No	Data extraction fields/Authors	Title
1	Brewis et al 1998	Structure of family planning in Samoa
2	Burslem et al (SPC) 1998	Naked wire and naked truths: reproductive health risks faced by teenage girls in Honiara
3	Cammock et al 2018	Awareness and use of family planning methods among iTaukei women in Fiji and New Zealand

4	Daube et al 2016	Barriers to contraceptive use in South Tarawa, Kiribati
5	Davis et al 2016	Male Involvment in reproducitve, maternal and child health: a qualitative study of policy maker and practioner perspectives in the Pacific
6	Hayes and Robertson, 2012	Family planning in the Pacific Islands: Current status and prospects for repositioning family planning on the development agenda

7	House and Ibrahim 1999	Ferility patterns of Adolescent and older women in Pacific Island Countries: Programming Implications
8	House and Katoanga 1999	Reproductive and family planning in the Pacific Island countries
9	Kennedy et al 2011	Adolescent fertility and family planning in East Asia and the Pacific: a review of DHS report

10	Kennedy et al 2013a	The case for investing in family planning in the Pacific: costs and benefits of reducing unmet need for contraception in Vanuatu and the Solomon islands
11	Kennedy et al 2013b	"Be kind to young people so they feel at home": a qualitative study of adolescents and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu

12	Kennedy et al 2014	These issues aren't talked about at home": a qualitative study of the sexual and reproductive health information preferences of adolescents in Vanuatu

13 Kenyon & Power 2003 Family planning in the Pacific Regions: Getting the basics right

14 Kiribati, DHS 2019 Kiribati Demographic and Health Survey 2009 Final Report

15	Kura et al 2013	Male involvement in sexual and reproductive health in the Mendi Distrcit, Southern Highlands province of Papua New Guinea: a descriptive study

16	Lee 1995	Reproductive Health and Family Planning in the Pacific - Current Situation and the Way Forward
17	Lincoln et al 2018	Knowledge, Attitudes and Practices of Family Planning among women of reproductive age in Suva, Fiji in 2017
18	Marshall 2017	A snapshot of services'. Access, standardisation, education: Ministry of Health community clinics, South Tarawa, Kiribati

19	Marshall Islands DHS 2007	Republic of the Marshall Islands Demographic and Health Survey 2007
20	Mody et al 2013	The World Health Organisation-United Nations Population Furnd Strategic Partnership Program's implementation of family planning guidelines and tools in Asia-Pacific countries.
21	Morisause et al 2017	Identifying barriers to accessing family planning contraceptives amongh women aged 15-49 years in Maprik District, East Sepik Province, Papua New Guinea
22	Naidu et al 2017	Knowledge, attitudes, practice and barriers regarding safe sex and contraceptive use in rural women in Fiji

23	Nauru, DHS 2007	Republic of Nauru Demographic and Health Survey 2007
24	Papua New Guinea 2016-18	Papua New Guinea Demographic and Health Survey 2016-2018 Key Indicators Report

25	Raman et al 2015	Identifying and overcoming barriers to adolescent sexual and reproductive health in the Solomon Islands: perspectives and practices of health, education and welfare workers

26	Robertson 2007	Current status of Sexual and Reproductive Health: Prospects for Achieving the Program of Action of the International Conference on Population and Development and the Millenium Development Goals in the Pacific
27	Roberts 2007	Evaluation of men as partners in reproductive health through organised workforce for the United Nations Population Fund - UNFPA)

28 Rowling D; Hartly D; Owen J & Strachan 1994, Family planning: personal and political perspectives from Choisuel Province

29 Samoa DHS 2014 Samoa Demographic and Health Survey 2014

30 Solomon Islands DHS 2015 Solomon Islands Demographic and Health Survey 2015 final Report

31	Tonga DHS 2012	Kingdom of Tonga Demographic and Health Survey, 2012
32	Tuvalu DHS 2007	Tuvalu Demographic and Health Survey 2007
33	UNFPA 2004	ICPD +10 Progress in the Pacific
34	UNFPA 2009	ICPD AT 15 Achievements, challenges and priorities in the Pacific Islands

35 UNFPA 2014a Pacific Regional ICPD Review, Review of the implementation of the International Conference on Population and Development Programme of Action Beyond 2014

36 UNFPA 2014b Summary of updated population and development profiles

37 UNFPA 2015a Kiribati Sexual and Reproductive Health Rights Needs Assessments

38 UNFPA 2015b Samoa Sexual and Reproductive Health Rights Needs Assessments

39 UNFPA 2015c Solomon Islands Sexual and Reproductive Health Rights Needs Assessments

40	UNFPA 2015d	Kingdom of Tonga Sexual and Reproductive Health Rights Needs Assessments

41 UNFPA 2015e Vanuatu Sexual and Reproductive Health Rights Needs Assessments

42 UNFPA 2019 The State of Pacific's Reproductive, Maternal, Newborn, Child and Adolescent Health Workforce

43 Vanuatu, DHS 2013 Vanuatu Demographic and Health Survey 2013

44 White et al 2018 Contraceptive knowledge, attitudes and use among adolescent mothers in the Cook Islands

45 Zaman et al 2012 Family Planning in Asia and the Pacific: Addressing the Challenges

Year of publication	Country of origin	Aims/Purpose	Study population and sample size (if applicable)
1998	Samoa	Assess family planning acceptance	155 women 15-49 years
1998	Solomon Islands	To investigate the underlying cause of high rates of teenage pregnancies & STI and propose ways in which the MHMS could address the problem.	Key informants - 49 people, 18 FGDs with 122 participants of teenage girls, young women, mothers and teachers of the school. In-depth interviews with 24 participants including teenagers attending antenatal clinics, college students (pregnant of single mothers), mothers of teenagers, casino workers, girls with other jobs, and early school leavers. A self-administered questionaire given to 266 students (153 boys, 113 girls) completed during class time.
2017	Fiji	To identify family planning patterns in different socioeconomic and cultural contexts and explores whether family planning disparities observed among minority groups in developed countries apply to iTaukei Fijians in New Zealand	Women (n=212) 15-49 years

2016	Kiribati	To investigate knowledge and use of family planning and identify barriers to contraceptive uptake for men and women, to inform future approaches aimed at increasing access to family planning	Women and men (n=500) 15-49 years
2016	Cook Islands, Solmon Islands, Fiji, Vanuatu, Papua New Guinea	Explores the attitudes and beliefs of maternal and child health policy makers and practioners regarding benefits, challenges, risks and approaches to increasing men's involvement in maternal and child health education and clinical services in the Pacific	Senior Maternal Child Health policy makers and practioners (n=17)
2012	Pacific Island Countries	To gain support from the governements and civil societies to prioritise FP programs and increase investments in FP in order to achieve the MDGs and espeically Universal access to Reproductive Health	Not provided

1999	Pacific Island countries	To investigate whether adolescent birth rates are high and rising over time in PICs as is widely believed	Not provided
1999	Pacific Island Countries	To develop national self-reliance in the population field	Not provided
2011	Marshall Is, Nauru, PNG, Samoa, Solomon Islands, Tuvalu,	DHS review: to identify accessible information about adolescent fertility, current use, knowledge and access to FP information and services	Not provided

2013	Vanuatu and Solomon Islands	To examine health, demographic and economic consequences of reducing unmet need for family planning in Vanuatu and Solomon Islands.	Uses demographic modelling
2013	Vanuatu	To explore the barriers preventing adolescents from accessing Sexual Reproductive Health services (SRH) and the feature of youth friendly health service as defined by adolescents	Qualitative study - 66 FGDs conducted on 341 male and female adolescents (15-19 years). 12 semi-structured interviews with policy makers and service providers (thematically analysed.

2014	Vanuatu	To explore the barriers, enablers and SRH information and service delivery preferences of adolescents in Vanuatu	Qualitative study - 66 FGDs conducted on 341 male and female adolescents 915-19 years). 12 semi-structured interviews with policy makers and service providers (thematically analysed.

2003	Pacific Islands Region	To provide an overview of family planning in the Pacific and identify key issues	Not provided
2019	Kiribati	Presents summaries of the findings of the 2009 Kiribati Demographic and Health Survey implemented by the Kiribati National Statistics Office	Women (n=1,978) 15-49 years and men (n=1,135) 15-54 years

2013	Papua New Guinea	to explore and assess the knowledge, attitude and role of men from Mendi district in regards to antenatal care, supervised birth, family planning and prevention of HIV/AIDS/STI and to assess the service providers capacity to involve men in its programes	Married men between aged 15-44, residing in their household with their wife/wives. Sample size: 122 aged 21-44 years, a mean of 36 years

1995	UNFPA Pacific Island Countries (Cook Islands, FSM, Fiji, Kiribati, Marshall Is, Nauru, Niue, Palau,, PNG, Solomon islands, Tokelau, Tonga, Tuvalu, Vanuatu, Western Samoa)	To assess the current RH/FP situation within the above ICPD RH/FP components for the fifteen Pacific islands countries to which UNFPA provides assistance.	Not provided
2018	Fiji	To identify the level of knowledge, attitudes and practices of family planning among women of reproductive age in Suva, Fiji in 2017	Women (n=325) 15-49 years
2017	Kiribati	To determine strengths and gaps of sexual reproductive health services across 14 community clinics in South Tarawa, Kiribati	Community clinics and staff (n=14)

2007	Marshall Islands	To provide key estimates of the demographic and health of the country	Women (n=1,626) 15-49 years and men (n-1,055) 15-54 years
2013	Asia-Pacific countries	To assess the impact of strategic partnership programes - a collaboration between the WHOo & UNFPA to improve evidenced-based guidance for country programs through the introduction of seleted practice guidelines to improve sexual and reproductive health.	
2017	Papua New Guinea	To determine the contraceptive prevalence and barriers to contraceptive use in the Maprik District of East Sepik Province in Papua New Guinea	Women (n=193) 15-49 years
2017	Fiji	To explore the knowledge, attitudes, practice and barriers regarding safe sex and contraceptive use in rural women in Fiji	Rural women (n=1490) 18-75 years

2007	Nauru	To provide up to date information for policy-makers, planners, researchers and program managers, for use in planning, implementing, monitoring and evaluating population and health programs within the country	Women (n=667) and men(n=653) 15-49 years
2018	Papua New Guinea	To obtain and provide information on basic indicators of social progress including fertility, childhood mortality, and reproductive and child health. Report on the up to date and reliable information on key health and demographic health topics	Households with women and men (n=19,200) 15-49 years

2015	Solomon Islands	To identify barriers to ASRH (Adolescent sexual reproductive health)service provison in Solomon Islands and explore opportunities to effectively address them	A mixed methods study - FGDs, semi-structured interviews,snapshot survey of 147 teachers, prinicpals, teachers, youth and health workers

2007	Pacific Island countries (American Samoa, Cook Islands, Micronesia - FSM, Fiji, Kiribati, Mashal Is, Nauru, Samoa, Solomon Is, Tonga, Tuvalu, Vanuatu)	To reposition family planning as an integral develoment strategy for poverty reduction and as a mechanism for achieving fundamental reproductive rights to be acknowledged at the highest political level.	Not provided
2007	Fiji and Solomon Islands	To assess the design, efficiency and effectiveness of the Men as partners project in Fiji and Solomon Islands	Male workers: Solomon Islands (n=16); Fiji (n=21)

1994	Solomon Islands	To collect data regarding FP knowledge, attitudes and practices among married men & women of reproductive age in Choiseul province	Women 15-19 years (n=150) Male (15-54 years (n=90)
2014	Samoa	To provide up to date information for policy makers, planners, researchers and program managers, for use in planning, implementing, monitoring and evaluating population health programs within the country	Women (n=4,805) 15-49 years; men (n= 1,669) 15-54 years
2015	Solomon islands	To provide up to date data on fertility and child mortality, family planning, maternal health	Women (n=6,226) 15-49 years; men (n=3591) 15 years and above

2012	Tonga	To provide up to date information for policy-makers, planners, researchers and program managers, for use in planning, implementing, monitoring and evaluating population and health programs within the country	Women (n=3,068) and men (n=1,336) 15-49 years
2007	Tuvalu	To provide up to date information for policy-makers, planners, researchers and program managers, for use in planning, implementing, monitoring and evaluating population and health programs within the country	Women(n=850) and men (n=428) 15-49 years
2004	13 Pacific Island Countries	Report of the official outcomes of the ten-year review of the International Conference of Population and Development (ICPD) reported by thirteen Pacific Island Countries	Not provided
2009	Pacific Island Countries	Report of achievements, challenges and priorities in the Pacific at 15 years following ICPD	Not provided

2014	Pacific Island Countries	Assess the progress in the Pacific at 20 years after ICPD	Not provided
2014	15 PICs (PNG, Fiji, Solomon Islands, Vanuatu, Samoa, Kiribati, Tonga, FSM, Marshall Islands, Palau, Cook Islands, Tuvalu, Nauru, Niue, Tokelau)	Provides a summary of updated population and development profiles of 15 Pacific Island Countries	Not provided
2015	Kiribati	To determine the existence and use of relevant SRH indicators, policies & laws to assess Kiribati's commitment to a Rights based approach to SRH and delivery across	Health facilities (n=16); senior Ministry of Health officers, medical assistants and non-government officers (n=6)

2015	Samoa	To determine the existence and use of relevant SRH indicators, polocies & laws to assess Samoa's commitment to a Rights based approach to SRH and delivery across	Health facilities (n=11); government and non-government health service providers, managers and technical advisors (6)
2015	Solomon Islands	To determine the existence and use of relevant SRH indicators, polocies & laws to assess Solomon Is commitment to a Rights based approach to SRH and delivery across	Health sector officer (1); non-government officers (n=6)

2015	Tonga	To determine the existence and use of relevant SRH indicators, polocies & laws to assess Tonga's commitment to a Rights based approach to SRH and delivery across	Health facilities (n=14); Ministry of Health officers (n=11); non-government organisation officers (n=4)

2015	Vanuatu	To determine the existence and use of relevant SRH indicators, polocies & laws to assess Vanuatu's commitment to a Rights based approach to SRH and delivery across	Ministry of Health service providers/managers (n=25); non-government organisaiton officers (n=5); development partners (n-4)
2019	Pacific Island Countries	To provide an evidence base to support policy dialogue at national and regional levels to assist countries in the region to meet the challenges of the sustainable development goals relating to reproductive, maternal, newborn, child and adolescent health (RMNCAH)	Not provided
2013	Vanuatu	To provide up to date information for policy makers, planners, researchers and program managers, for use in planning, implementing, monitoring and evaluating population health programs within the country	Women (n=2,508) and men (n=1,333) 15-49 years

2018	Cook Islands	To provide insight into how sexual and reproductive health care and education could be improved in order to reduce the incidence of unplanned pregnancy among young women in the region	Women (n=10) who were mothers before aged 20 years old
2012	Asia-Pacific countries	Report on the Regional consultation on FP in Asia and the Pacific in Bankok 8-10 Dec 2010	Not provided

Research methods	Area of intervention (clinical, policy, educational)	Concept (a plan or intention)
Qualtitative		
Multiple methods (6 methods) mix of quant and qual approach - review of existing data, Key informants, focus group discussion, participant observations and self-administered questionaire. Rapid assessment/needs assessments/situation al assessment		1. To provide a model of how to collect information relevant to sexual health education and prevention programs that can be replicated in other countries, 2. To summarise the key findings and implications from the study conducted in Honiara over 3 months in early 1997
Cross-sectional study		

Mixed methods	
Qualtitative	
Report	to address the challenges of FP in the pacific

Discussion paper	adolescent fertility rates have declined but unmet needs of older women (above35 yrs) have increased so will need to be considered in future RH/FP programes
Discussion paper	
Review	Adolescent fertility and access to family planning information and service

Intervention research

Qualitative study

qualitative study	Health information preferences of adolescents in Vanuatu

Discussion paper	to give an overview of FP in the pacific and get the basics right
Report (Mixed methods)	

Mixed methods/descriptive study	Assess knowledge and attitudes regards to family planning and service providers capacity to involve men

Discussion paper	This is an initial assessment done to help address whether existing indicators are adequate to address key issues of RH/FP and to monitor progress, identify data gaps and to prioritise RH indicators
Qualitative cross-sectional study	
Report (Mixed methods)	

Report (Mixed Methods)

Program description

Assess the impact of strategic partnership programs to improve evidenced-based guidance for country programs on sexual and reproductive health

Mixed methods

Qualitative cross-sectional study

Report (Mixed methods)

Report (Mixed methods)

A mixed methods
study

Discussion paper	Current Status of Sexual and Reproductive Health including FP in the Pacific to see how they perform towards achieving the ICPD PoA and the MDGs
Program description	To contribute towards RH status of the population in Fiji and the Solomon Islands through the provision of adequate RH information, counseling and services in line with the principles adopted at the ICDP

Mixed methods	Family planning behaviour and contraceptive use in Solomon Islands (knowledge, attitudes and prevalence)
Report (Mixed methods)	
Mixed methods	

Report (Mixed methods)

Report (Mixed methods)

Report

Report

Report

Report from Data collected from population census and demographic health surveys.

Report (Mixed methods)

Report (Mixed methods)

Report (Mixed methods)

Report (Mixed methods)	A comprehensive SRH care package has three key prinicipal components: family planning, sexual health and maternal health

Report (Mixed methods)

Report

Report (Mixed methods)

Qualitative	
Report	To gain support from the govenments and civil societies to prioritise FP programs and increase investiments in FP in order to achieve the MDGs and especially access to reproductive health

Duration of intervention (if applicable)	How outcomes are measured
NA	

NA	NA

NA

NA

2015 MGD target CPR is 55% (Tonga CPR is 28.4%). Burden of diabetes and cardiovascular disease are high and contributing factors include: aging population, increasing urbanisation, and westernised diets

Key findings that relate to the key questions (1. How have FP services been implemented in PICTs in 1994-2019? 2. What are the successes and challengegs in providing FP services in PICTs?)

Awareness and use of contraception have markedly increase in both rural and urban areas
Availability and accessibility to contraceptives reportedly high.
Contraceptives made accessible and affordable for rural and urban woman by government.
Younger women desired larger families.
FP needs further investigation to be clearly understood.

Approach to RH/FP - FP is not available to unmarried regardless of age. Main contraceptive for teenagers is condom. Majority of girls do not attempt to access the routine FP services in Honiara.
Challenges: Pervasive beliefs among service providers and girls/teens (parents, boyfriends, teenage girls share misconceptions. Shameful to buy condoms from shops/phamacies. Majority of students who have had sex (54% girls and 44% boys) had never used a condom. access to contraceptives including condoms almost non-existent**Facilitating environment**: A girl can access FP services if she had a friend in a clinic, minority of teen say they could get condoms if they knew a sympathetic health worker.

Family planning service not culturally sensitive. Cost of service and language are main barriers. Need culturally relevant services

Unsuitable service delivery. Barriers include not interested in family planning, knowledge gaps, personal reasons, family and social obligations

FP services not focused on men/men are not involved.
Perceived challenges – socio-cultural norms, physical layout of clinic, health workers attitudes and work loads.
To engage boys and men early in the life cycle.

Recent analysis of countries in Asia and the pacific offers strong evidence that meeting the need for FP can accelerate the achievement of the MDGs. Investing in FP alone can contribute to reducing costs of achieiving MDG targets for educaiton, child mortality, maternal mortality and environmental sustainabililty.

Adolescent fertility in the PICs is declining, though still high in the world. Unmet for family planning in the 35 to 49 years women raises the need for fP services for this group. **FP approach** - No special attention and priority to older women's reproductive health needs this has been overshadowed by concern of with adolescent RH needs. **Challenges**: higher fertility among women over age 35 yrs in many PICs with large number (1 in 2) unmet need for FP to limit further childbearing. Common causes of unmet need include: inconvenient and unsatisfactory services, ignorance and lack of information about their fecund state and the need to use reliable contraception and what services are available. Fear of side effects, lack of long term methods for couples who completed their family formation,opposition from husbands and other members of extended families. lack of access, high cost and fatalism. **Facilitating environment**: Identify the nature & characteristics of unmet need can help FP program to better respond to demands of women> SUCCESSES: RAISING REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS. 2. DECLINING FERTILITY RATES OF ADOLESCENTS IN 3 DECADES, BUT STILL HIGH BY WORLD STANDARDS

Before Cairo conference MCH/FP centred on the pregnant mother and her child.
FP targets married women. In practice MCH/FP implemented separately from other SRH components (STI/HIV).
Challenges: raising awareness, identifying priorities for adolescents SRH needs and integrating services into more holistic and comprehensive approach.
Success: reproductive health training program was established in Fiji.

Approach to FP -Married and unmarried adolescencents have less access to RH/FP services. They have lower use and higher unment needs for contraception, poorer knowledge of FP less access to information and services than older women. It cannot be assumed that adolescents will automatically benefit from policies and programs that are aimed at the general population.Challenges inlcude: financial barriers, poor geographical access, lack of knowledge of services, concerns about availability of health workers and commodities, not wanting to go alone when no female provider are particularly noted by adolescents compared to older women.

Increasing investiment in family planning cound contribute to improved maternal and infant outcomes and substantial public savings and lower dependency ratio

Majority of SRH services provided by government facilities, small number of youth oriented facilities by NGOs. BARRIERS: Low utilisation of mainstream services by adolescents significant barriers to improving SRH (a challenge). BARRIERS DEMAND SIDE: socio-cultural norms and taboos regarding sex and adolescent sexual behaviour (stigma and shame, fear of disclosure, fear of being seen attending services, opposition and disapproval from parents and communities, community or religious 'rules' that inhibit discussion of sex or access to services). Uncertainity of what they will be asked by a service provider and or anxiety about physical examination, lack of knowledge about SRH and services, lack of experience attending health services. SUPPLY SIDE BARRIERS: Judgmental attitudes of health service providers, cost of services and commodities, lack of privacy and confidentiality, lack of services/skilled service providers, inconvenient location of services, insufficient time for counseling, unreliable commodity supply. FEATURES-YOUTH FRIENDLY H/SERVICE: 1. Friendly health service providers, 2.reliable commodity supply, 3.no cost, 4.confidentiality, 5.male and female providers available, 6.convenient opening hours, 7. things to do in the waiting room, 8. privacy, 9. standalone youth clinic. MAJOR REASON FOR NOT USING FP BY ADOLESCENTS: Inadequate knowledge about condoms and contraception. Lack of knowledge about what they would be asked or what would happen at the clinic and not knoweling how to talk with nurses were also reasons for not accessing services. A lack of experience attending a health service contributed to anxiety, as did misinformation or discouragement from friends. Adolescents needed to be better informed about SRH

SRH - information targeting adolescents are mainly on STI's n HIV, it lacks prevention of pregnancy, use of condom to prevent pregnancy not only prevention of STI, puberty, sexuality and relationships. CHALLENGES: Providing relevant information that's adolescence need, not because of donor's priority. ENABLING ENVIRONMENT: Utilise peer educators and health workers as considered knowledgable and trustworthy by adolescence, parentss not common source but preferred, schools important venues but under utlised. Provide broad range of sources of information eg multiple channels to reach in and out-of-school youths and respond to individual needs and contexts. BARRIERS TO ACCESSING HEALTH SERVICES: mains socio-cultural norms n taboos, financial costs, poor geographical access to clinics, concerns about confidentiality and judgemental attitudes of health workers - inhibited adolescents' access to facility-based SRH information. In schools sometimes attitudes of teachers, parents and communities presents key challenges though curriculum-based sexuality education were initiated and presented. for nurses lack of training and judgemental attitudes are barriers. for teachers they have judgemental attitudes and lack of knowledge about SRH, fail to provide accurate and comprehensive information.

Traditionally many Pacific health centre operate a once a week session which is likely to be inconvenient for many clients.
CHALLENGES: No privacy in clinics, confidentiality easily breached in small villages and clinics, Geographical locations, health workers attitudes, Fear of repercussions from parents by nurses/health workers if found offering FP to young people. population policies not updated (for 15 PICs funded by UNFPA, 3 have official policies, 8 have policies in development, 4 have chosen to incorporate population issues into their development and sectoral plans. there have been a number of sound population policies in the Pacific eg PNG Nationa Health Plan (2001-2010) stating couples have.....
Implementation of population policies far from smooth, policies are either too cumbersome for effective coordinating structure or others have proved ineffective because they lack detail and a coordinating structure. Chee in countries like PNG and marshall islands, population developed in the 1980s lacked detail in the actual budgeting of the policy and in accounting for himan resources. Some policies also emphasise approaches to FP that have been shown to be ineffective. example (Margret chung 1992 argues that many pacific population policies ain at recruiting new acceptors rather than reducing the drop-out rate. This is because service providers define the main problem with low FP use to be the 'traditional' nature of their clients rather than the quality of service delivery. Funding an ongoing barrier

Contraceptive prevalence rate – 22% (married women), 16.5% (all women).
Government/public sector strategically important in providing service through health facilities. Few use private sectors. Others source contraceptives from relatives overseas. Service offered for free.
Challenges in contraceptive use include the desire for many children and religious prohibition.

SERVICE ISSUES: Family planning clinic services are usually female oriented/women targeted services and men feel embarrased accessing these services. Men were never targeted on awareness/education on safe motherhood initiatives. Services to men were limited to condom distribution for FP and HIV prevention. only few men access themCHALLENGES/SUCCESSES: For the one clinic reported involving men in the service and contraceptive uptake at this centre was good, even to the extent of men collecting pills for their wives. health workers work closely with men educating them on the importance of FP. This created interest and motivated husbands to support their wives. Health workers at other health facilites lacked the capacity to work with men. They suggested the need for further training on counselling, gender issues and interpersonal communications. CHALLENGES: Illiteracy, inadequate knowledge, cultural factors, lack of appropriate services were found to negatively influenced make participation in SRH. Although men had heard about FP, only a small proportion of participants and their wives use contraceptives. Many were unaware of the importance and benefits of family planning. Factors such as wanting more children and fear of religious condemnation and partnes having extra marital relationships hindered couples from accessing contracepttives. Misunderstanding of the dual functions of condom for pregnancy prevention and as a means of disease prevention. Fear of sterility. Need for couple centred FP & RH programs. Services for men inadequate, condoms distributed by female health workers.

FP service approach - many PICs adopt the primary healthcare approach which RH/FP are an integral part. MCH programs are still very much part within the conventional MCH/FP framework and focuses on pregnancy care and contraception and employs the pregnancy outcome ast the main indicator of women's health. MCH services somtimes confined to married women only. Is narrowly focused, does not address special needs of specific age groups as teenagers, women over 40s n 50s. conventional MCH/FP programs pay little attention to related areas as reproductive tract infections, STIs, abortion and infertility. usually separate programs on STDs. low male participation in the pacific. Low contraceptive prevalence rate. **CHALLENGES**: 1. RH/FP data gaps and deficiencies (under-reporting, information gaps, low data utilisation, data inconsistencies), 2. Girls education and women's literacy, 3. shortage of female health workers, 4. Consent form required to use contraceptives, 5. High TFR, 6. majority live in rural areas did not access services. 7. less narrowing choice of contraceptives mainly on injectables and hormonal methods most popular. 8 Social and cultural reasons for low participation in FP, 9. low male participation and limited male methods to condom use and male sterilisation. **SUCCESSES**: 1. availability of a wide range of contraceptive choices throughout the pacific, 2. acceptance of male sterilisation is relatively high in Kiribati. 3. There seem to be a renewed interest in health and population issues in PICs through global and regional developments such as ICPD.

Health centres were the primary sources of in-depth knowledge and awareness regarding contraceptive use compared to other highly influential initiatives.
Barriers to contraceptive use include: religious beliefs, cultural beliefs, gender disparities, the need for regular visits to health centres.
Ideal number of desired children in families is between 3 and 5.
Way forward –greater gender equality, programs to address issue by describing the number of children in an ideal family unit.

Basic FP service provided at most community clinics.
No FP guidelines, lack of standardisation of care across all clinics.
Staff need further education to increase knowledge, confidence and skills to enable contraceptive choices.

Contraceptive prevalence rate – 45%.
Government is the main source of modern contraception. Services provided for free.
Almost universal contraceptive knowledge for men and women.
Common reasons for non-use are fear of side-effects, loss of fertility and desire for more children.

This study program focused more at the national & provincial levels and encouraged national programes to take responsibilty of implementation at sub-national levels. Paper summarizes information collected from key informants- who were often program administrators and may not be fully aware of the actual use of FP materials in clinics. Addresses one component of FP services.
This is a top down approach to managing FP services. Sometimes the evidenced-based guidelines created may not be applicable to the context of Pacific Island Countries. Promoting FP guidelines and tools are only effective if there are supplies to meet the increased demand.

Service not culturally accessible.
Village health workers discourage use of contraception.
Low contraceptive prevalence, high unintended pregnancies and unmet need.
Challenges: lack of knowledge, staff attitudes, costs, stock availability.
Worried about side-effects, use traditional methods
Husband/partner opposition, clinic too far.

Unmarried people had difficulties accessing service.
High knowledge about pregnancy and how to avoid it (>80%, but low knowledge about the practicalities of contraception (43%).
Higher education level of women does not correlate with knowledge about emergency contraception and condom use and pregnancy prevention.
Barriers: partner disagreement, lack of contraceptive knowledge.

Contraceptive prevalence – 36%.
FP service not integrated with other reproductive health services.
Wide knowledge of condom use.
High use among younger women and currently married men and lower use in women 35 years and older. Men are reported to use 4 male methods.
Lack emphasis on discussing FP issues due to lack of home visits.
Desire for more children is the common reason for non-use.

Contraceptive prevalence – 37%.
Health facilities common places to source services and contraception. Free services from public sector.
Married educated women most users of service Men and adolescents have less access.
Common challenges: lack of knowledge, want more children, side-effects, hard to get methods and religion.

Achieved mixed progress in incorporating gender and rights into SRH agenda. SRH Approach - SRH services are theoretically available but in reality some services may be inaccessible due to cultural belief. Lack of clarity regarding health workers roles in ASRH, no workers were provided with job descripiton for ASRH. This made health workers think ASRH was not part of their official duties and added to their already overburdened workloads. Challenges: cultural norms, scarce resources (shortage of staff), uncertainity about roles and lack of incentives - health workers not aware of roles of ASRH. ENABLING ENVIRONMENT: engaging community gate keepers, more transparency and collaboration with sectors to reduce duplication of services, Regular dissemination of information and appropriate training, changes to school curriculum acknowledged but need to train teachers to deliver content appropriately. Youth venues and accessible youth friendly clinics esp in rural areas. Funding for ASRH Government and NGOs to must collaborate an dbuild network. develop standalone or adolescent friendly services to operate 7 days a week. BARRIERS: Complex barriers which hinder the provision of these services - cultural norms, attitudes described in 'gaps', lack of staff incentives, poor infrastructure, lack of skills and knowledge. identified judgmental attitudes and beliefs which will limit appropriate care or access to information.

FP status - Emphasis on FP diminishes partly due to global waning and challenges of emerging threat from HIV/AIDS. Under reporting on CPR and TFR and in most cases absence of information on unmet need is evident. This does not give clear picture of RH/FP status Conducting Demographic health surveys have not been the tradition in most PICs(prior to 2006 only two countries had DHS data.
Challenges: 1. Socio-economic heterogeneity of PICTs.2 Difficulty of determining whether data exists for relevant indicators. 3 Ambiquity of interpreting certain indicators and targets in contexts of small populations in PICTs.4. Relatively conservative socio-cultural setting, routine health information systems do not capture the needed community-based data 5. No DHS conducted in most countries.
Facilitating environment: the need to measure unmet need for contraception. CPR will need to be validated in PICs through DHS or related surveys in order to monitor progress of SnRH/FP programs.
SUCCESSES: Have intergrated RH into primary health care prior to ICPD in 1994. Some countries have adopted legislations/policies advancing reproductive rights but clearly there is need for further action PICs have taken measures to increase access to quality RH services through training and increased staffing, increase number of service delivery points. and introduction of evidenced-based guidelines in SRH including FP. Many countries reported taking action for promoting safe motherhood including improving family planning services and contraceptive use. Expanded the choice of contraceptives and availability. Incorporation of SRH including FP n HIV in national and subnational development plans has been achieved in most PICs, the extent to which it has translated into

The evaluation reveals the importance and the acceptance of the fundamental rationale for MIRH: THE RELATIONSHIP BETWEEN HOME LIFE AND WORKPLACE PRODUCTIVITY, and raises discussion on the relationship between population growth and rural development and the relationship between family size and poverty.
Concept of male involvement in reproductive health well received in Pacific countries but services lack strategies to deal with sensitivities in sexual health issues.
Need to measure unmet need for contraceptives.
Contraceptive prevalence rates need to be validated through demographic health surveys or related surveys in order to monitor progress.

FP service implementation: 1. Funding has never been allocated to a national FP program, although successive National Health Plans have identified the need for FP services. 2. Following release of the 1988 population policy, the Maternal and Child Health Unit was established within the Ministry of Health. Coordination of FP service provision commenced on a national basis. 3. There is no coordinated effort to implement government policy. 4. International donor aid continues to fund all activities of the FP program. 5. No provision is made in the national health budget to fund FP program. 6. Majority of FP providers in SI are health-clinic based nurses who combine new FP work with their already heavy general clinical workload. 7. Training of FP providers is opportunistic, nurses have limited knowledge about FP. 8. Non government Organisations involved in FP activities are: Solomon Islands Planned Parenhood Association founded in 1973 and the 'O' clinic established in 1978 sponsored by the Catholic Church. **CHALLENGES**: 1. difficulties in organising FP services as a developing country. 2. Logistical issues like Geography, climate and dispersed population affects provision of education and clinical services. 3. cultural and religious contraints influence acceptance of services. 4. lack of infrastructure and resources to provide alternative services, irregular supplies of contraceptives. 5. FP services in SI are closely integrated with maternal and child health services (while this is a recognised primary health care strategy, it also stems from a lack of infrastructure and resources to provide alternative services). Men and young unmarried people have poor access to health-clinic based services. **SUCCESSES**: 1. The National Health Plans have identified the need for FP services. 2. The

Contraceptive prevalence – 27%.
Government sector is the main source of provider
Contraceptives are free.
Women had more access than men .
Knowledge increase over the last 5 years, almost the same in both men and women.
Challenges: respondents and husband/partner opposition, religious beliefs, method related, health concerns and wanting many children.

Contraceptive prevalence rate – 29%.
Contraception mostly provided in government/public sectors, few by private, faith based and non-government organisations. Service is mostly free.
High unmet need in rural than urban areas, high fertility rate and mortality rates.
Unmarried and young women and men have less access.

Contraceptive prevalence rate – 34%.
Women in rural areas more likely to use a method than urban women. Knowledge high among currently married women and men.
The government provided most services and contraception.
Condoms distributed in clinic through peer educators. Services are provided free.
Reasons for non-use include: fear of side-effects, desire for many children, health concerns, husband/partner opposition and religious prohibition.

Source mainly from public/government sector.
High knowledge in all women and men including unmarried sexually active men.
Reasons for intending to use contraceptives include fear of side-effects, desire for more children, health concerns, opposition by respondent and religious beliefs (fear of side-effects and desire for more children are common reasons.

Pacific countries remain highly supportive of ICPD but progress in implementing its recommendations varied across the region.
Some countries developed population policies others have taken steps to prepare but not reaching implementation stage.
Less progress in integration of population into sector plans and strategies.
Most countries now capable of conducting a population census but the capacity to process, analyse, and interpret census survey results from policy perspective remains limited.

SRH not well coordinated and holistic due to vertical, fragmented and under resourced nature of programs.
FP not reaching groups who need it.
High unmet need in older women, lifetime fertility remains above 4 children per woman in several countries.
Programs require renewed political support and innovative strategies to meet needs of disadvantaged groups.
Need to conduct more socio-cultural research on factors inhibiting use of FP.

Progress made but pace and extent varied greatly between countries.
Integrated and comprehensive approach to achieving SRH rights yet to be fully established.
Integration of population issues into education systems still under development.
High costs of transport because of remoteness of many communities, a significant barrier.
Effective stakeholder engagement and partnerships reported as common facilitators by governments. Many countries now have population policies and sexual reproductive health programs have improved.
To devote resources to research and understand behaviours of Pacific peoples so that programs on STIs, contraception, and FP are based on best evidence.

CHALLENGES in pacific communities: social and heterogenous in culture, very religious, sensitive issues of SRH often challenging to discuss and address. Geography of region provides unique challenges, situation differs from country to country. Weak statistics (health information) difficult to measure MMR (bcos small pop size, difficult to calculate robust statistical indicators as annual variation of events can be enomous.Geographical disperson of communities in rural areas & outer islands, MMR tend to be higher

Integration of SRH services & HIV needs to improve access to range of services for both men n women. Apart of cost saving and sharing aspect of integration this is important because behaviours that prevent HIV transmission also prevent STIs and unintended pregnancies and many HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. There has been a gradual move towards integration of SRH & HIV programs in the Pacific. FP services provided by health clinics, observed to be available and accessible, home visits done, depo most commonly used method by catholics, as using longer term method is against their religion. HIV/STI services limited to outer islands. Poor level of service delivery to outer islands. CHALLENGES: a young and growing population (55% of pop under 25 yrs), CPr one of the lowest (18%) in the region well below MHMS target (57%), high adolescent birthrate (49%). Understaffing, outdated policies & guidlines, inadequate reporting systems, fiscal and geographical challenges in outer islands.

Samoa remains committed to upholding SRHR through its constituaiton etc...Despite these commitments and gains, cultural and attitudinal barriers continue to challenge the health sector's progress towards achieving universal access to SRHR. Attitudinal barriers present at all levels: including individuals and communities, village and church leaders, school management committees, within all levels of government, in Ministries and service providers. CHALLENGES: Attitudes of some service providers, a young growing nation, rising fertility, young people limited access to contraception reflected samoas high adolescent pregnancy rate,, unmet need for FP 45.5%. SERVICE DELIVERY: All facilities in samoa offer ANC n family planning services both within centres (weekdays), although FP clients will be seen at any time and through daily/2-daily community visits.

Achieved mixed progress in incorporating gender and rights into SRH agenda. SRH Approach - SRH services are theoretically available but in reality some services may be inaccessible due to cultural belief. Lack of clarity regarding health workers roles in.A YOUNG AND GROWING NATIONS (58% of pop are under 25 yrs of which 39% are under age of 15, TFR of 4.1%. Challenges: Poor health infrastructure,, under-staffing, outdated policies/guidelines, inadequate reporting systems, the fiscal and geographical challenges of preventing stock out of essential drugs, equipment and medical consumables in all health facilities esp outer islands. Crucial for SRH advocates and stakeholders both in SI n region is to rigorously and consultatively identify gender and other socail determinants of health within each local context; and integrate findings into SRH program designs in a effort to address the impact of activities on women, girls , boys and men with the ultimate goal of promoting equal access to health care for all

A young and growing population, 56% less than 24 yrs and 37% are aged less than 14 yrs, 9% are 65 and over. Key issues to address are high burden and incidence of NCDs, high adult fertility rates, high teenage fertility rates, high burden and incidents of STIs and low rates of contraceptive prevlance. Tonga has relatively high adolescent birth rate of 30%. All facilities assessed provide range of SRH and HIV services (in clinic or outreach) FP is amongst other RMNCAH services. Challenges to improving SRH delivery to achieve universal access include, understaffing, outdated policies/guidlines, need for information educational and communication materials at clinics for community outreach. the fiscal and geographical challenges of preventing stock outs of essential drugs and medicinal consumables in all facilities esp out islands. Public health services provided free of charge, health facilities well dispersed which results in high levels of access to healthcare except for limited access for small populations on small isolated islands. No mentoring programs to monitor skills retention. All 14 health facilities assed provide family planning services, HIV awareness and the promotion of use of condoms to prevent STIs n HIV but nothing mentioned for prevention of pregnancy. And assessment of how FP services were provided a that clinic level was not done. It is not clear if the YFHS and condom programing include FP educational talks. CHALLENGES: geographical isolation, economic, cultural and fiscal constraints that present stumbling blocks to the development agenda. Understaffing, outdated policies/guidelines, and fiscal and geographical challenges of preventing sotck outs of essential drugs and medical consumables esp outer islands. The need to rigorously and consultatively identify

A young and growing poplulation, 58% of pop under 25 yrs.Prevalence of HIV remains low, however there is evidence of signficant and rising prevalence of STIs esp amongst young people. Has one of the highest rates of CPR in the region, owing to a suitable methods mix and available to meet specific individual and couples needs. However use is not uniform thro out country amongst specific age groups. Higher level health facilities (hosp n helath centres provid comprehensive range of reproductive health (inclu FP). Aid Posts are reported not meeting their SRH n FP promotion and referral responisbilities. Almost all facilities in the country provide condoms for STI/HiV prevention, ANC newborn clinics etc. SRH including family planning are delivered by RNs, MWs n doctors, clinics staffed by Nurse Aides are not qualified to provide/dispense FP commodities. All health facilities have condoms available and are providing these for STI and HIv prevention.

Most countries have sufficient nurses to meet need for RMNCAH care but shortage of nurse-midwives.
Most have official policy to access RMNCAH care but out of date and not fully costed.
Barriers to service integration – staff shortage and need for further training.
Gender barriers significant, concerns about confidentiality in small settings.
Integration of youth-friendly RMNCAH services rare in the region.

Contraceptive prevalence rate - 38%.
The government sector is the primary source of service and contraception, service is generally free.
Use is high among currently married women and high wealth quintile.
Knowledge is high among currently married and those with 3 to 4 children.
Reasons for not intending to use: fear of side effects, opposition from respondent/husband/partner, fertility reasons and lack of knowledge.

Access to contraception is not sufficient, rates of adolescent pregnancy remains the same despite availability of services.
Early sexual debut.
Insufficient and inaccurate knowledge about fertility and SRH services.
Beliefs about sexuality, sex considered taboo.

Although FP is an integral part of the agenda agreed at the 1994 ICPD. Investments in FP by many countries and donors have declined drastically, resulting in stagnation of program achievements. CHALLENGES: The high proportion of young people entering the reproductive age in many PICs has significant implications for appropriate contraceptive service. The increasing proportion of unmarried young people whose contraceptive needs are not well met in many Asia Pacific countries. the low use of contraceptives among married and unmarried. The disturbing rates of abortions signify the need for re-orienting contraceptive services to those underservced groups most in need. Other groups in need of special attention include - Older women, Poor and uneducated women, Migrants (in Asia). Research showed young people did not go to public health centres for FP.

Gaps in research

There is a need for teenage friendly services which anticipate concerns girls have for confidentiality and respect and provide quality family planning services and diagnosis and treatment of STI.

The possibility of achieving health -related MDGs (5 a n 5b) in some countries in the Asia n pacific is SMALL. WHAT IS NEEDED: Sustainable Crosse-sectional FP related policies and programs are needed given the lack of recognition of the importance of FP to economic and social development and poverty reduction as well as the lack of women's empowerment

Childbearing by older women - A forgotten issue? Older woemn - A special target group. While applauding the objective of raising the reproductive health status of adolescents, we would appeal to governments, NGOs and donor agencies not to overlook the special reproductive health needs of older women in current and future reproductive health and family planning programs

Providing youth-friendly health services alone will not alleviate the burden of poor SRH among adolescents in Vanuatu. Investment is required in well-evaluated, context-specific strategies that aim to a create more supportive environment for adolescents and their sexual and reproductive health.

Much of SRH informaiton targeting adolescent are on STIs and HIV. Important gaps identified including prevention of pregnancy, condom use, puberty, sexuality and relationships. Probably due to high STI rates and donor-driven priorities. Little is known about the information needs and preferences of adolescents in the Pacific to inform policy and programs in this region. High burden of of early and unintended pregnancy in Vanuatu. Less emphasis on the use of condoms to prevent pregnancy or the promotion of dual protection.

Servicess for men are inadequate, male literacy also contributed to mens participation

The survey was not designed to capture any social and cultural issues that could impact upon a couples utilization of family planning services. However, the SPP mechanism offers a strategy/framework that countries may condiser in order to maximise the benefits and impacts of introducing and updating national norms and standards into national policies.

Provision of ASRH service education (educators) - majority suppported sexuality education to be taught at school, n comfortable discussing ASRH issues with students, thought further questions elicited a number of contraindications. **Provision of ASRH health workers** - has some contradictory attitudes n practices with respect to youth and ASRH service provision. None were aware of institutional policies with respect to SRH. **ASRH training**: health n education sectors: Most recieved basic training in SRH, none had adolescent-specific training. Lack of knowledge of relevant ASRH policies is concerning. The Pacific Policy Framework for Universal Access to Reproductive Health (2008-2015) represents the governments commitment to achieving universall access to RH services and removing barriers especially for adolescents. With the right political support, evidence from from the Asia-pacific region suggests that school based and peer sex education and increasing school retention acutually increase adolescents access to RH services. Pooling funds, reducting duplication of services and

The quality of information and services in SRH care needs improvement despite having integrated RH programs into PHC. Access to contraceptives for teenagers remains unsatisfactory. In most PICs national reproductive health policies and or strategies need to be updated or developed. there is an urgent need to promote access for all women and men especialy young people in rural n outer islands, disadvantaged or marginalised groups to a full range of SRH informaiton, fp services n commodities. Current FP programs in most countries should be strenghtened. To address deeplu-rooted gende4-based inequities in order to achieve MDG

Solomon Islands is a multi-cultural country, therefore evidence gathered from one provinice may not necessarily reflect/represent the country

Disparities remain to futher identify and address underlying factors that contribute to unmet need for fp, low CPR, teenage pregnancy, high incidence of STI, low condom use.

Youth focused SRH services key area of health sector, but despite investment in equipment, infrastructure and capacity building of clinical staff the interventions are not operating effectively to meet the SRH needs of young people. Work still needs to be done to address awareness and attitides of many service providers and ancillary staff to embrace rights-based approaches to SRH service delivery particularly in regards to the provision of youth friendly services and appropriately respond to and manage gen-based violence assault

FP Approach - Contraceptives are provided most in public/government sectors, few services in private, NGO and faith-based providers. CHALLENGES: high unmet needs for FP, higher in rural than urban, young women access less FP services, low utilisation of FP services. OPPORTUNITIES: Most health services provide FP clinics and contraceptives. FP is a priority in SI and has the governments support. women in rural areas are more likely to use contraceptives than those in urban areas.

SRH is not a prioritised strategic focus (not on a top priority list, gaps with in system include need for comprehensive current best practice SRH training program for the school of nursing, health practitioners and peer educators. Tonga has not current SRH policy but has a national intergrated sexual and reproductive health strategic plan (2014-2018) whic h guides SRH program. Some disparities remain - 25% unmet need for FP, Low CPR 28% (2012), teenage pregnancies, high incident of STIs and poor self-referrals for treatment and low female condom use. Community outreach programs actively conducted in Tonga through 'settings' approach, 4 settings are used: schools, villages, workplaces and churches, daily talk back shows, weekly TV shows broadcasted, but there are no SRH outreach programmes that specifically target vulnerable sub-populations. Community outreach primarily focuses on NCDs as the tip MOH priorities, SRH topics inclu HIV/STI n FP are advocated. but CO in schools is basic n typically only includes basic body physiological changes n STI/HIV. research underlying factors associated with

Major challenges to improve SRH service delivery n status exist across country as understaffing, outdate policies, strategiesn clinical guidelines, inadequate reporting mechanisms, systems and processes and under resourced commodities distribution systems. many can be addressed through strong national level leadership from within the Ministry of Health's department of public health (from the national reproductive health program, through informed, consultative planning and program implementation at the provincial level. Strategic priorities must be establised based on available evidence and through consultation with key affected populations and other stakeholders to ensure services meet actual needs and are likely to be acceptable and utilised.

The possibility of achieving health-related MDGs (5a+ 5b) in some countries in Asia-Pacific is small. What is needed - sustainable cross-sectional FP related policies and programs are needed given the lack of recognition of the importance of FP to economic and social development and poverty reduction as well as the lack of women's empowerment. recent analysis of countries in APac offers strong evidence that meeting the need for FP can accelerate the achievement of MDGs. Investing in FP alone can contribute to reducing costs of achieving MDG targets for education, child mortality, maternal mortality and environmental sustainability.

My notes

Additonal notes

The overall fertility rate for adolescents, along with the rate of childbearing amongst older women has generally declined througout majority of the PICs over the last 3 decades. However fertility amongst women age 35 and over still remains very significant and appreciably higher than among adolescents in these countries. A comparision is made of the most recently estimated ASFRs for 15-19 year olds with 35-39 and 40-44 year olds both in PICs with other regions of the world. It is evident that older women in the former continue to experience relatively high fertility compared with adolescents opposite to many other regions of the world. Yet the persistently higher fertility of older women in the PICs does not appear to attract anywhere near as much attention from planners, policy -makers, donors and the media as the fertility behaviour of adolescents in the current post-ICPD era of concern with adolescent reproductive health and sexuality.

The narrow focus on only one or two aspects of SRH is a recognised weakness of sex education programs globally, despite good evidence that comprehensive approaches that also build life skills are needed to reduce risk behaviours.

education workers overwelmingly supported sexuality education but many did not support the teaching of core topics such as anatomy, sexuality, gender and norms, contraception, HIV/STIs and **human relationships. My thoughts** . *This could be why knowledge about sexual relationships is very low in SI and the Pacific* . Findings suggest teachers are avoiding tipics which they percieve as inappropriate. Health workers views - responses reflected ambivalent attitudes and worrying lack of skills and confidence in core health practices relation to adolescents. Although they reported were willing to prescribe contraception to unmarried adolescents, there was some reluctance when questioned further example: over half would refuse to prescribe any form of contraception to young women unless they had already had one or more children. This suggests that health worker willingness to prescribe contraception may not only be dependent on the parity of their clients, but also their marital status as sex and pregnancy outside of marriage is widely condemned in SI. They may percieve their main role as serving the needs of married women and indeed participants that some health owrkers were turning unmarried adolescents away from their health service. The lack of knowledge of relevant ASRH policies is concerning , given the rile of policy in provideing appropriate guidelines for practice. MY THOUGHTS: A YOUNG AND GROWING NATIONS (58% of pop are under 25 yrs of which 39% are under age of 15, TFR of 4.1%

The paradigm shift in population and development that occurred at the ICDP in Cairo in 1994 from reduction in population growth for socio-economic progress to ensuring sexual and reproductive health and rights as a fundamental human right and as a means for improving the quality of life, has also become apparent in the Pacific.

Challenges: Poor health infrastructure,, under-staffing, outdated policies/guidelines, inadequate reporting systems, the fiscal and geographical challenges of preventing stock out of essential drugs, equipment and medical consumables in all health facilities esp outer islands. Crucial for SRH advocates and stakeholders both in SI n region is to rigorously and consultatively identify gender and other socail determinants of health within each local context; and integrate findings into SRH program designs in a effort to address the impact of activities on women, girls , boys and men with the ultimate goal of promoting equal access to health care for all

This article may be used in the discussion, consider to remove

1. Knowledge – good >80% of both gender
2. Attitudes to FP – high approval rate for use of FP methods. Both gender aged 15-24yrs had limited knowledge. Male disapproval
3. Prevalence of contraceptive use – methods were not readily available to isolated population.
4. Female sample – issue with male nurse, beliefs about FP. Shame relating to sexual taboos.
5. Male sample – few men attend clinic bcos of shame n lack of male clinic staff. **Comments/challenges/Facilitating environment.** FP only available through health clinics. Majority of staff are female. An average of 2-3 nurses including NA per clinic. Women access service more than male. Barriers include gender of staff nurse, geography, climate religion, age, distance, lack of knowledge. Outreach FP depends if nurses have time and are not busy in the clinic. The Themes are: 1) FP service only available through health clinics. Mostly women access the service, majority of nurses are female. Face challenges as per theme section.

If SRH topics are clearly outlined from the MOH health promotion unit then these can be easily coordinated and impplemented in community and village settings.

RH update - While fertility rates have declined over past decade, it remains high in most pacific population stagnating at 4 children /woman. Unmet need for FP still an issue for some especially young and disadvantaged. CPR for all PIC remain below developing countries average 62%, high unmet needs for FP contraceptives.

While peer educators maybe available in the country for SRH information n services, they will also need adequate knowledge about family planning contraceptives and services as well in order to give comprehensive information about contraceptives.While SRH awareness are conducted in schools and other places, it is not clear if this awareness includes informaiton about family planning.

TFR - 4.6 SIDHS 2006-2007 census, 4.7 Census 2009, 4.4 2015 SIDHS. Rural women have more unmet needs for FP than urban . Overal knowledge of at least one contraceptive is high in men and women

Many of these challenges can be addressed through continued strong national lelvel leadership from MH through better informed consultative and collaborative planning and program implementation. The model of conducting key informant interviews and focus group discussions with a sample of MOH senior managers, health managers and representatives from CSos, NGOs and development partners was planned to provide a cross section of information for the reveiw. However this cannot be considered as fully conprehensive as information collected from sample does not necessarily reflect all SRHR programs in the country. this would have been achieved only by visiting all health facilities but was not done. A further limitation of this assessment is data only collected from service providers and facilities only, service users were not included in the sample. Future assessments should consider a combination of senior health planners, implementers and users.

Significant structural, economic, cultural, attitudinal, geographical and fiscal challenges act as barriers to the development and implementation of services and processes with uphold SRHR and contribute to improved sexual and reproductive health particularly for women and young people. Within the health system major challenges to improved SRH and to delivery of services which meet basic SRHR include: under-staffing, outdated policies, strategies and clinical guidelines, inadequate reporting mechanisms, systems and processes and under-resourced commodities distribution systems

Time to review existing policies + focus on unmet needs esp for young people. Future FP for region need to take into consideration population momentum and growth which would put pressure on exisitng FP resources, governances, policy markets for contraceptive security would vary from country to country. No one program model could fit every situation and factors influencing contraceptive demand would be wide ranging both across and within countries. CHALLENGES IN THE PACIFIC: educated versus uneducated, main reason for unmet need was not access but "unwillingless" arising from fear of side-effects, health concerns or some form of sociocultural opposition. Adolescents faced the largest barriers to the use of contraception for socio-cultural reasons. Service providers in publlic health facilities were slowly abandoning their moralistic attitudes towards adolescent sexuality. Research showed NGO's did better in addressing the needs of the adolescents.