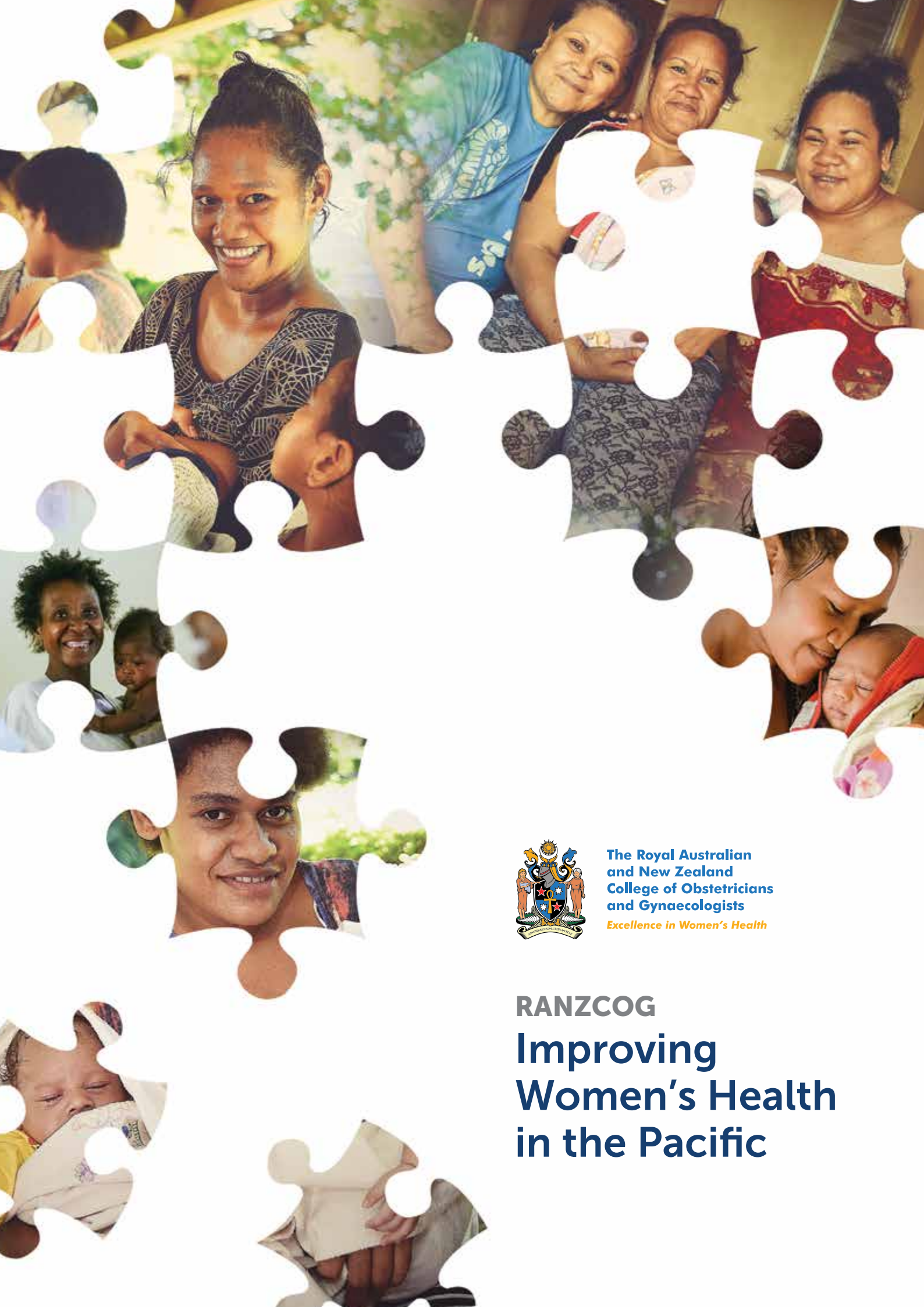

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Excellence in Women's Health

RANZCOG

Improving Women's Health in the Pacific

Executive Summary

Investment in women's health secures high social and economic returns. Recent economic modelling indicates that the socioeconomic return on investment in women's health yields substantial dividends: increasing health expenditure by just $5 per woman per year up to 2035, in 74 high-burden countries, could potentially yield up to nine times that value in economic and social benefits.

(Bloom DE. Demographic upheaval. IMP Finance and Development 2016; 53: 1)

The protection and promotion of women's health is vital to the health and development of Pacific Island Countries (PICs), not only in the present but also for future generations. There are unequal levels of development in the Pacific: while a number of PICs have made remarkable gains in women's health, a great deal of work still needs to be done in other countries. Thousands of women throughout the region face health challenges that are avoidable, and these challenges confront them at every stage of life.

In many settings cultural norms do not permit women autonomy over their own lives - particularly in the area of sexual and reproductive health and family planning. In some PICs women are brought up to believe that they need to be subservient. These attitudes and cultural norms are often associated with violation of human rights, gender inequality and domestic violence. Such circumstances compromise the health and socioeconomic status of women.

Furthermore when women's status is low it limits their access to education and health care, and their power to make decisions about their own sexual and reproductive health. Many of the health problems facing women and girls in the Pacific are linked to disempowerment in the communities in which they live. Any discussion of improving their health must therefore take into account cultural and sociological constraints.

In the Pacific underlying socio-cultural circumstances are major contributors to maternal and newborn deaths, low antenatal coverage, high rates of home birth, low contraceptive use, and high rates of unplanned pregnancy. Many PICs did not achieve the health Millennium Development Goals (MDG) targets. The Sustainable Development Goals (SDGs) represent a global health agenda to guide development in a more holistic way: building on the gains of the MDGs, and making further progress to improve wellbeing. The SDG agenda places high importance on inequity and human rights with the aim of benefiting all populations in an integrated multisector approach, recognising that non-health sectors – including nutrition, education, water, sanitation, hygiene, and infrastructure – are essential to improving health and well-being.

It is also important to recognise the physical environment of the Pacific. One of the unique challenges for the equitable delivery of healthcare is that the population is scattered over many islands or in poorly accessible mountainous regions. These geographical challenges impose serious logistical problems in the delivery of reliable and high quality primary care for remote islands. Issues that include infrequent transport links and poor communication lead to high operational costs. For these reasons, development efforts commonly bypass the most disadvantaged areas, leaving only low-quality services for the poor. The resulting maldistribution of services leads to a disproportionate percentage of health expenditure devoted to medical evacuation in some of the smaller countries where this is an option.

Women's health is not an abstract issue, and cannot be isolated from the social and political environment in which women live. It is strongly influenced by a complex inter-relationship between biological factors and social determinants. The context of women's lives – how gender inequality increases women's vulnerability and curtails access to healthcare and information – is a major influence on health outcomes. In this document we provide an overview of ten key health challenges facing women in the Pacific.

The ten key priorities are:

1. Reduce maternal and perinatal mortality
2. Strengthen the skills of birth attendants and improve women's access to health facilities for supervised birth
3. Improve access to contraception and family-planning measures
4. Reduce the potential for harm to women from HIV infection
5. Reduce the incidence of cervical cancer
6. Address needs associated with lifestyle issues such as obesity, poor diet and inactivity
7. Improve health literacy
8. Improve health infrastructure
9. Eliminate gender-based violence
10. Address gender inequality

Within these ten priority areas for women's health, we highlight the key steps the WHO, other UN agencies and NGOs believe are required to effect change.

While RANZCOG has a limited impact in many of the key priority areas, the College reaffirms its commitment to those areas in which it has expertise: working collaboratively with Pacific countries to strengthen the reproductive health workforce with a focus on educational support; provision of resources; networking support and facilitation of training, research and continuing professional development opportunities for obstetricians and gynaecologists, midwives, and other reproductive health workers.

Professor Steve Robson
President

Ms Alana Killen
Chief Executive Officer

Priority 1
Reduce maternal and perinatal mortality

Preventable maternal and perinatal deaths are highest in Papua New Guinea, Solomon Islands, Kiribati and Vanuatu. Poor access to basic health services, limited availability of life-saving emergency obstetric care, poor infrastructure and difficult transportation, and delayed referrals of life-threatening conditions are major contributing factors.

Key actions

- Support and promote planned pregnancy and pre-pregnancy care wherever possible, and include immunisation (for example, tetanus) and diagnosis and management of chronic infections, such as HIV.
- Promote care during pregnancy, with the aim of providing adequate access to antenatal visits.
- Ensure nutrition is supported with supplementation such as iron, vitamin A, and folic acid and lobby for fortification of staple foods if required and feasible.
- Ensure provision of antenatal care to maximise early identification of complications, and to plan place of delivery with mother and spouse.
- Promote and support hygienic and safe birth practices.
- Support and promote a skilled birth attendant to attend every birth.
- Support birth at health facilities wherever possible, thereby improving management of complications during labour and birth.
- Ensure clinical protocols are in place for the management of common obstetric complications.
- Establish a guideline for efficient referral to the next level of care when needed.
- Support local responses to haemorrhage and infection.
- Promote and support resourcing of local field health facilities, and systems for timely and safe inter-facility transfer if escalation of care is required.
- Establish maternal and perinatal care audits.
- Support and promote access to contraception immediately after birth and/or prior to discharge.
- Support and promote postnatal visits and care, including contraceptive provision.

One of the commonest causes of death and disability for young women is pregnancy. The dangers lie in having too many pregnancies, with inadequate birth spacing, and facing barriers to accessing skilled care. Women are most vulnerable during the labour, birth, and early postnatal period.

The most common causes of death during pregnancy and birth are obstetric haemorrhage and anaemia, infection, obstructed labour, hypertensive disorders and unsafe abortions. For these reasons, contraception, family planning services and access to skilled health workers who can supervise birth are the most effective strategies for reducing maternal morbidity and mortality.

Practical, cost- and clinically-effective interventions have been shown to reduce maternal mortality when implemented, and data suggest that resource-poor countries can reduce the rate of maternal death by an uptake of a relatively limited number of interventions.

The most cost-effective strategy to reduce maternal mortality is the provision of contraception, and it would be likely to reduce the maternal mortality rate by almost 30%. Furthermore, the ability of women to control their own fertility is fundamental to their participation in broader society. Therefore, access to contraception should be the foremost priority in any strategy aiming to reduce maternal deaths in the region. Unfortunately, the unmet need for reproductive health and family planning services across the Pacific appears to be increasing. Rates of teenage pregnancy are high, commonly reflecting this need.

Priority 2

Strengthen the skills of birth attendants and improve women's access to health facilities for supervised birth

In some countries, many women do not have access to skilled birth attendants. A major reason is the remoteness of communities and long distances to the nearest health facility. This means many women have home births assisted by traditional birth attendants or a family member.

Key actions

- Conduct ongoing capacity building programs for maternity care providers at all levels.
- Continue to develop multi-professional practical team training for obstetric emergencies for all birth attendants.
- Focus on primary health care workers and provide upskilling training in maternity care for non-midwifery personnel. This is especially relevant for PNG, Solomon Islands, Vanuatu and Kiribati, where populations are largely rural and remote.
- Develop a package of basic maternity services and emergency obstetric care to serve as a tool to facilitate training for community-based providers.
- Continue to develop midwifery-led services to capacity build in all provinces and districts, ensuring that trained midwives are placed in rural health facilities.
- Work with academic institutions to incorporate health leadership into their courses.
- Ensure there is an effective and functional referral system in place for urgent referral of life-threatening situations.
- Waiting homes can be considered in remote rural communities. Pregnant women during the last few weeks of pregnancy can be encouraged to move closer to health facilities and transit in waiting homes.

The care of women during pregnancy – especially during labour, birth, and the early postnatal period – is a critical factor in reducing rates of morbidity and mortality. In addition to supporting midwifery, nursing and medical training programs, evidence supports the need for inter-professional practical drills and skills staff training in their own health facilities to improve care. Specific training for the whole health team in teamwork and communication which is embedded in drill practices has been found to be crucial in improving outcomes.

We distinguish four levels of birth attendants: doctors, nurses and midwives, trained birth attendants, and 'traditional' birth attendants. Improving the recruitment and training of birth attendants at all levels is important, but there is evidence that training the third and fourth groups produces the greatest improvement in outcomes.

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Priority 3
Improve access to contraception and family-planning measures

Effective family planning reduces the risk of maternal mortality associated with childbirth by exposing women to fewer pregnancies. Where safe abortion is not available, effective family planning is even more important as a means of reducing mortality associated with unwanted births. Globally, 13% of all deaths in pregnancy are due to unsafe abortion.

Key actions

- Ensure that a range of contraceptive choice is offered, so every woman can select a method that meets her needs.
- Ensure all rural health workers are trained to provide sexual and reproductive health services, including family planning.
- Make contraception an essential component of health care services provided during the antenatal period, immediately after delivery or after abortion, and during the year following childbirth or abortion.
- Promote postpartum contraception, especially among women who live in remote communities and who may not have another contact with health service after discharge following child birth.
- Encourage the use of long-acting reversible methods, (IUDs and implants); and when the family is complete, promote the permanent methods of family planning (vasectomy, and tubal occlusion).
- Eliminate social and non-medical restrictions on the provision of contraceptives to adolescents, to help reduce early pregnancy and its associated health risks.

It is important to recognise that family planning and reproductive health has benefits at all levels of society. Allowing women control over their fertility expands choices in educational and economic opportunities. Additionally, access to family planning services has not only health implications for women, but broader economic and development consequences. Reducing the proportion of school-age children in the community reduces the burden on schools, and allows families and those same communities to invest more in education. It also reduces pressures on the environment and improves affordability of housing and access to employment, as well as access to public services such as healthcare. At the macroeconomic level, reduced pregnancy rates can promote socioeconomic development by reducing the proportion of dependent children in the population. Families with fewer children may have a greater capacity to save or invest.

Priority 4
Reduce the potential for harm to women from HIV infection

The prevalence of HIV has undergone a marked increase in the Pacific and there is potential for rapid growth in infection rates. This potential is exacerbated by several synergistic factors, combined with a lack of reproductive health literacy:

- Political, social and economic change
- Mobility of the population
- The emergence of new patterns of sexual behaviour
- Increases in the rate of substance abuse
- Increases in the number of sex workers

At the moment, the total number of HIV cases remains comparatively low, but trends in new infections mean that there is no cause for complacency. The prevalence of HIV infection in antenatal clinics in Papua New Guinea is 1.5%.

Key actions

- Incorporate 'Prevention of Parent-to-Child Transmission' (PPTCT) services as a key component of routine antenatal care to prevent mother to child transmission of HIV and syphilis.
- Provide resources for prompt treatment of other sexually transmitted infections, which increase the risk of infection with HIV.
- Support and resource sexual health education in schools and the community.
- Provide access to affordable condoms.
- Improve and promote access to voluntary HIV testing and counselling as part of antenatal care.
- Promote advice and support to reduce HIV infection among intravenous drug users.
- Improved access to care, support and treatment, including sustainable access to affordable supplies of medicines and diagnostics.

Studies have shown that many Pacific Islanders have high levels of knowledge regarding HIV transmission and protection methods. However, women in the Pacific confront a number of gender-based challenges that put them, and eventually their babies, at risk of HIV infection. Many women have reduced access to resources, opportunities and ability to make decisions about their own reproductive health, and this increases their vulnerability to HIV infection. Since women are most commonly the primary care givers in the home, they face a 'triple HIV burden': personal vulnerability to infection, the risk of transmission to their child and responsibility for care of other family members who might be infected.

In PICs, the women most vulnerable to HIV are:

- The wives and partners of men involved in seafaring occupations
- Women involved in transactional sex, particularly foreign sex workers
- Students who are mobile, separated from their families and sexually active

Lastly, different codes of sexual conduct are tolerated for men and women in some Pacific countries. Gender-based social norms increase women's vulnerability to HIV/AIDS, and this should prompt interventions to raise women's awareness and empowerment.

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Women in the Pacific commonly face challenges in negotiating contraceptive use because control over their fertility is asserted by their husbands. They face a fear of rejection, stigmatisation, violence or abuse that prevents them from accessing HIV counselling and diagnostic services, disclosing their HIV status, and accessing HIV prevention programs in pregnancy.

Priority 5
Reduce the incidence of cervical cancer

Cervical cancer is the most common female malignancy in the Pacific. The burden of the disease is substantial, with incidence rates as high as 50 per 100000 women per year, and mortality rates of 24 per 100000 per year. Studies suggest that more than 75% of cervical cancers are preventable. However, most countries do not have a well-established and comprehensive cervical cancer control program.

Key actions

- Establish a comprehensive cervical cancer control program with clear guidelines on primary, secondary and tertiary prevention methods.
- Advocate for HPV vaccination as the most effective primary prevention.
- Inform politicians and health policy decision-makers, schools, parents, communities and healthcare workers of the benefits of HPV vaccination.
- Advocate for HPV vaccination programs, including embedding cold chain and transport logistics, and sourcing of vaccines.
- Advocate for effective screening programs that are feasible and affordable such as visual inspection with acetic acid (VIA) and cheap HPV testing.
- Foster and encourage new research into point-of-care HPV testing and new vaccine regimens.

Most deaths occur when women are relatively young – a profound tragedy for families and their communities. Presentation and diagnosis occur at a late stage because few women across the Pacific are able to access screening and treatment programs for pre-invasive disease. In the typical circumstance when cervical cancer is detected at a late stage, treatment opportunities are very limited.

Effective, low-technology and low-cost screening methods exist that can be implemented in resource-poor countries to enable early detection and treatment.

Because women's health in developing countries is dominated by prevalent communicable and infectious diseases as well as maternal mortality, cervical cancer is often a low-priority public health problem. Competing health needs, widespread poverty, poor-quality health infrastructure, uninformed and disempowered women and endemic civil and environmental instability, among other factors, make the establishment of prevention programs in low resource countries particularly challenging.

Another important barrier to establishing cervical cancer screening is the requirement for cytology-based programs. However, alternative protocols to cytology-based screening programs – such as VIA and HPV DNA testing – show promise in the setting of Pacific countries. In addition, vaccination programs against the most common cancer causing types of HPV, types 16 and 18, present a range of challenges and opportunities.

VIA has been shown to have a sensitivity at least equivalent to cytology for detection of high-grade cervical dysplasia, but it does not require the use of colposcopy or histology in 'screen and treat' protocols. Thus, it eliminates the need for a laboratory infrastructure. It is therefore an affordable, low-technology diagnostic tool that gives immediate results. Although specificity and positive predictive value for VIA are both lower than cytology, resulting in 'over treatment' of women included in the 'screen and treat' protocols, complications

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from treatment appear to be minor and otherwise safe and acceptable to women if cryotherapy is used. VIA is prone to variable performance in different settings and thus requires stringent quality-control methods that can be difficult to implement when scaled up.

HPV DNA testing has a higher sensitivity than cytology for the detection of high-grade precursors, despite lower specificity and positive predictive value. Importantly, it has a nearly 100 % negative predictive value. Although current methods for HPV DNA testing are unaffordable in developing countries, initiatives are afoot to develop rapid tests that will give a real-time result and be affordable for these settings.

Some countries (Fiji, Cook Islands) have already introduced HPV vaccination as part of their routine immunisation programs while others are still in piloting or considering cost implications (PNG, Vanuatu, Solomon Islands).

Priority 6
Address needs associated with lifestyle issues such as obesity, poor diet and inactivity

Non-communicable diseases (NCDs) have become the leading causes of death in many PICs. It is likely that the proportion of people affected by NCDs will rise in the Pacific, and this trend is being driven by an ageing population and by behavioural risk factors such as tobacco use, physical inactivity and poor diet. Obesity and NCDs in pregnancy increase the risk of adverse maternal and newborn outcomes.

Key actions

- Promote a healthy lifestyle as part of the maternal health care package from pre-pregnancy and throughout the life cycle.
- Incorporate active NCD screening and effective management at all levels of maternity care, especially during the antenatal period.
- Use findings of current research to advocate for public health initiatives.
- Include NCD management as a major component of all training programs.
- Establish strong NCD screening and treatment for all medical, nursing and paramedical students.

Obesity and unhealthy lifestyles such as smoking, physical inactivity and poor nutrition are a significant public health concern affecting many Pacific nations. Women are at increasing risk of obesity and other chronic diseases associated with changes in lifestyle. Targeting lifestyle issues requires sensitivity and a deep understanding of the root causes. These may be socioeconomic, psychological, cultural, or a combination of several factors. The solutions have to fit the majority of the population, and obesity should be the priority target, as it is at the root of many NCDs. Rather than focusing on obesity at the individual level, the immediate environment of the obese individual in broader socioeconomic contexts should be targeted, such as the food and beverages industry. Most importantly, incentives at several organisational levels, the media and educational institutions, along with changes in food policies, will need to be provided to low-income populations.

Diabetes is especially prevalent in the Pacific; seven of the ten countries in the world with the highest diabetes prevalence rates are Pacific countries. Diabetes places a heavy health burden on individuals, households and governments. Typically a life-long disease, diabetes has the potential for complications, including blindness and amputations, and life-long drug treatment is often necessary. Diabetes is also associated with chronic renal disease requiring dialysis, which puts severe strain on the financial sustainability of the healthcare system.

Tied to the diabetes epidemic is an obesity epidemic. The Pacific has high overweight and obesity levels: the top seven most obese countries in the world are in the Pacific. Over one quarter of the adult population in most PICs is clinically obese, with rates in some PICs reaching 58%.

Differences in obesity and physical activity level across developing nations can be the result of socioeconomic factors as well as gender. Gender differences in BMI persist in the PICs, with women having a higher BMI than men. Importantly, more than 70% of women maintain insufficient physical activity levels, and this trend appears to be increasing, further raising the risks of morbidities related to obesity and a sedentary lifestyle.

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Priority 7
Improve health literacy

'Health literacy' is a wide range of skills that promote and encourage people to seek out, understand, evaluate, and use health information. There is a clear correlation between poor health literacy and increased mortality rates.

Health literacy is one of the foundational life skills for the empowerment of women. It allows them to care for themselves independently, and learn first-hand the information that will allow them to stay healthy and productive. Women who are health literate can make better informed and independent decisions about their own care, including fertility choices and prevention of HIV infections. Moreover, a woman's health literacy directly affects her ability to not only act on health information, but also to take more control on behalf of her family and community.

Key actions

- Support a primary health approach to solicit community participation, education and awareness using community networks.
- Use the delay model to discuss prevention of maternal deaths with communities.
- Engage in long-term collaboration with education systems to promote improved education and literacy.
- Advocate for universal free primary education in all Pacific countries.
- Advocate for informal education where formal primary level education does not reach all rural communities.

People who are health literate are able to make informed choices, reduce risks to their health and, ultimately, increase their quality of life. The degree to which people can access, understand and communicate information in different health contexts impacts on their ability to understand information given by healthcare workers, to follow directions, take medication correctly and keep appointments. A person's health literacy directly affects their ability not only to act on health information, but also to take more control of their health as individuals, families and communities.

Priority 8
Improve health infrastructure

To promote women's health, Pacific countries need strong public health services and delivery systems that are fully capable of catering to the entire community's needs. These systems must have capacity to respond to injuries and disease outbreaks, and to care for and prevent chronic diseases.

Key actions

- Lobby governments and donors to allocate adequate resources for improved health infrastructure, particularly rural health clinics.
- Development of integrated, people-centred health services.
- Support for health workforce development.
- Support for national and regional leadership, governance, and partnerships.
- Support for improved health information systems.
- Strengthening laboratory and pharmaceutical management.
- Strengthening service provision to ensure maternal and child health.
- Achieving and maintaining high vaccination coverage rates
- Identifying and building on successful health promotion programs.
- Support programs to address and, ideally, reduce avoidable disease burden.
- Ensure reliable and timely data on key indicators, to inform planning and evaluation.
- Prepare for and respond to large scale events and outbreaks.
- Address climate and environmental health risks that affect health status.

To strengthen these public health systems, and enable them to build a larger capacity, educational partnerships with colleagues in developed countries should be fostered and encouraged. The recruitment, training and professional development of health administrators, technicians and sector leaders should also be a priority.

Fractured aid programs are an additional obstacle to a robust public health system. To confront health challenges facing the Pacific, 'piecemeal' aid programs must be transformed into comprehensive multinational partnerships with the host nation overseeing the program. Achieving this requires multinational cooperation in the form of 'health coalitions' that harness not only medical and scientific but political, humanitarian and economic capital.

Priority 9
Eliminate gender-based violence

Women and girls must live their lives free from gender-based violence (GBV). Surveys undertaken in the Pacific suggest that the incidence of violence against women in the region is at levels among the highest internationally – almost two thirds of women report experiencing violence from an intimate partner or other family member.

Key actions

- Provide support and funding to train local service providers to address gender-based violence.
- Incorporate early detection and management of gender-based violence during antenatal care.
- Increase access to protection and support services for victims and survivors of gender-based violence.
- Provide resources and support to organisations that aim to foster change in attitudes of men towards gender-based violence.
- Advocate for robust reporting frameworks and governmental accountability to UN Resolution 1325++ on Women, Peace and Security.
- Introduce the topic of GBV as early as possible at primary school level.

The prevention of violence against women is complex and requires society-wide change. Campaigns to raise awareness and change community attitudes rely, ultimately, on improving the status of women.

Priority 10
Address gender inequality

Across the Pacific many of the five million girls and women are unable to enjoy basic human rights, and cannot reach their human, social, economic and intellectual potential. Aside from the personal importance of access to equality and human rights, gender inequality compromises sustainable economic development in the Pacific.

Key actions

- Advocate for human rights, health equality and gender empowerment
- Address the unequal number of women in key leadership roles through direct action
- Support and strengthen feminist groups and coalitions in the region
- Identify, mentor, train, and support female leaders and emerging leaders
- Engage male champions of change to visibly promote women in leadership roles
- Provide support and resources to capacity-building in women's rights groups and organisations

Gender equality is crucial to sustainable development for three key reasons:

1. It is a moral and ethical imperative
2. It is a critical step toward redressing the disproportionate impact of economic, social and environmental stresses on women and girls
3. It is important to build up women's agency and capabilities to create better synergies between gender equality and sustainable development outcomes

Widespread, serious and pervasive discrimination affects many Pacific women. Occasionally, girls and women are brought up believing they are undeserving of respect. This attitude is commonly institutionalised, and in the Pacific women's access to justice remains limited; laws to protect women are uncommon and often are not enforced. Few women are appointed to decision-making roles, and Pacific-region parliaments have the lowest representation of women in the world.

Women face these issues from early in their lives. Impediments to education and empowerment include early marriage and pregnancy, risks associated with travelling to and from schools and higher education institutions, insecure toilet facilities, risks of harassment and sexual assault, not only from students but also their teachers, and the direct and indirect costs associated with education. Increasing levels of urbanisation in many Pacific countries has resulted in higher population densities with resultant overcrowding of schools. It has also fostered poverty, which affects enrolment and retention rates. Education services have variable quality with poor provision of high-quality education to outer islands and remote rural communities.

Women have reduced and unequal economic opportunity with low labour-force participation and significant disparity with men. Discrimination in job opportunities, lack of property rights and poor local infrastructure negatively affect women's workloads and their participation in the formal and informal sectors. To make matters worse there is scanty legal framework to protect women. There are few legislative protections in key employment areas such as non- discrimination provisions in recruitment and retrenchment, paid maternity leave, affirmative action policies, wage discrimination and sexual harassment.

Improving Women's Health in the Pacific

RANZCOG's Role

RANZCOG has for many years made a contribution to reproductive health workforce development in the PICs – our programs underpin many of the steps required to achieve the goals.

Advocacy

RANZCOG is committed to advocacy for women and their reproductive health at a global level, and has representation on, or connections with, regional and international groups concerned with obstetrics, gynaecology and reproductive health, including:

- World Health Organisation Partnership for Maternal, Newborn and child Health
- International Federation of Gynaecology and Obstetrics
- Asia Oceania Federation of Obstetrics and Gynaecology
- Pacific Society for Reproductive Health
- Papua New Guinea Obstetrics and Gynaecology Society
- University of Papua New Guinea School of Medicine and Health Sciences
- Fiji Obstetrics and Gynaecology Society
- Fiji National University College of Medicine, Nursing and Health Sciences

At a local level, we collaborate with Australian and New Zealand Specialist Colleges, Societies and Organisations.

Promotion of Networking across Australia, New Zealand and the Pacific

RANZCOG is active in promoting and facilitating volunteer networks that link doctors across Australia, New Zealand and the Pacific. We are establishing improved links and information for volunteers and potential volunteers so that the expertise and skills of these individuals can be harnessed to support colleagues across the Pacific. We are also strengthening networking connections that can expand and produce real results in practical terms for doctors working at the grassroots levels and in isolation in the Pacific countries.

Health Workforce Development for Pacific Doctors and Midwives

RANZCOG has made Associate Membership available for specialist obstetricians and gynaecologists in the Pacific since 2007. Associate Members of RANZCOG have access to a Continuing Professional Development (CPD) program, resources, networking, and collegial support.

We are committed to developing clinical leadership skills among doctors and midwives so that they are empowered to improve their teams' performance with confidence and knowledge. Since 2004, RANZCOG has provided 205 scholarships to doctors and midwives from 14 Pacific countries. This includes 105 leadership and training scholarships to doctors to attend hands-on training workshops, the RANZCOG Annual Scientific Meetings and conferences held in Australia, New Zealand and internationally as well as 100 midwifery leadership fellowships.

Our Midwifery Leadership Fellowship Program for senior Pacific midwives has been offered since 2004 and is paying dividends in increasing the confidence, experience, and knowledge of senior midwives. The program is also raising the level of contribution that senior midwives can make to their health services across the Pacific countries. To date, 100 senior Pacific midwives have undertaken this program and the results have been presented internationally. This is an ongoing project that will continue to build the capacity of teams caring for women in the intrapartum period, as well as those working in reproductive health in community-based settings.

RANZCOG has worked with collaborative partners to provide approximately 80 scholarships to enable doctors and midwives to attend the biennial Pacific Society for Reproductive Health (PSRH) meeting between the years 1995 and 2007. Our support for PSRH as a multidisciplinary network for education and development continues through core funding provided to PSRH on an annual basis.

RANZCOG is also an active educator in locally run training workshops in the Pacific. For example, during 2012–14, approximately 330 reproductive health workers participated in the RANZCOG Intrapartum Care workshops held in Fiji, Tonga, Vanuatu and Kiribati. This activity was funded by the DFAT Pacific Islands Project.

Currently there are RANZCOG Associate Members in the following Pacific Island Countries.

American Samoa	2
Cook Islands	1
Fiji	15
Federated States of Micronesia	1
Kiribati	1
Palau	1
Papua New Guinea	18
Samoa	2
Solomon Islands	4
Tonga	3
Vanuatu	3

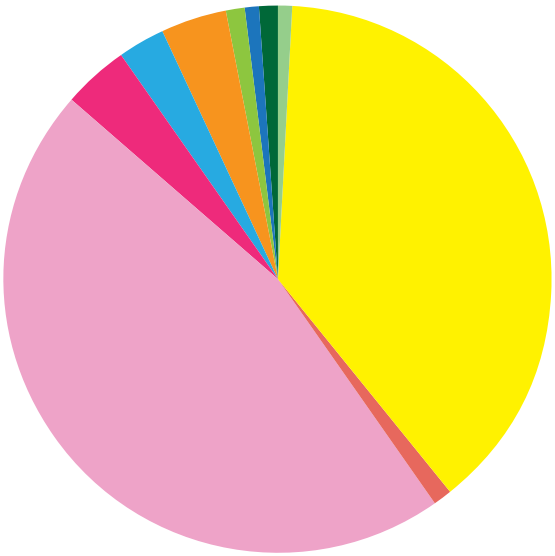
Educational Support for the O&G Specialist Workforce in the Pacific

A large part of RANZCOG's work in the region has been providing educational advice, curriculum support and educators to assist the academic and teaching staff at the training institutions and medical schools of the Pacific.

RANZCOG provides educational resources to doctors in training, and provides medical schools with guidelines and educational assistance in delivering a training program that will produce a motivated and innovative women's health workforce.

Many Australian and New Zealand RANZCOG Fellows provide support through education, research, mentoring, teaching and guidance on a voluntary basis.

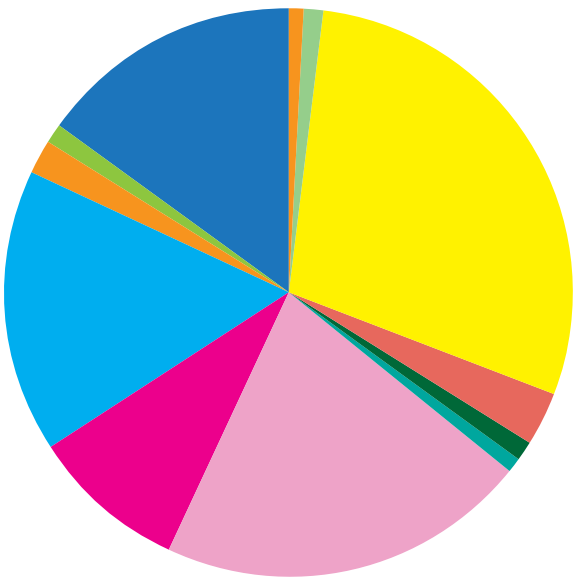
As well, various consultancy programs funded by the New Zealand Ministry of Foreign Affairs and Trade (MFAT), are conducted in Kiribati, Fiji, Samoa, Tonga, Niue, Tuvalu, Vanuatu and Samoa. Similar services are funded by the Australian Department of Foreign Affairs and Trade (DFAT) and administered by the Royal Australasian College of Surgeons under the Pacific Islands Project.



- Timor Leste 1
- American Samoa 3
- Vanuatu 1
- Papua New Guinea 48
- Samoa 2
- Kiribati 1
- Tonga 4
- Fiji 40
- Solomon Islands 3
- Cook Islands 1

Total: 105

Number of Training Scholarships for doctors to attend regional and international training workshops, attachments and meetings.



- Vanuatu 15
- Palau 1
- Tuvalu 1
- Nauru 1
- Tonga 2
- Kiribati 3
- Solomon Islands 16
- Fiji 29
- Samoa 9
- Micronesia 1
- Papua New Guinea 21
- Cook Islands 1

Total: 100

Number of senior Pacific midwives undertaking a BSF or PMFLP Midwifery Fellowship (to Dec 2017).

Where to now for RANZCOG?

RANZCOG is committed to increasing our engagement, advocacy and practical support to empower the reproductive health workforce in neighbouring Pacific countries.

The key activities will include:

- Advocacy at a national, regional and international level, for Pacific health workforce development and health system strengthening, to enable health care professionals to work in an environment that supports quality and safe services.
- Provision of training and education to professionals working in sexual and reproductive health through access to RANZCOG educational resources, in-country training and professional exchanges.
- Developing partnerships with national Departments of Health, Ministries of Health and other relevant organisations in the Pacific countries, to collaborate in offering support and expertise.
- Providing research and audit training.
- Increasing awareness of the importance of investment in family planning.

Appendix A: Country Snapshots

A country snapshot has been included for some of the countries where RANZCOG provides assistance: Papua New Guinea, Fiji, Solomon Islands, Vanuatu, Kiribati, Tonga, Samoa and Federated States of Micronesia.

A number of other island countries and territories located in Oceania have specific challenges relating to their geography and size and a list of these countries and territories is as follows:

- American Samoa (US Territory, pop 55,599)
- Cook Islands (island country, pop 21,000)
- French-Polynesia (overseas country attached to France, pop 280,208)
- Guam (US Island territory, pop 162,896)
- Marshall Islands (country in Oceania, pop 53,066)
- Nauru (country in Oceania, pop 13,049)
- New Caledonia (French territory, pop 278,000)
- Northern Mariana Islands (US territory, pop 55,023)
- Niue (island country, pop 1,612)
- Palau (country in Oceania pop 21,503)
- Tokelau (territory of NZ, pop 1,411)
- Tuvalu (country in Oceania, pop 11,097)

Federated States of Micronesia

The Federated States of Micronesia is an island nation with a culturally diverse and geographically dispersed population and a developing economy. It comprises the States of Chuuk, Kosrae, Pohnpei, and Yap. From Yap in the West to Kosrae in the East, the FSM consists of 607 islands (of which 71 are uninhabited) spread over 2,500,000 square kilometres of the Northern West Pacific. The total land area is about 270 square kilometres. The annual population growth rate for the FSM was recorded as -0.4% over the 2000-2010 period.

Challenges in the provision of health care include geographically dispersed communities, especially the outer islands that are only accessible by boat, competing government priorities, declining funding support, lack of skilled or trained human resources for health and inequitable expenditure on NCD complications and off-island referrals at the expense of funding for preventative and primary health care services. Cultural barriers remain strong and continue to prevent women from accessing appropriate health care – even more so when the only available health care provider is male.

POPULATION
104,460

POPULATION FEMALE
48.8%
(% OF TOTAL)

MATERNAL MORTALITY RATE
100
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
8.8
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<15%

WOMEN'S HEALTH SPECIALISTS
2

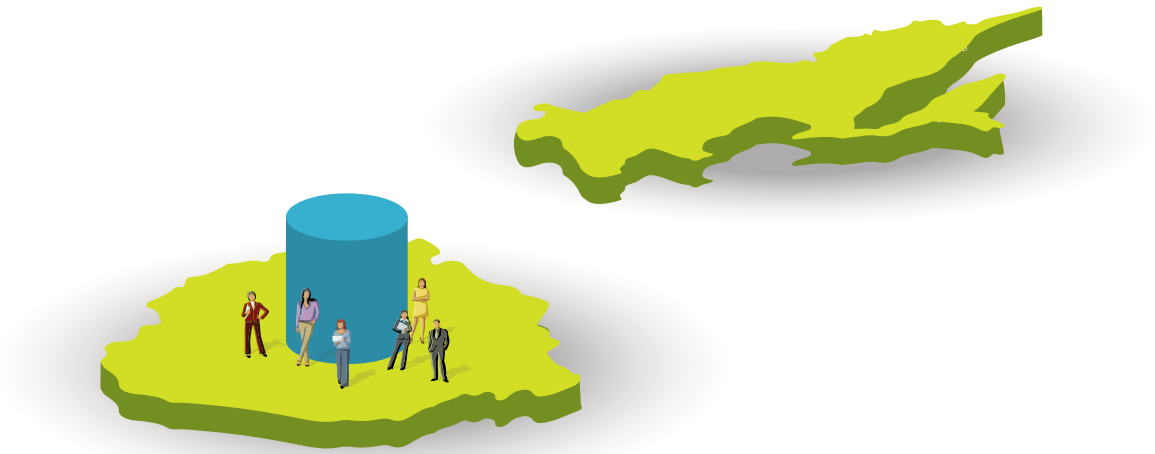
WOMEN REPRESENTATIVES IN PARLIAMENT
<5%

CERVICAL CANCER MORTALITY
UNKNOWN
(PER 100,000 PERSON YEARS (ASR))

Fiji

The Republic of Fiji is an archipelago of more than 300 islands, of which about 110 are inhabited permanently. Of the population of almost 900,000, almost 90 % live on the main islands of Viti Levu and Vanua Levu. The islands are mountainous and covered in rainforest, imposing geographical challenges. However, Fiji has the most urbanised population of all Pacific Island Nations.

Fiji is fortunate to have equitable access to health care with an extensive network of services based on a primary health care concept; Fijians in general enjoy a good standard of health. Almost all Fijian women deliver in a health facility and have care provided by a skilled birth attendant – almost all women receive antenatal care. The current maternal mortality rate is less than 30 per 100,000 and infant mortality rate less than 15 per 1,000 births. The contraceptive prevalence rate is close to 50%.



POPULATION
892,145

POPULATION FEMALE
49.2%
(% OF TOTAL)

MATERNAL MORTALITY RATE
30
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
9.6
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<20%

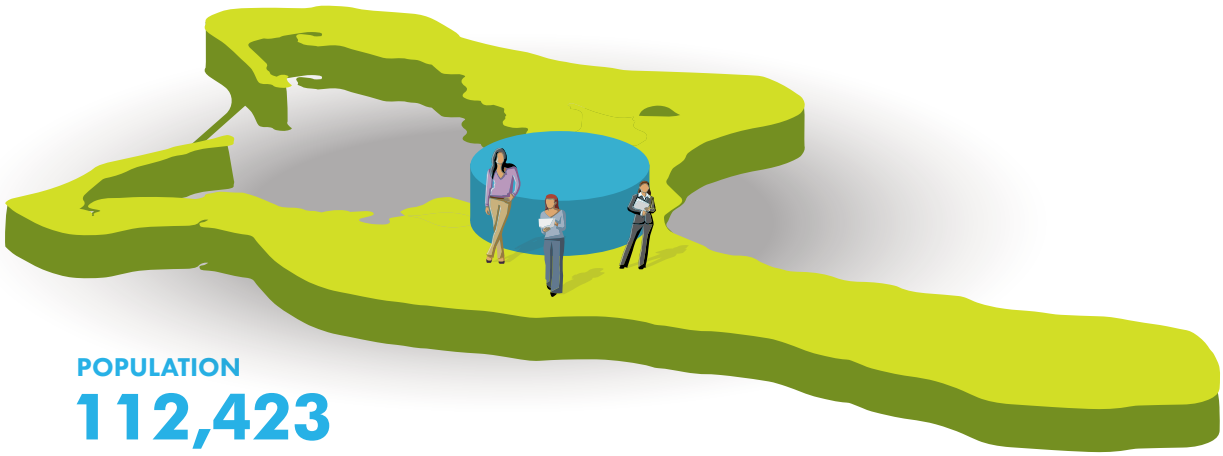
WOMEN'S HEALTH SPECIALISTS
24

WOMEN REPRESENTATIVES IN PARLIAMENT
<20%

CERVICAL CANCER MORTALITY
23.9
(PER 100,000 PERSON YEARS (ASR))

Kiribati

The Republic of Kiribati is an island nation comprising 33 atolls with a total land area of just over 800 square kilometres. Kiribati has three main island groups: the Gilbert Islands, Line Islands, and Phoenix Islands. The vast majority of habitable land is a mere two metres above sea level. Of the three major hospitals, the largest – Tungaru Central Hospital – serves the 50 000 inhabitants of South Tarawa, home to almost half of the total population of just over 100 000. There is a critical shortage of obstetrician gynaecologists, and severe restraints on access to even basic equipment: training is an ongoing issue.



POPULATION
112,423

POPULATION FEMALE
50.7%
(% OF TOTAL)

MATERNAL MORTALITY RATE
90
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
23.7
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<15%

WOMEN'S HEALTH SPECIALISTS
1

WOMEN REPRESENTATIVES IN PARLIAMENT
<10%

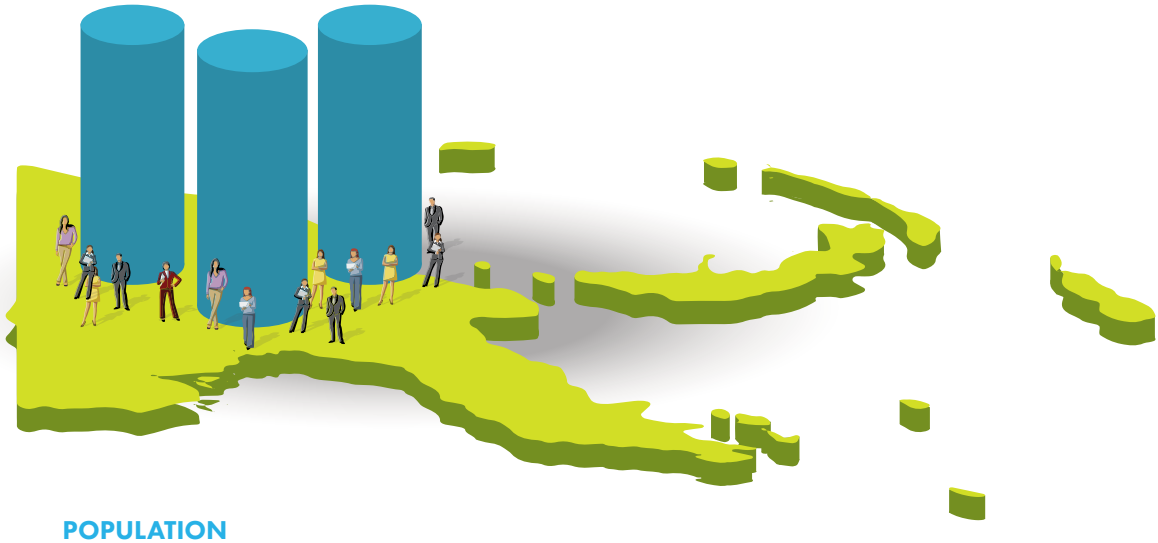
CERVICAL CANCER MORTALITY
UNKNOWN
(PER 100,000 PERSON YEARS (ASR))

Papua New Guinea

The population of PNG is difficult to estimate with certainty, but likely is very close to 10 million making it larger than all other Pacific Island Nations combined. With a land area of close to half-a-million square kilometres, the geography of PNG is diverse: much of the main island is rugged and mountainous, but with thousands of islands as well. This geography has a major impact on health services since 90% of PNG's population live in areas with limited road and sea access – especially during the monsoon and hurricane seasons.

Violence against women and gender inequality have a major impact on women's lives and health. Cervical cancer is common since there is no national cervical screening program, and very limited access to radiotherapy services. Reducing family size by choice has significant implications on both women's health and the PNG economy as a whole – yet there is a high level of unmet need.

Training and retraining the health workforce required to serve such a large country presents enormous challenges. The numbers of doctors, nurses, midwives, and health workers is constrained and sustainable long-term strategies must focus on capacity-building in this area.



POPULATION
7,619,321

POPULATION FEMALE
49%
(% OF TOTAL)

MATERNAL MORTALITY RATE
215
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
24.5
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<10%

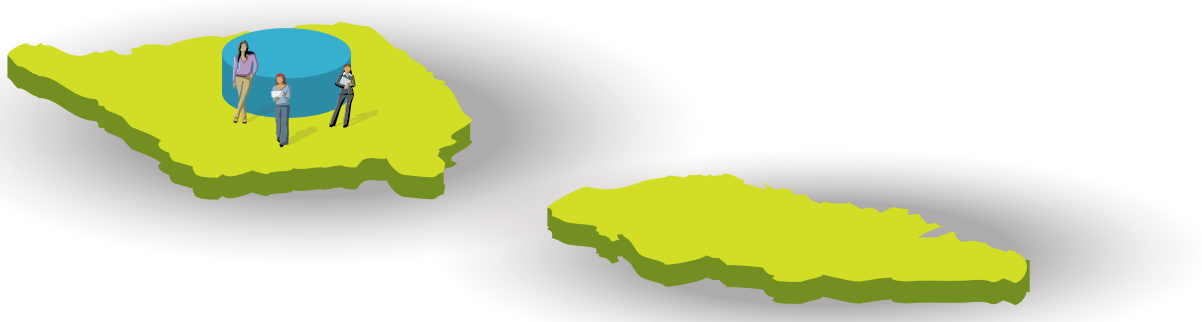
WOMEN'S HEALTH SPECIALISTS
48

WOMEN REPRESENTATIVES IN PARLIAMENT
<5%

CERVICAL CANCER MORTALITY
21.7
(PER 100,000 PERSON YEARS (ASR))

Samoa

Samoa has two main islands – Upolu and Savai'l – on which three-quarters of the nearly-200 000 population live. The capital of Apia is on Upolu, and is home to Samoa's main hospital, the Tupua Tamasese Meaole (TTM) Hospital, a 200-bed facility which serves also as the headquarters for the Ministry of Health. The maternal mortality rate currently sits at about 46 per 100 000, and approximately between 80 and 90 percent of births are managed by a skilled attendant. However, the contraceptive prevalence rate is probably less than 20% with an adolescent birth rate of more than 25 per thousand women. The unmet need for contraception might be as high as 50%.



POPULATION
193,228

POPULATION FEMALE
48.4%
(% OF TOTAL)

MATERNAL MORTALITY RATE
51
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
9.5
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<10%

WOMEN'S HEALTH SPECIALISTS
4

WOMEN REPRESENTATIVES IN PARLIAMENT
<10%

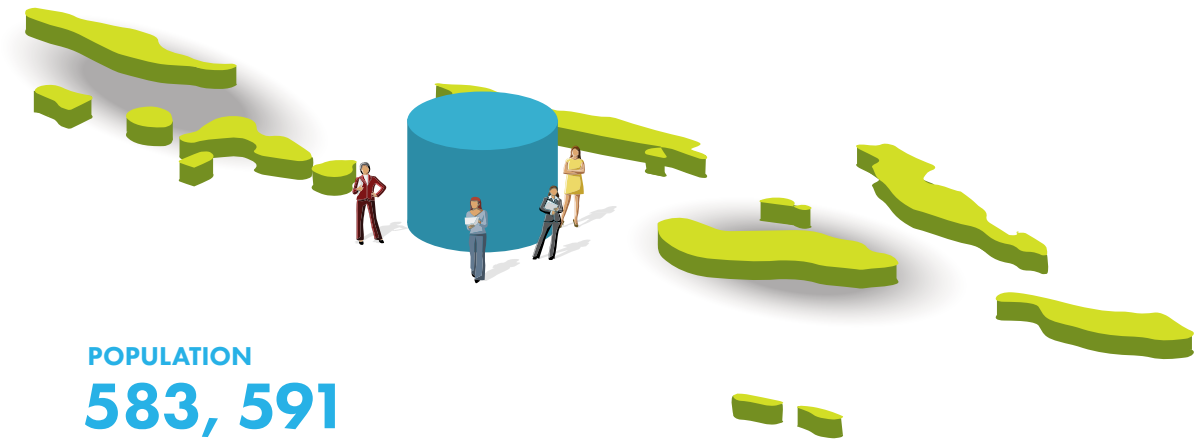
CERVICAL CANCER MORTALITY
6.9
(PER 100,000 PERSON YEARS (ASR))

Solomon Islands

The third-largest country in the Pacific, the Solomon Islands' archipelago extends for almost 1500 kilometres and consists of more than 900 islands. The population is approximately 600 000 and there is a large number of women of reproductive age.

The Solomon Islands face a critical shortage of all health care workers. Although the rate of skilled birth attendance is high, maternal mortality rates also are high at approximately 114/100000 births. Similarly, infant mortality is about 24 per 1000 births nationally. Key challenges faced by reproductive health care workers include high rates of adolescent pregnancy and birth, minimal access to antenatal care, and a high rate of unmet need for contraception.

The only referral hospital for tertiary care in the Solomon Islands is the National Referral Hospital in the capital Honiara, on the main island of Guadalcanal. About three-quarters of all admissions to the hospital are through the obstetrics and gynaecology department – there are almost 6000 births each year. Despite this workload, the department has only three specialists and two registrars.



POPULATION
583, 591

POPULATION FEMALE
49.2%
(% OF TOTAL)

MATERNAL MORTALITY RATE
114
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
12.2
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<10%

WOMEN'S HEALTH SPECIALISTS
5

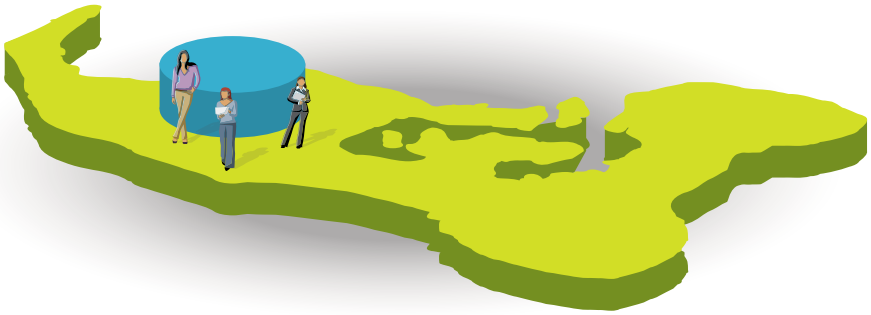
WOMEN REPRESENTATIVES IN PARLIAMENT
<5%

CERVICAL CANCER MORTALITY
17.9
(PER 100,000 PERSON YEARS (ASR))

Tonga

The Kingdom of Tonga is a chain of 175 islands, of which 36 are inhabited permanently. More than three-quarters of Tonga's 110 000 population live on the main island of Tongatapu. Almost all births are now attended by a skilled health attendant, and maternal mortality rates have recently fallen to less than 76 per 100 000.

The contraceptive prevalence rate is only about 25%, however, and adolescent birth rate close to 20 per 1000 women. Obesity, diabetes, and associated cardiovascular non-communicable diseases are highly prevalent. As many as one woman in seven tests positive for chlamydia in pregnancy.



POPULATION
106,170

POPULATION FEMALE
49.9%
(% OF TOTAL)

MATERNAL MORTALITY RATE
124
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
6.9
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<20%

WOMEN'S HEALTH SPECIALISTS
4

WOMEN REPRESENTATIVES IN PARLIAMENT
<5%

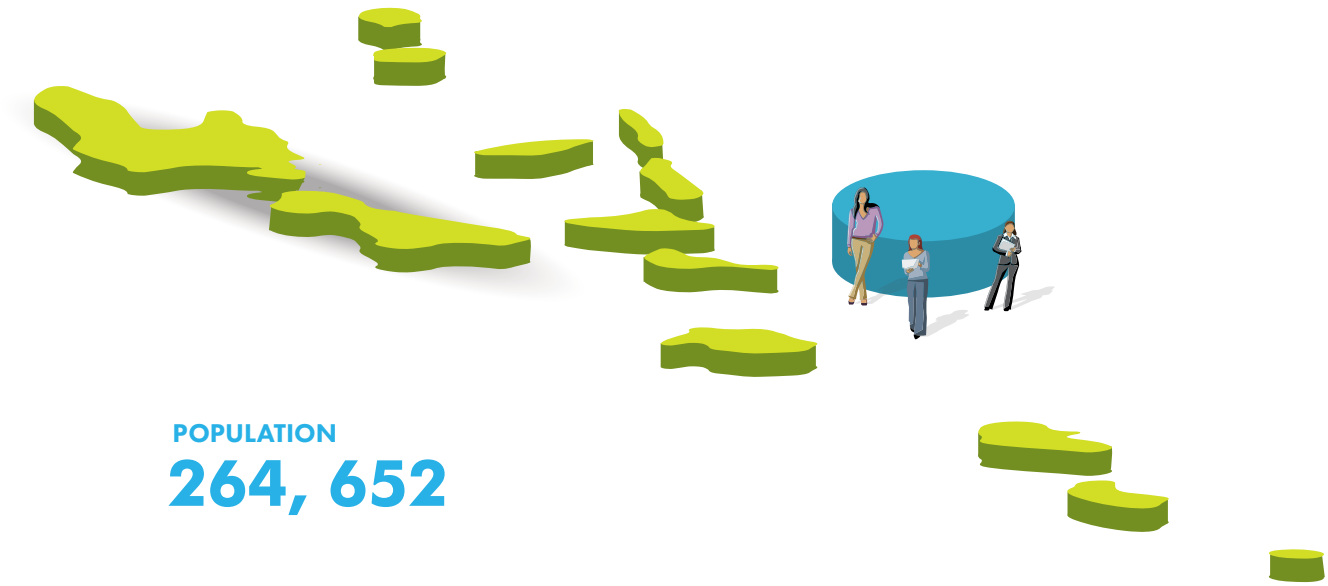
CERVICAL CANCER MORTALITY
UNKNOWN
(PER 100,000 PERSON YEARS (ASR))

Vanuatu

The Republic of Vanuatu is a group of more than 80 islands, most of which are inhabited permanently. The total population is approaching 300 000, with three-quarters of ni-Vanuatu living in rural areas dependent on subsistence farming. There are more than 140 000 women in the reproductive age group. The ratio of obstetricians to women is about one to 35 000.

Levels of skilled birth attendance are high, at about 90%, and although maternal mortality rates are declining (down from 225 per 100 000 in 1990 to 78 in 2015) the MDG standard remains elusive. The contraceptive prevalence rate is almost 50% and unmet family planning is less than 25%.

Key issues facing the women of Vanuatu are pressures on the national budget, natural disasters, a thinly-stretched health workforce, and sustainable referral networks. Reproductive health workers are challenged by training needs, difficulties with infrastructure and equipment, and medical and family planning supplies. The harsh geography places a massive strain on referral and transfer chains.



POPULATION
264, 652

POPULATION FEMALE
49.3%
(% OF TOTAL)

MATERNAL MORTALITY RATE
78
(2015)
(MODELLED ESTIMATE, PER 100,000 LIVE BIRTHS)

NEONATAL MORTALITY RATE
11.6
(2015)
(PER 1000 LIVE BIRTHS)

CAESAREAN SECTION RATE
<15%

WOMEN'S HEALTH SPECIALISTS
4

WOMEN REPRESENTATIVES IN PARLIAMENT
<5%

CERVICAL CANCER MORTALITY
9.8
(PER 100,000 PERSON YEARS (ASR))

Appendix B: Partnerships – working together

Department of Foreign Affairs and Trade, Australia	• Australia Awards program supports the RANZCOG Pacific Midwifery Leadership Fellowship Program 2010-2018 • The AusAID International Seminars Support Scheme supported attendance of doctors and midwives at PSRH meetings, 1995-2007 • RANZCOG is an active member of the DFAT Pacific Islands Project for 20 years, providing surgical and mentoring support visits, and a series of training workshops in-country between 2012-2014 • RANZCOG assists the DFAT Australia Timor-Leste Program of Assistance for Secondary Services
Medical Colleges in Australia and New Zealand, particularly the Royal Australasian College of Surgeons	RANZCOG is a member of the inter-College Committee on Global Health and contributes to the RACS-led Pacific Islands Project
O&G Colleges internationally	Collaboration on global health matters with ACOG and RCOG
Australian Society for Colposcopy & Cervical Pathology	From time to time opportunities for scholarships are offered by Special O&G interest groups. ASCCP has been a long time supporter of colposcopy training in the Pacific, providing support for workshops and teachers
Pacific Society for Reproductive Health (PSRH)	RANZCOG, in conjunction with senior Pacific O&G Specialists, established the Pacific Society for Reproductive Health, housed at RANZCOG from 1991 to 1999 when the secretariat moved to Fiji, and later to New Zealand. RANZCOG continues to provide core funding annually to sustain the PSRH secretariat, as well as expert guidance and professional assistance from time to time on request.
International Federation of Gynaecology and Obstetrics (FIGO)	RANZCOG is an active a member of FIGO. We have representation on the Board of FIGO and have contributed to various subcommittees and international guideline development.
Asia Oceania Federation of Obstetrics and Gynaecology (AOFOG)	RANZCOG is an active member of AOFOG. RANZCOG Fellows have held the Presidency of AOFOG in 1981–83 (Prof P Elliott) and 1991–93 (Prof G Bishop). We have provided input to the Council meetings, Executive meetings and subcommittees. RANZCOG hosted the VIII Asia & Oceania Congress of Obstetrics & Gynaecology in Melbourne in 1981 and the XXI Asia & Oceania Congress of O&G in Auckland in 2009. RANZCOG provides a funding contribution to the AOFOG Young Gynaecologists Award (YGA) program to support young gynaecologists from developing countries attending the biennial Congress, and also supports two of our own young gynaecologists to attend the YGA program and join the network of Asia Oceania YGAs.
Papua New Guinea O&G Society	RANZCOG provides speakers to the annual symposium of the PNG O&G Society. RANZCOG works collaboratively with the Society on opportunities for CPD for Associate Members and engagement with Associate Members in PNG.
Fiji O&G Society (FOGS)	RANZCOG provides speakers to the annual symposium of the Fiji O&G Society. Working collaboratively on opportunities for CPD for Associate Members, and engagement with Associate Members in Fiji.

National Dept of Health PNG and Ministries of Health in the PICs	• RANZCOG works collaboratively with the National Dept of Health PNG and Ministries of Health in all the PICs, to provide Fellowships for senior midwives to attend the RANZCOG Pacific Midwifery Leadership Fellowship Program annually. • RANZCOG liaises with the National Dept of Health PNG and Ministries of Health in the PICs regarding support for their O&G specialists through the RANZCOG CPD Program, with the view to offering the CPD Program as a pathway to continuing certification of O&G specialists.
University of PNG School of Medicine and Health Sciences	**Collaboration with the UPNG SMHS for 20 years to provide:** • Lecturers and facilitators for O&G postgraduate courses • Research mentors • Locums and advertisement of academic positions within the SMHS • Curriculum development • Assistance with educational tools for use by the academic department • Academic Fellowships to enhance the skills and knowledge of young O&G academics • Provision of online learning resources to the O&G trainees • Provision of 3 scholarships per year to O&G trainees within the SMHS
Fiji National University College of Medicine, Nursing and Health Sciences (formerly Fiji School of Medicine)	**Collaboration with the Fiji National University CMNHS for 20 years to provide:** • Lecturers and facilitators for O&G postgraduate courses • Research mentors • Locums and advertisement of academic positions within the CMNHS • Curriculum development • Assistance with educational tools for use by the academic department • Academic Fellowships to enhance the skills and knowledge of young O&G academics • Provision of online learning resources to the O&G trainees • Provision of 3 scholarships per year to O&G trainees within the CMNHS
Australian and New Zealand Hospitals	RANZCOG has agreements with the following hospitals to host the Pacific Midwifery Leadership Fellowship Program • Liverpool Hospital, Sydney, Australia • Nepean Hospital, Sydney, Australia • Middlemore Hospital, Auckland New Zealand
Australian Volunteers International (AVI)	RANZCOG assists AVI with advertisement of places for volunteers, as part of Australian Volunteers for International Development (AVID). This includes agreement to support the Solomon Island Graduate Intern Support Project (SIGISP) and provision of an O&G advisor to the project committee.
Family Planning NSW + Family Planning Australia	FPNSW has been an active contributor to the Midwifery Leadership Fellowship program in Sydney, by providing workshop facilitators and resources for program participants.
Send Hope Not Flowers	**RANZCOG and Send Hope Not Flowers have engaged in joint programs as follows:** • Maternal Health Project at Port Moresby General Hospital, 2014. • Fundraising support for Vila Central Hospital following Cyclone Pam in 2015
Soroptimists International South West Pacific (SISWP)	RANZCOG engaged with SISWP on its Birthing in the Pacific project in 2014.

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Statistics and other country data were compiled from World Bank, CIA World Factbook and World Health Organisation websites.

RANZCOG Global Health Committee

Chair: Professor Steve Robson, RANZCOG President
Dr Amanda Noovao Hill, Dr Karaponi Okesene-Gafa, A/Prof Kirsten Black, Dr Nicola Fitzgerald, Dr Rebecca Mitchell, Dr Sharron Bolitho, Dr John Tait, Dr Martin Sowter, Dr Roy Watson, Dr Rufina Latu, Ms Alana Killen, RANZCOG CEO.

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