinic, which focuses on HIV testing, treatment, care and support, has in past years taken steps to deliver a more comprehensive package of sexual and reproductive health services through the integration of services and strengthening linkages with nearby sister clinics and NGOs.

As well as providing HIV-related services, the Hub Clinic now provides testing and treatment for sexually transmitted infections and reproductive tract infections; family planning and contraceptive services; pap smears; infertility testing; and counselling on sexual and reproductive health. It also provides treatment for patients with TB/HIV co-infection. A person accessing the clinic is able to receive the majority of services in one sitting. Outreach programmes, including community and school visits, peer education and a radio slot to educate people about sexual and reproductive health are also delivered through the clinic.

Unable to provide *all* specialised SRH services required by clients, the Hub has established a strong referral system with the nearby Adolescent Health Clinic and Oxfam Women's Wellness Clinic. When a client requires psychosocial support, the clinic is assisted by the NGO, Empower Pacific. Through expansion, integration and linkages, the Hub now provides high quality services to its key population – people living with HIV – but also reaches other populations, including young people, sex workers and people of diverse sexual orientation and gender identity.

Lessons learnt

- ❖ When integrating and expanding services, build on existing strengths and resources.
- ❖ All staff in the clinic should be trained on all aspects of sexual and reproductive health and on ways to support key populations, such as youth, MSM and sex workers. This ensures that services can be delivered by the same health worker in the same sitting.



Strengthen and roll out strategic health communication (SHC) and comprehensive sexuality education (CSE).

Health promotion, demand creation and social and behaviour change are crucial to improving uptake of SRH services and commodities. Approach 3 focuses on taking steps to provide the information, skills and tools to empower individuals to take control of their sexual health and well-being, through provision of comprehensive sexuality education (CSE) in schools, outreach to remote areas, inter-personal communication and peer-to-peer programmes, and strategic health communication (SHC) campaigns.

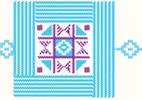
Awareness raising or providing people with information on SRH services is an important step, but will not achieve positive health behaviours by itself. To achieve meaningful behaviour and normative change, PICTs face the challenge of shifting health education and communication activities away from typically implemented but outdated communication modalities that sometimes contribute to awareness raising but seldom achieve sustained behaviour change. Achieving meaningful social and behaviour change requires research-based, tailored, culturally responsive and targeted strategic health communication interventions, characterised by utilising a wide mix of communication opportunities; increasing emphasis on formative audience research and audience participation; maximising indigenous ways of communicating; setting specific, measurable behavioural objectives; involving multiple stakeholders and multiple sectors; paying close attention to behaviour and social change theory; and concurrently addressing social and community norms and causes of vulnerability. Efforts should also be made to document good SHC practices and, through partnerships and leveraging of resources, support scaling them up.

Achieving meaningful social and behaviour change requires research-based, tailored, culturally responsive and targeted strategic health communication interventions

Young people rarely receive adequate preparation for their sexual and reproductive lives, which can leave them vulnerable to poor sexual health and well-being, including unintended pregnancy, abuse, violence and STIs, including HIV. Evidence has shown that age-appropriate, gender-sensitive and life skills-based CSE can provide young people with the knowledge and skills to make informed decisions about their sexuality and lifestyle (UNFPA 2013e). CSE currently exists to varying degrees throughout PICTs but should be strengthened and expanded under the Shared Agenda.



Young people use popular music and dance to encourage peer to say "No" to alcohol and drugs which contribute to risky sexual behaviour.



CASE STUDY 3: Innovative strategic health communication, Kiribati



Young people practice their drama on sexual health and well-being. In the Pacific, drama is a powerful tool for awareness raising and behaviour change.

The Kiribati Ministry of Health and Ministry of Internal and Social Affairs, in collaboration with the Kiribati Family Health Association (KFHA), the Kiribati Red Cross (KRC), the National Youth Council and SPC, undertook an innovative strategic health communication (SHC) campaign to increase STI testing and consistent condom use by young people in South Tarawa and Kiritimati Island.

Key strategies employed in the campaign included drama, street theatre, dance contests, road shows, social marketing, expanded clinic hours on Friday and Saturday nights and mass media. Trained in using drama to prompt behaviour change, youth volunteers from the KFHA and KRC performed dramas about condom use, STI testing, couples' communication and negotiation skills. The mix of education and entertainment (education) attracted over 1,000 young people to a two-day road show in Bairiki.

Ministry of Health nurses and laboratory personnel, together with NGO clinic staff, were present at the event, allowing young people to access HIV and STI testing on-site. Samples collected at the event were then screened at the laboratory and trained counsellors provided results to individuals on the evening of the final day. Incentives including branded string bags were used.

Lessons learnt

- ❖ A key aspect of SHC campaigns is the collaboration between the Ministry of Health and local NGOs. Some of the benefits include increased coverage of the target population, pooled resources and skills, and ensuring consistent key messages.
- ❖ All stakeholders, particularly the target audience, should be involved in the planning, design, implementation and monitoring of campaigns.
- ❖ Successful strategic health communication campaigns use a mix of strategies – media, marketing, point of service promotion and inter-personal communication.



Empower key stakeholders to create inclusive environments through legal, social, structural and policy reform.

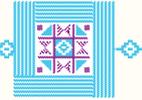
Legal, social and political structures influence people's vulnerability to sexual ill health and poor overall well-being. According to WHO, the 'social drivers' of poor sexual health and well-being include social exclusion and inequality, in particular gender inequality; poverty; and unequal access to education and health care. WHO further states that there are five domains that influence sexual health: 1) laws, policies and human rights; 2) education; 3) society and culture; 4) economics; and 5) health systems (WHO 2010a). The domains are interwoven throughout the five approaches of the Shared Agenda; however, it can be argued that they are of particular importance when looking at creating an enabling environment for positive sexual health and well-being.

There are currently barriers to the realisation of sexual and reproductive health and rights for all within PICTs' constitutions, legislation, policies and practices, such as anti-sodomy laws and laws that specifically impact and criminalise sex work, soliciting and same sex practices. Examples include a lack of laws on domestic violence and protection of the rights of women, men and children; and laws that criminalise and discriminate against LGBTQI people, people living with disabilities and people living with HIV. Approach 4 aims to build on the strengths of existing societal structures, address existing barriers and promote progressive social policies to create an enabling environment in which all people are empowered to live healthy and safe sexual lives. Interventions to achieve this aim include legislative and policy reform that promotes human rights approaches, inclusion, choice and protection for all. This includes the reform of laws that discriminate, based on HIV status, gender, sexual orientation and gender identity.

Approach 4 aims to build on the strengths of existing societal structures, address existing barriers and promote progressive social policies



Creating an enabling environment helps ensure that women, and men are able to realise their full sexual health and well-being.



CASE STUDY 4: The Family Protection Act 2013, Tonga



Ofa Guttenbeil Likiliki (right), Director of the Women's Crisis Centre and Lepolo Taunisila SPC country focal person in Tonga, played a vital role in development of the Family Protection Act.

The 'Changing Laws, Protecting Women' project of SPC Regional Rights Resource Team (RRRT) supported national efforts, including national committees on violence against women (VAW), to advocate for legislative reform to address violence against women.

With the ultimate goal of protecting families in Tonga, specifically women and children, key national players joined forces as partners in a campaign to advocate for a family protection bill. The partners received training, access to information on various lobbying strategies, and participated in sub-regional VAW consultations. The development of the bill was initially done by SPC RRRT, and then passed on to the Government of Tonga through the Attorney General's office and supported by the Ministry of Education, Women's Affairs and Culture – Women's Affairs Division, and SPC RRRT.

Through collaborative and concerted efforts between government and civil society, the Family Protection Act 2013 was passed by the Government of Tonga. The act promotes protection of all persons by criminalising domestic violence and providing a range of protection and safety orders.

Lessons learnt

- ❖ Partnerships and collaboration between government and civil society was extremely successful in garnering and sustaining support for the bill during its journey in parliament.
- ❖ Using national research and evidence to lobby for legislative reform is essential.
- ❖ Be prepared with key messages designed to reassure opposition and be aware and sensitive to cultural and religious concerns with the bill.



Tailor services and programmes to meet the needs and rights of key populations.

Some populations are more vulnerable to and/or practice behaviours more likely to lead to poor sexual health for themselves or others. In the context of the HIV response, these populations are often called ‘key populations’. Key populations are those that are vulnerable to poor sexual health, face high levels of violence and discrimination, are marginalised or under-served, or are otherwise most in need of access to sexual health services, knowledge and skills. Key populations can vary by context. Vulnerability is complex and is related to individual and group identities and expressions, social agency, bodily autonomy and integrity, behaviours and the environment (as discussed in Approach 4). People are not inherently vulnerable. They are made vulnerable. There are at least two dimensions that shape their comparatively poorer ability to achieve good sexual health. The first is increased risk to diseases including HIV and STIs. The second is reduced opportunity to achieve a high degree of sexual health. Both are shaped by the socio-economic environment, and distribution of power and resources.

Key populations are those that are vulnerable to poor sexual health, face high levels of violence and discrimination, are marginalised or under-served, or are otherwise most in need of access to sexual health services, knowledge and skills.

The second dimension is linked to the first, in that it is related to differences in access to and quality of prevention and care services. SRH services and programmes are usually tailored to the needs of a ‘view’ of a ‘general population’. This imagined idea of a general population can result in diverse, key populations not being able to access adequate services and being further marginalised. For example, women may be suffering intimate partner violence and not be able to leave their homes to access adequate SRH care and services, and young people may feel uncomfortable accessing SRH services in small island spaces, or be denied access to certain services altogether due to their young age. LGBTQI people may not enter general medical systems at all due to homophobia and stigma from health workers. Another example is migrant populations who may be unable to access SRH services due to cultural and language barriers.

Some populations that are often identified as ‘key populations’ are: migrant populations; commercial and transactional sex workers, LGBTQI, people living with disabilities, people living in remote areas, seafarers and other mobile men with money, young people and children, and women. However, key populations differ between countries and further understanding of key populations is necessary in order to deliver equitable sexual health services and programmes.

Approach 5 aims to increase the reach of services and programmes to meet the needs of key populations through tailored interventions. Approach 5 also aims to reduce the differences in exposure to sexual health risks between marginalised sub-populations and the general population, as well as reducing the disparities in sexual health outcomes. Examples include sensitisation and capacity development of health workers to better address the needs of specific and under-served populations, designing prevention, care and support interventions that work for key populations, targeting structural inequalities and providing opportunities and resources for better healthcare and well-being.

Inclusion of representatives from key populations in research, programme design, planning, implementation and evaluation is imperative to ensure positive enabling conditions, and

appropriate service delivery and programming that promote the sexual and reproductive health and rights of all. For example, improving young people's sexual and reproductive health and their involvement in doing so is a key component of the Pacific Youth Development Framework 2014–2023 (PYDF).



APPROACH 5: Addressing the sexual health needs of men who have sex with men and transgender, regional



Tonga Leitis members pose with New Zealand AIDS Foundation Program Coordinator. New Zealand AIDS Foundation builds capacity of MSM and transgender networks in Samoa and Tonga.

The Pacific has a number of regional and national non-government organisations and networks that address the sexual health needs and rights of men who have sex with men (MSM) and the transgender community through innovative and holistic initiatives. The Pacific Sexual Diversity Network (PSDN) is a regional network of such organisations with members in Samoa, Tonga, Vanuatu, Cook Islands, Fiji and Papua New Guinea. National organisations include Wan Smolbag in Vanuatu, HomoSphere in New Caledonia, Tonga Leitis Association, MenFiji and the New Zealand AIDS Foundation.

The organisations work in a variety of ways to promote sexual health and wellbeing and address discrimination based on HIV status, sexual orientation and gender identity. For example, Wan Smolbag theatre is the producer of the popular television series *Love Patrol*, which tackles issues such as sexual health, corruption, religion and gender equality. Wan Smolbag peer educators also provide information on sexual health, distribute condoms, and encourage MSM to visit the Wan Smolbag reproductive health clinic. Similarly the Tonga Leitis Association conducts outreach, advocates for condom use and provides social support of Leitis. The organisation also encourages Leitis to stay in school and provides scholarships for study.

Lessons learnt

- ❖ The participation of vulnerable populations such as MSM in designing, implementing and evaluating interventions is key to delivering effective and appropriate interventions and services to the intended populations.
- ❖ Partnership between governments and non-government organisations is crucial in supporting the needs and rights of people of diverse sexual orientation and gender identity.



Monitoring, evaluation and learning

Stakeholders are committed to improving sexual health and well-being through enhancing results in the areas of planning, monitoring, evaluation, learning and reporting. This commitment focuses on learning for improved outcomes as well as accountability of all stakeholders.

All data will be collected and collated at the national level. National-level data will then be reported at the regional level through existing mechanisms, where they shall be further compiled and analysed to identify trends and issues across the region. Monitoring of the Shared Agenda shall be supported by the regional oversight body. Monitoring of the Shared Agenda is based on a set of selected indicators (see table 3). These indicators align to Millennium Development Goals (MDGs), International Conference on Population Development (ICPD) indicators and Global Aids Response Progress Reporting (GARPR) indicators. The following mechanisms are to be established to measure success towards achieving the Shared Agenda:

- ❖ monitoring and evaluation framework for high-level indicators (See table 3);
- ❖ National implementation plans and monitoring and evaluation frameworks with output, outcome and impact level indicators which are linked to the Shared Agenda outcome and impact indicators in table 3.
- ❖ National annual progress reports
- ❖ mid-term and end-of-term reviews of the Shared Agenda.

It is also recognised that attribution is difficult to assess, as the link between outputs and outcomes and impacts is not a simple linear cause-and-effect relationship. Internal and external factors influence relationships, including political, economic, socio-cultural and environmental factors, and actions of national governments and other development partners. For ease of reporting, only a few high-level indicators have been adopted to monitor progress towards achieving the key outcomes and goal of the Shared Agenda. The quality of monitoring and evaluation and activities will have major implications on the successful roll out of the Shared Agenda.



Luke Nayasa, an HIV advocate with his family at home in Fiji. People living with HIV are key role-players in creating an enabling legal environment that prevents stigma and discrimination.

Impact and Outcome Indicators

REF	IMPACT INDICATORS	DEFINITION	DATA SOURCE	RESP.	LEAD SUPPORT	FREQUENCY
Goal: to attain the highest standards of sexual health and well-being, and realise sexual and reproductive rights are for all people in the Pacific						
IM1	HIV prevalence rate amongst people 15–24 years old/most at risk populations	Indication of sexual behaviour, sexual activity amongst young people and most at risk populations. Indication of status of HIV epidemic amongst young people and most at risk populations. Number of existing active cases of HIV among youth population aged 15–24 years / total population aged 15–24 years x 100	Population-based surveys (DHS/family health surveys)	PICTs	SPC/UNFPA	5 years
IM2	Syphilis rate among pregnant women	Indication of positivity rate of syphilis among pregnant women attending ANC care during pregnancy. The number of ANC who tested positive for syphilis/ number of ANC who are tested.	Population based surveys	PICTs	WHO	5 years
IM3	Adolescent fertility rate (%)	The adolescent birth rate measures the annual number of births to women 15 to 19 years of age per 1,000 women in that age group. It represents the risk of childbearing among adolescent women 15 to 19 years of age. It is also referred to as the age-specific fertility rate for women aged 15–19.	Vital registration/survey (population)	PICTs	SPC/UNFPA	5 years
IM4	Proportion of ever-married or partnered women aged 15–49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Numerator: Women aged 15–49 who currently have or ever had an intimate partner, who report experiencing physical or sexual violence by at least one of these partners in the past 12 months / total women surveyed aged 15–49 Denominator: Total women surveyed aged 15–49 who currently have or had an intimate partner	Population-based surveys (DHS/family health surveys/violence against women studies)	PICTs	UNFPA/ UNWOMEN	5 years

OUTCOME 1: Inclusive and comprehensive sexual health services are integrated at all levels of health services (prevention, treatment, care and support) and are accessible to and meet the needs of all people in the Pacific, with an emphasis on key populations

REF	OUTCOME INDICATOR	DEFINITION	DATA SOURCE	RESP.	LEAD SUPPORT	FREQUENCY
OC1.1	Testing (HIV and other STIs) amongst most at-risk populations	Percentage of most at risk populations tested for HIV and STIs that know their results within the last 12 months	Population-based surveys (DHS/family health surveys)	PICTS	SPC/UNAIDS	3–5 years
OC1.2	Percentage of ante-natal clinic (ANC) attendees positive for STIs who received treatment	Number of ANC attendees with positive STIs who receive appropriate treatment in the last month	Vital statistics	PICTs	WHO	3–5 years
OC1.3	Unmet need for contraception	Women with unmet needs are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child	Population-based surveys (DHS/family health surveys)	PICTS	SPC/UNFPA	3–5 years
OC1.4	Proportion of service delivery points offering an essential package of sexual and reproductive health services	Essential package of sexual and reproductive health services as defined by national policy	Services availability readiness assessment (SARA)	PICTS	SPC/UNFPA	3–5 years





Young people in Chuuk, FSM promote consistent condom use to their friends and peers.

OUTCOME 2: All people in the Pacific, with an emphasis on key populations, have the knowledge, skills, and tools to protect and promote their sexual health, well-being, and rights

REF	OUTCOME INDICATOR	DEFINITION	DATA SOURCE	RESP.	LEAD SUPPORT	FREQUENCY
OC2.1	Percentage of populations at higher risk who correctly identify ways of preventing the sexual transmission of HIV and other STIs and who also reject major misconceptions about HIV transmission	<p>Numerator: Number of respondents aged 15–24 years who gave the correct answer to all five questions</p> <p>Denominator: Number of all respondents aged 15–24</p> <p>Disaggregated by key populations</p>	Population-based surveys (DHS/family health surveys/IBBS/KAP)	PICTs	SPC/UNAIDS	3–5 years
OC2.2	Condom use at last sex among people with multiple sexual partnerships	The percentage of young men and women aged 15–24 reporting the use of a condom during sexual intercourse with a non-cohabiting, non-marital sexual partner in the last 12 months	Population-based surveys (DHS/family health surveys/IBBS/KAP)	PICTs	SPC/UNAIDS	3–5 years
OC2.3	Proportion of young people utilising youth friendly Health Services	Outcome indicator for level of health-seeking behaviour and demand for services, such as: HIV test, STI test, pregnancy test, condom supply. Number of young people aged 15–24 years attending youth clinics / total population aged 15–24 years x 100	Population-based surveys (DHS/family health surveys/IBBS/KAP)	PICTs	SPC/UNFPA	3–5 years

OUTCOME 3: All Pacific Island countries and territories have an enabling and empowering social and legal environment that promotes and protects good sexual health, well-being and rights, free from discrimination

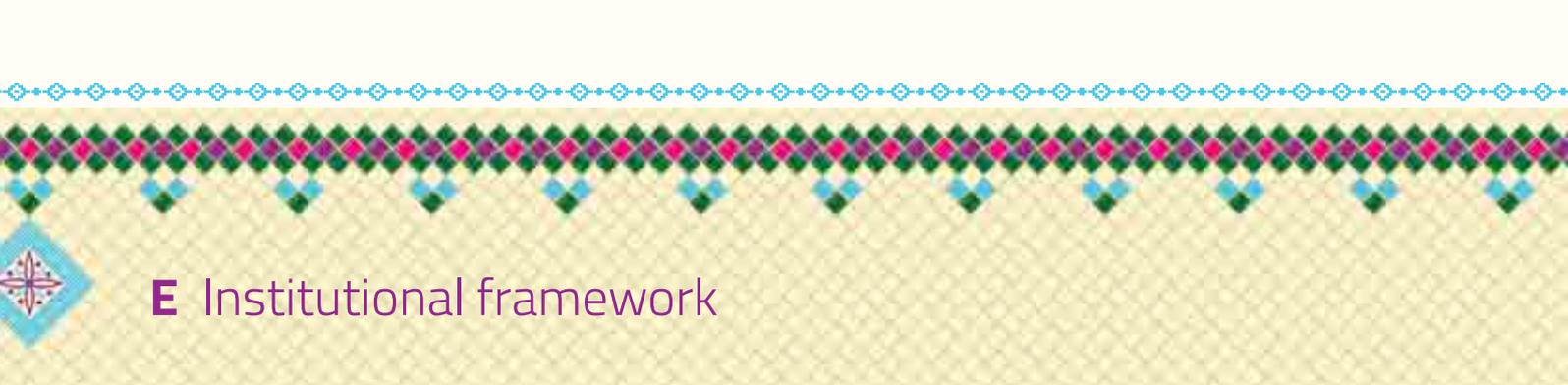
REF	OUTCOME INDICATOR	DEFINITION	DATA SOURCE	RESP.	LEAD SUPPORT	FREQUENCY
OC3.1	Country progress towards human rights compliance (CEDAW, CRC, UPR, CRPD)	Review of the extent to which international human rights obligations are incorporated into national laws and policies relevant to sexual and reproductive health	National data	PICTs	/RRRT/ OHCHR /UNWOMEN	3-5 years
OC3.2	Percentage of women and men aged 15-49 expressing accepting attitudes towards people living with HIV	<p>Numerator: Number of women and men aged 15-49 who report accepting attitudes towards people living with HIV</p> <p>Denominator: All respondents aged 15-49 who have heard of HIV</p>	Population-based surveys (DHS/family health surveys/ IBBS/KAP)	PICTs	SPC/UNAIDS	3-5 years
OC3.3	Approval/disapproval of intimate partner violence (public opinion on sexual violence)	<p>Numerator: Number of women and men aged 15-49 who approve/disapprove (on a psychometric scale) any degree of intimate partner violence.</p> <p>Denominator: All respondents aged 15-49 yrs</p>	Population-based surveys	PICTs	UNFPA/ UNWOMEN	3-5 years



Factors for success

There are a number of factors that will determine the success of the Shared Agenda:

- ❖ The Shared Agenda provides a guide for national planning and is expected to be integrated into national health plans based on the country context and needs. By doing so the Shared Agenda avoids the pitfalls of the 'one size fits all approach'. Many PICTs have completed national HIV/STI strategic plans, and it is proposed that these be expanded to incorporate the scope of the Shared Agenda. These plans offer a key entry point for advancing HIV and SRH linkages and integration (FPI 2010).
- ❖ Resource mobilisation strategies will focus on both traditional and potential new donors beyond the scope of the HIV funding, accessing funding under HIV, sexual and reproductive health, gender and related issues.
- ❖ As a result of the two HIV-focused regional strategies over the past ten years and funding modalities, there are strong HIV and STI committees and coordinating mechanisms at both the regional and national level. At the regional level these include the AIDS Team and the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM). PICTs have national AIDS councils or country coordinating mechanisms. At both the regional and national level, such committees are tasked with overseeing and monitoring the implementation of the Shared Agenda.
- ❖ The Shared Agenda is aligned with global commitments and regional strategies, frameworks and documents to avoid duplication and enhance coordination of activities. While the Shared Agenda indicators are standardised (already being collected as part of DHS or other surveys), it is recognised that these surveys are not undertaken on a regular basis in all PICTs. Countries are required to strengthen monitoring and evaluation and surveillance. Support will continue to be provided by regional partners to do so.
- ❖ There are a number of risks that threaten the implementation of the Shared Agenda. They include economic, political, social and environmental instability. Financial resources have greatly declined, which jeopardises implementation of the Shared Agenda. It is necessary for governments, CSOs, development partners and donors to develop funding plans to implement the Shared Agenda. Risk assessments and risk management strategies at the national and regional levels are recommended to mitigate foreseeable risks.
- ❖ Finally, it is anticipated that, through the implementation of the Sexual Health and Well-Being Shared Agenda 2015 - 2019, PICTs will be better positioned to realise a comprehensive and fully integrated vision and strategy for sexual and reproductive health and rights beyond the expiration of the Shared Agenda.



E Institutional framework

Governance, coordination and partnerships



'Partnership between government, CSOs and regional partners is crucial to improve sexual health and well being in the region... CSOs have the feel of what is happening on the ground and know exactly what the experiences of the people at the grass roots level are and have the key to open some of the bottlenecks' (CSO Consultation 2013).

The Shared Agenda Governance and Oversight Mechanism as set out in Figure 7, was endorsed by 22 PICTs Ministers of Health on July 10th 2014. The Shared Agenda is governed by the Directors of Health who meet on an annual basis. The purpose of the Governance body is to monitor progress, promote political will and make key strategic decisions. A Shared Agenda regional oversight body is to be appointed by the Governance Body, who shall undertake a more active role in the provision and coordination of technical assistance and monitoring of the Shared Agenda. The oversight body shall consist of representatives from governments, regional development agencies, donors, and civil society and key populations. The oversight body will report the progress of the Shared Agenda annually to the Governing Body.

Key tasks of the Oversight Body include;

- ❖ coordinate the provision of technical assistance to PICTs and the roll-out of regional public goods under the five key approaches;
- ❖ monitor the progress of the Shared Agenda, based on the results framework and indicators;
- ❖ report annually to the governing body on the progress of the Shared Agenda;
- ❖ liaise with the governing body on key high level decisions to be made;
- ❖ liaise and provide technical support to the national bodies whose role is to coordinate and oversee implementation and monitoring of the Shared Agenda within PICTs;
- ❖ maintain and strengthen regional and national partnerships and collaborative efforts to achieve the outcomes and goal of the Shared Agenda;
- ❖ mobilise resources and oversight of donor reporting at the regional level;
- ❖ knowledge management and networking, particularly the facilitation of south to south sharing of experiences.

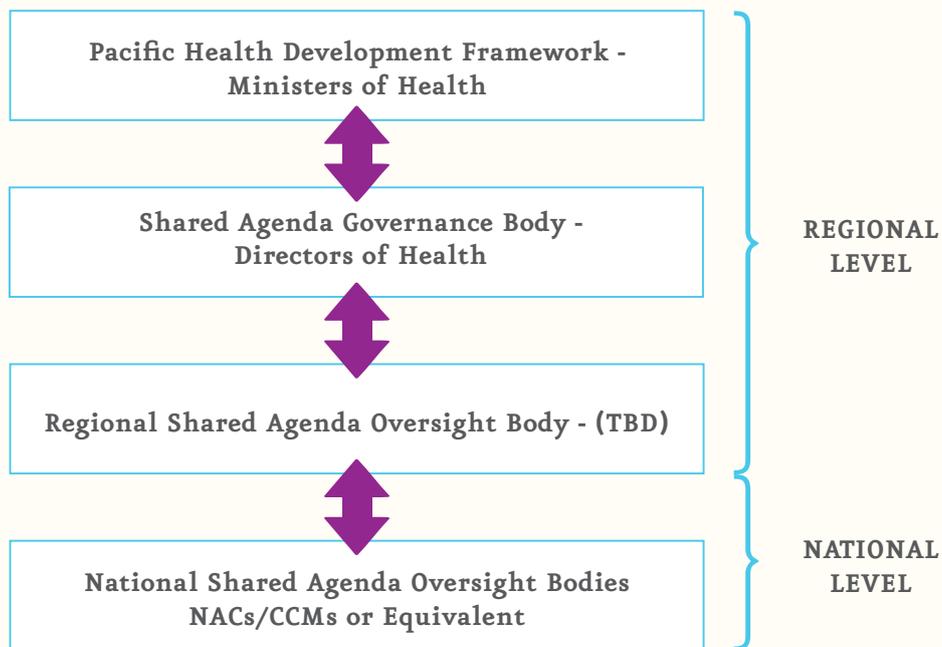


Figure 7: Shared Agenda governance and oversight mechanism

Maximising the benefits of the Shared Agenda requires energetic partnerships of various sectors to reach populations, advocate for key and marginalised populations, build on existing systems, develop effective policies and create a supportive and enabling environment. Partnerships ensure a range of expertise, avoid duplication of efforts and maximise the use of available resources. To establish relationships it is necessary to map capacity and clearly define roles, invest in collaborative approaches, share information, and strengthen communication and coordination efforts. Transparency of efforts is necessary to ensure trust and effective collaboration. Strong, durable partnerships are essential for successful implementation of the Shared Agenda.



A clinic in Port Vila, Vanuatu collects and analyses monthly clinic data to monitor service uptake to ensure services reach all those who need them.

Implementation of the Shared Agenda

Governments and CSOs, with assistance from technical/development partners, are responsible for the implementation of the Shared Agenda at the national level. Costed national implementation plans should be developed or activities integrated into existing plans tailored to the five key approaches.

It is recommended that existing national coordinating mechanisms, such as national AIDS councils or committees and country coordinating mechanisms, coordinate and oversee the implementation of the Shared Agenda in country and will be linked to the regional oversight body. It is important that the national coordinating mechanisms be multi-sectoral, and that strong partnerships among stakeholders working in HIV/STI, reproductive health, maternal and child health, social welfare, adolescent health, women's health, youth etc. be formed to facilitate integration and linkages of programmes and services.

Regional development partners play a crucial role in the implementation of the Shared Agenda through the provision of technical and financial support to PICTs and capacity building in the region. Regional development partners are also tasked with the delivery of regional public goods, such as surveillance; development of regional policies, guidelines and tools; and regional-level procurement. A regional development partners division of labour has been developed (see Annex 2) and regional organisations should align their work plans to the five key approaches of the Shared Agenda.

Regional development partners play a crucial role in the implementation of the Shared Agenda through the provision of technical and financial support to PICTs and capacity building in the region.



Nurses in Tarawa, Kiribati. Sexual and reproductive health service delivery is enhanced when nurses are approachable and non-judgemental. Training nurses is a central component of delivering quality sexual health and well-being services.

Resourcing the Shared Agenda

In the past there has been substantial funding for HIV and other STIs, which has allowed for a focused response. As priorities shift within the region, however, funding is less available for sexual and reproductive health. PICTs are expected to take greater ownership of the response in a number of ways, including greater absorption of costs. The institutionalisation of programmes and absorption of budgets into national government will ensure sustainability of activities. However, donors are still expected to play a critical role in sexual and reproductive health activities in the region, with governments facing competing priorities in health financing. It is anticipated that bilateral funding shall play a greater role than it has done in the past.

The institutionalisation of programmes and absorption of budgets into national government will ensure sustainability of activities.

Financing will have multiple sources:

- ❖ national budgets,
- ❖ bilateral and multilaterals (donors, UN agencies, etc.),
- ❖ global entities (Global Fund, etc.),
- ❖ issue or constituency-specific funds (women, LGBTQI, people with disabilities, etc.), and
- ❖ public–private partnerships.



Young people in Kiritimati developing messages to encourage their peer to use condoms every time, every round.

Annex 1 | Sexual reproductive health and rights

Sexual reproductive health and rights (SRHR)

The Shared Agenda is entrenched in a human rights approach based on the rights set out in the *Universal Declaration of Human Rights* and on the most relevant sexual and reproductive health rights. In 1999 the World Association for Sexual Health developed the *Universal Declaration of Sexual Rights*, which includes 11 rights.



1. The right to sexual freedom
2. The right to sexual autonomy, sexual integrity, and safety of the sexual body
3. The right to sexual privacy
4. The right to sexual equity
5. The right to sexual pleasure
6. The right to emotional sexual expression
7. The right to sexually associate freely
8. The right to make free and responsible reproductive choices
9. The right to sexual information based upon scientific inquiry
10. The right to comprehensive sexuality education
11. The right to sexual health care

The rights formed the basis for the Yogyakarta Principles in 2007, a set of 29 principles to guide the application of international human rights law in relation to sexual orientation and identity.

WHO defines reproductive rights as follows:

'Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.'

Tonga Leitis Association (TLA) member shares a cultural performance at the TLA planning retreat. TLA advocates for the rights of MSM, transgender, gay and bisexual people in Tonga.

Annex 2 | Regional development partners division of labour¹

AGENCY	APPROACH 1: USE RESEARCH AND EVIDENCE	APPROACH 2: INTEGRATE AND LINK SERVICES	APPROACH 3: PROMOTE HEALTHY BEHAVIOURS	APPROACH 4: CREATE ENABLING ENVIRONMENTS	APPROACH 5: REACH KEY POPULATIONS
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SPC provides technical and scientific expertise through the delivery of regional public goods and the provision of technical assistance and capacity building to its 22 PICTs members.

The Public Health Division supports PICTs to build capacity in active and passive surveillance, operational research, and monitoring and evaluation in sexual and reproductive health, particularly HIV and STIs, and to utilise data to develop evidenced-based plans and policies.	The Public Health Division supports guidelines, strategic frameworks, plans and policy development for integrating and/or linking STIs/HIV into broader SRH services and programmes within the country-specific health care delivery system. The division also focuses on capacity building in STI/HIV diagnosis treatment, care and support and laboratory strengthening.	The Public Health Division has developed regional strategic health tools and mechanisms, and provides technical assistance and capacity building through sustainable regional strategic health communication accredited courses for nurses, social workers and risk reduction counsellors and through in-country capacity building initiatives to increase awareness of high local rates of STIs and promote both preventive and health care seeking behaviours.	The Education, Training and Human Development Division, through the Human Development Programme and the Regional Rights Resource Team, provides technical assistance and capacity building for lawyers, magistrates, civil society and key government service providers in addressing SRHR and gender-based violence. Technical assistance is provided in drafting laws to update current legislation in line with CEDAW and other human rights standards to address VAW and improve access to SRHR.	The Education, Training and Human Development Division, through the Human Development Programme, supports PICTs to ensure an inclusive approach to the design and delivery of services with special emphasis on women, their partners and people with disabilities.
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¹ Excludes partners located in Papua New Guinea

AGENCY	APPROACH 1: USE RESEARCH AND EVIDENCE	APPROACH 2: INTEGRATE AND LINK SERVICES	APPROACH 3: PROMOTE HEALTHY BEHAVIOURS	APPROACH 4: CREATE ENABLING ENVIRONMENTS	APPROACH 5: REACH KEY POPULATIONS
SPC (cont)	<p>The Education, Training and Human Development Division is positioned to provide high quality technical assistance regarding the inclusion of socio-cultural dimensions in research initiatives, with a focus on culture and traditional knowledge, youth and gender equality; it can provide technical assistance and advice to improve the relevance and quality of indicators.</p> <p>The Statistics for Development Division monitors Millennium Development Goal indicators.</p>	<p>The Education, Training and Human Development Division through the Human Development Programme works with youth, women and cultural groups to promote healthy behaviours.</p> <p>The Strategic Engagement Planning and Policy Facility supports country assessment of need with regard to young people, which includes country mapping and coordination of technical assistance, and engagement of young people in development of initiatives.</p>	<p>Capacity building also takes place in mainstreaming gender across programmes and services of governments.</p> <p>The Strategic Engagement Policy and Planning Facility, through the PYDF, supports development of national coordination mechanisms that will work to facilitate shared decision-making between governments and youth to develop participatory initiatives and policies, under the PYDF, including for SRHR, mental health and NCDs.</p>	<p>The Strategic Engagement Policy and Planning Facility provides guidance/technical assistance on linking to and engaging youth networks and key populations of youth (as identified in the PYDF) through regional and national youth structures.</p>	<p>The Strategic Engagement Policy and Planning Facility provides guidance/technical assistance on linking to and engaging youth networks and key populations of youth (as identified in the PYDF) through regional and national youth structures.</p>
WHO	<p>Provision of technical assistance to PICTs in developing/enhancing passive and active surveillance protocols; development of surveillance plans; conduct of epidemiologic</p>	<p>Provision of technical assistance to PICTs to develop service delivery models on the prevention, treatment, care and support continuum, and maximising</p>	<p>Convening policy dialogues and development of policy briefs related to SRH (STI, HIV, MCH, gender) and health systems.</p>	<p>Provision of technical assistance to PICTs to develop tailored responses to STI and HIV prevention, treatment, care and support, based on current country</p>	

analysis, situation and response analysis, and adaptation of regional policies and guidelines; generating annual reports; and translating strategic information into advocacy briefs related to SRH (STI, HIV, MCH, gender) and health systems.

cross-programme collaboration; enhancing existing ones; convening policy dialogues and development of policy briefs related to SRH (STI, HIV, MCH, gender) and health systems.

context (specifically for key populations at higher risk, asymptomatic women with STI, and male clients and male partners of ANC); developing advocacy briefs on strengthening tailored-responses for key populations at higher risk, asymptomatic women with STI, and male clients and male partners of ANC)

UNFPA

Support PICTs to conduct census ,population surveys (e.g. RH survey and DHS) and reproductive health commodities surveys, including forecasting, procurement, warehouse, and supply chain management.
Support PICTs to integrate SRH into health information systems.

Support PICTs to integrate HIV into SRH and develop SRH, family planning, gender-based violence and youth friendly health services and programmes.
Provide and distribute condoms to PICTs.

Support PICTs to develop and build capacity in CSE policy and curriculum development. Build capacity of teachers and peer educators in CSE.

Develop strategies to reach young people, sex workers, men who have sex with men and transgenders with SRH services and programmes.
Provide assistance in the health sector response to gender-based violence.
Support PICTs in prevention of adolescent pregnancy.

AGENCY	APPROACH 1: USE RESEARCH AND EVIDENCE	APPROACH 2: INTEGRATE AND LINK SERVICES	APPROACH 3: PROMOTE HEALTHY BEHAVIOURS	APPROACH 4: CREATE ENABLING ENVIRONMENTS	APPROACH 5: REACH KEY POPULATIONS
UNICEF	<p>In collaboration with other regional partners, support focus countries to have updated HIV surveillance data by conducting relevant studies (SGSS, IBBS, studies in young people). Provide relevant training to national partners to interpret strategic information to strengthen HIV programmes. Support countries with the development of national annual work plans to strengthen HIV response.</p> <p>In collaboration with other regional partners, provide support to organisations of high risk groups to update HIV surveillance data (MSM, SW).</p>	<p>Scale up integrated PPTCT services in focus countries and link with broader maternal and child health services. Scale up integrated youth-friendly health services. Capacity building training for CSO partners to strengthen provision of HIV testing and counselling services.</p>	<p>Introduce integrated communication for development initiatives which increase vulnerable populations' (women, children and youth) access and utilisation of SRH and HIV services. Capacity building training to faith-based organisations in focus countries to implement HIV awareness programmes. Lead the integration of CSE in focus countries.</p>	<p>Update PPTCT policy guidelines and youth-friendly health services guidelines in focus countries. Engage CSO partners in the development of PPTCT and YFHS-related policies and guidelines and their dissemination.</p>	<p>Strengthen peer education programmes in focus countries. Introduce life-skills programmes for young key affected populations in focus countries. In collaboration with other regional partners, provide support to organisations of high risk groups to design HIV prevention programmes.</p>



UNDP	<p>Social operational research on specific areas of social determinants of sexual health (especially links to poverty, social exclusion, discrimination and governance/ human rights). Develop capacity with CSOs to undertake social and human rights operational research and utilise findings for policy dialogue, advocacy and programming.</p>	<p>Mainstream attention to HIV and health into action on gender equality, poverty reduction and the broader efforts to achieve and sustain the MDGs/SDGs (including the understanding the social and economic factors that play a crucial role in impacting health, and promoting specific action on the needs and rights of women, girls and key populations).</p>	<p>Promote attention to the role of legal environments in facilitating stronger HIV responses. Support the use of flexibilities in intellectual property and human rights law to lower the cost of AIDS treatment and diagnostics. Promote/support CSO participation in policy dialogue around legal environments and stigma and discrimination reduction.</p>	<p>Support national and local AIDS authorities to strengthen governance, coordination and accountability of HIV responses. Develop capacity with key populations and CSOs for organisational M&E, resource mobilisation, accountability mechanisms and human rights.</p>
UNAIDS	<p>Support generation of strategic information related to HIV for informed national planning through Global AIDS response progress report and provide technical support to generate strategic information on key affected populations.</p>	<p>Support the scale up of HIV testing programmes.</p>	<p>Provide technical assistance to PICTs to address legal and social barriers to accessing HIV-related services, with a focus on key affected populations and people living with HIV. Support and facilitate regional consultation platforms.</p>	<p>Support resource mobilisation plans for sustainable ART treatment. Support youth networks and communities to implement prevention leadership programmes to address stigma and discrimination. Promote approaches through CSOs and KAPs to address ART adherence.</p>

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UNWOMEN	Technical support for data collection, sharing and analysis on violence against women (VAW) response			Provide technical assistance to PICTs on harmonised human rights treaty reporting. Support CEDAW implementation and reporting. Provide support to improve availability of multi-sectoral VAW services. Strengthen capacity of multi-sectoral VAW service providers to provide survivor focused support to women and girls.	Increase awareness of women and girls of availability of multi-sectoral VAW services.
ILO	Support studies on productivity and Sexual Health and wellbeing at work.	Reinforcing linkages in work places using Occupational Safety and Health (OSH), Corporate Social Responsibility and Employee Wellness and Welfare policy interventions	Using health and safety wellness programmes, including HIV in workplaces (SOLVE methodology) to promote healthy and safe workplaces	Provide technical assistance to selected workplaces to address SH and wellbeing, stigma and discrimination. Support social dialogue with tripartite+ partners on relevant sexual health and wellbeing in workplaces including stigma & discrimination issues.	Using the established ILO tripartite partners relations, working men and women are reached to address SH and wellbeing, stigma and discrimination at the workplace.



UNESCO	Through research such as attitudinal surveys UNESCO works to support CSE tailored to the target audience and appropriate to the socio-cultural context. Research is also used to identify appropriate and effective supportive educational material for teachers facilitating CSE in schools.	UNESCO works to support linkages between SRHR health and education in schools.	UNESCO works with partners to strengthen CSE in primary and secondary schools and ensure these programmes are taught and sustained.	UNESCO supports governments to develop policies which ensure a supportive school and work environment in the education sector in the areas of stigma, discrimination and homophobic bullying	UNESCO supports children and youth through assisting countries to deliver comprehensive sexuality education.
CDC	<p>Integrated funding opportunity announcement (FOA) developed to complement and assist stakeholders to:</p> <ul style="list-style-type: none"> ❖ increase access to care and opportunities to diagnose, treat and prevent disease in people with multiple related risks; ❖ enhance prevention and control of HIV, viral hepatitis, STDs and TB; ❖ build capacity for laboratory services, human resources, and organisational development; ❖ improve surveillance for HIV, viral hepatitis, STDs and TB with community and international partners; ❖ expand and streamline standardised monitoring and evaluation of HIV, viral hepatitis, STDs and TB programmes and reduce duplicate inconsistent data systems within the six USAPIs; and ❖ reduce health disparities and increase overall health among residents of the six USAPIs. <p>- Also working to link specific STD screening (e.g. CT testing) in reproductive health services including family planning.</p>				

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CDC (cont)	<p>Provide technical assistance and guidance to six USAPIs' surveillance systems.</p> <p>Support laboratory capacity for local use of inexpensive and sustainable STI NAATs tests through identification and training of local laboratory staff; development of guidance, training plans, standard operating procedures and proficiency testing; and maintenance plans.</p>	<p>Support six jurisdictions on improving clinical/ programmatic best practices on:</p> <ol style="list-style-type: none"> (1) elimination of congenital syphilis; (2) chlamydia screening in young women using low cost, locally available NAATs; (3) STD case management; (4) partner notification and prevention services; and (5) awareness and recognition of antimicrobial resistant <i>Neisseria gonorrhoeae</i> in settings with limited lab capacity. 	<p>Support six USAPIs to develop and maintain healthy school climates that support all students, and promote the prevention of sexual behaviours that contribute to STD/HIV/ unintended pregnancy. Promote quality of life, health development and healthy behaviours.</p>		<p>Focus on populations with STI/HIV risk: sex workers, clients of sex workers, MSM, mobile populations and persons vulnerable to adverse outcomes caused by STI (adolescents and pregnant women). Use targeted interventions (e.g. outreach to schools; targeted screening in ANC and family planning clinics) with consistent messages and targeted testing and service provision.</p>



IFRC	<p>IFRC conducts community assessments to inform programming and feed into national planning. IFRC distributes and monitors distribution of condoms.</p>	<p>IFRC conducts blood donation collection and blood analysis. IFRC conducts community-based programmes that integrate HIV/STI prevention into a wide range of health issues, e.g. dual benefit of condoms, first aid, water and hygiene, NCDs and vector control.</p>	<p>Conduct strategic health communication in community programmes with Red Cross national societies in 12 Pacific countries. Empower youth to be agents of change through peer education.</p>	<p>Social empowerment of HIV positive people through income-generating activities</p>	<p>Community volunteers extend the reach of health services by taking condoms and information to places and populations that do not access the formal health sector. e.g. in and out of school youth, some people living with HIV, people frequenting hotels and night clubs.</p>
IPPF	<p>Provide technical support to CSOs, including family health associations, in planning SRHR Programmes.</p>	<p>Provide training of nurses on integration of HIV/AIDS with SRH. Provide training of young people on SRHR and establish SRHR integrated clinics.</p>	<p>Assist CSOs to formulate MOUs with government. Provide technical assistance for community-based distributors' training. . .</p>	<p>Provide technical support to CSOs to ensure that clients' right are fully understood by service providers and clients themselves. Provide SRHR services to key populations with informed choices of contraceptives (including outer island clients).</p>	

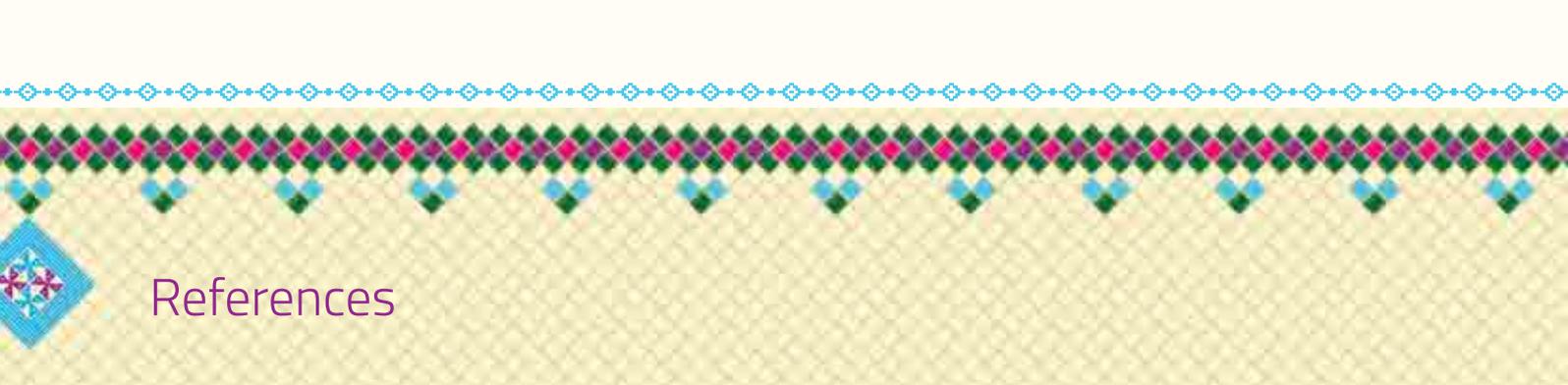
AGENCY	APPROACH 1: USE RESEARCH AND EVIDENCE	APPROACH 2: INTEGRATE AND LINK SERVICES	APPROACH 3: PROMOTE HEALTHY BEHAVIOURS	APPROACH 4: CREATE ENABLING ENVIRONMENTS	APPROACH 5: REACH KEY POPULATIONS
OSSHMHM	Support PICTs to develop evidence-based HIV policies. In conjunction with CSO partners, foster a culture and mechanism of reporting to the appropriate national systems and develop a system of using information to guide CSO activities.	Build clinical capacity in HIV and STI diagnostics, treatment, care and support.		Support governments and CSOs by providing technical assistance in legal, social and structural policies and/or legislation that is consistent with international standards and best practice.	In collaboration with government programme managers, clinical service providers, CSOs and development partners, establish standards of care for key populations that are consistent with best practice. Build the capacity of health workers to ensure provision of good quality services to key populations.



Evidence-based condom social marketing programs can increase consistent condom use to prevent unwanted pregnancy in Cook Islands condoms are branded with messages and images that will resonate with young people.

Development partner support by PICTs Annex 3

PICTs	SPC	WHO	UNFPA	UNICEF	UNDP	UNAIDS	UN WOMEN	ILO	UNESCO	CDC	IFRC	IPPF	OSSHMM
A. Samoa	●	●								●			
Cook Is.	●	●	●		●		●				●	●	●
FSM	●	●	●		●	●	●			●	●		●
Fiji	●	●	●	●	●	●	●	●			●	●	●
F.Polynesia	●	●											
Guam	●	●								●			
Kiribati	●	●	●	●	●	●	●	●	●		●	●	●
RMI	●	●	●		●	●	●	●	●		●		●
Nauru	●	●	●		●		●		●				
N.Caledonia	●	●											
Niue	●	●	●		●		●		●				●
CNMI	●	●								●			
Palau	●	●	●		●	●	●	●	●	●	●		●
PNG	●		●		●		●	●			●		
Pitcairn	●												
Samoa	●	●	●	●	●	●	●	●	●		●	●	●
Solomon.Is	●	●	●	●	●	●	●	●	●		●	●	●
Tokelau	●	●	●		●		●						
Tonga	●	●	●		●	●	●				●	●	●
Tuvalu	●	●	●		●	●	●	●			●	●	●
Vanuatu	●	●	●	●	●	●	●	●	●		●	●	●
Wallis and Futuna	●												



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