Adolescent Health Development Project Review

April – May 2007

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# List of Abbreviations and Acronyms

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<thead>
<tr>
<th>Abbreviation and Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>Acquired Immune Deficiency Syndrome</td>
<td>AIDS</td>
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<tr>
<td>Adolescent Health and Development</td>
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<td>Adolescent Reproductive Health</td>
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<td>Adolescent Sexual and Reproductive Health</td>
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<td>Australian Agency for International Development</td>
<td>AusAID</td>
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<td>Behaviour Change Communication</td>
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<td>Colonial War Memorial Hospital</td>
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<td>Community Based Life Skills</td>
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<td>Curriculum Development Unit</td>
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<td>Harmonized Approach to Cash Transfers</td>
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<td>Human Immunodeficiency Virus</td>
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<td>Integrated Management of Childhood Illnesses</td>
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<td>Maternal and Child Health</td>
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<td>Nurse Practitioner</td>
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<td>Pacific Island Country</td>
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<td>Pacific Regional Initiatives for the Delivery of Basic Education</td>
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<td>Pohnpei Island Central School</td>
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<td>Term</td>
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<tr>
<td>Prevention of Maternal to Child Transmission</td>
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<td>Primary Health Care</td>
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<td>Sexual and Reproductive Health</td>
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<td>Sexually Transmitted Infection</td>
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<td>Solomon Islands</td>
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<td>Solomon Islands Broadcasting Corporation</td>
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<td>United Nations</td>
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<td>University of the Pacific</td>
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<td>World Health Organisation</td>
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<td>Youth Friendly Services</td>
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Executive Summary

This report presents the results of a review of ‘Improving Adolescent Health and Development in the Pacific Region’ a joint project among the Secretariat of the Pacific Community (SPC), UNFPA and UNICEF. The review was undertaken to evaluate the achievements of the project, examine strengths and weaknesses and propose changes. It also aimed to assess the level of integration achieved between the Adolescent Reproductive Health (ARH) and Pacific Stars Life Skills (PSLS) components and make recommendations to increase the synergy and sustainability of the joint AHD project.

The review used a combination of methodologies, including interviews with key regional staff from the three partner agencies and, in the four countries visited, with in-country staff, local project partners, government officials, and young people; some group discussions and telephone interviews; and document review. A number of youth centres and clinics were visited, and some education sessions were observed.

Summary of Major Findings and Conclusions

Major Achievements

Overall, the AHD project has achieved some level of success against many of its set outputs as described in the log frame. Ongoing challenges common to developing small island states, such as the lack of staffing and infrastructure, have been encountered and will continue to be challenges in the future though some can be addressed in part through adequate resource allocation for key project related needs.

Strengthening Project Management and Delivery

Management Structure and Staffing

The size, diversity, ambition and geographic reach and spread of the current project is too great for the current level of staff to be able to manage well. The staff are dedicated and work very hard, but it is not humanly possible for them to meet the programmatic needs.

Insufficient in-country capacity in the competence areas required by the project is a major impediment to the depth and quality of implementation and to long-term sustainability.

Programmatic Priorities, Project Objectives and Outputs

The AHD project objectives and components are well chosen and are in sync with international and regional policy and planning briefs and frameworks.

Budget

In 2005-2006, funding support to the project was been roughly shared between UNICEF and UNFPA, whereas SPC’s support was limited to ‘in kind’ institutional support costs. In 2007, SPC began providing direct funding as well. Most funding is allocated to education and management; funding for the Youth Services component is considerably smaller.
Cross-Cutting Programme Issues

Programme Design, Strategy and Planning

The lack of detailed strategic planning which lays out how the project intends to achieve the set objectives over time has resulted in project activities which tend to be scattered and ad hoc rather than directed and cohesive. The project has tried out a large variety of modalities for providing youth with education and services in the Pacific; however, it is unclear whether the quality, depth and intensity of these interventions are sufficient to have the intended impact.

Technical Assistance and Capacity Building

Capacity building has been largely equated with training, and the trainings have generally been too short. Relying primarily on short trainings to build capacity and using some trainers with limited experience and expertise contributes to relatively low capacity among those trained, which in turn puts the quality and effectiveness of subsequent activities in jeopardy.

Standards for assessing trainees are lacking. Attendance at a training is equated with a participant having mastered the knowledge and skills taught.

Level of Integration

Integration has been minimal to date. At the international agency level, the agencies have not been working together as equal partners on all aspects of the project. The division in the management of the life skills (LS) component has contributed to the maintenance of separate life skills training; human, financial and material resources; and activities; hence the benefits that the merger was originally intended to produce have yet to materialised.

Despite the difficulties of the merging experience to date, UNFPA, UNICEF and SPC staff, in-country Coordinators, and project implementers have to a large extent expressed a desire for the project to fully integrate all components.

Record Keeping

Record keeping was highly varied. While fairly good records are kept at the implementation level in most project countries, with the exception of the life skills component, records were not collated by month, year and/or project cycle in most countries or at the regional level.

Monitoring

Numerous monitoring mechanisms are used by the project at different levels. In country, due to lack of time, Coordinators often monitor only remotely or not at all.
Research, Assessment & Evaluation

The lack of research about AHD issues has meant that most project activities have been planned and implemented without an evidence-based understanding of the problems they are trying to address.

A critical gap in the project design is the lack of baseline research, on-going assessment and impact evaluation. Before considering any expansion at this point in the AHD project, it is critical to assess the actual impact on the end beneficiary of the different approaches and modalities tried in the project.

Strengthened Life Skills Based Adolescent Sexual and Reproductive Health Information and Education:

Family Life Education

Working with Curriculum Development Units in the Ministry of Education to develop official curricula on adolescent sexual and reproductive health (ASRH) or FLE, while complex and lengthy, is the strategy which will ultimately achieve the greatest reach and sustainability. To develop a strategy for FLE programming in the region, more knowledge is needed about the current status of FLE or ASRH topics in official curricula across the region.

The hiring of an FLE Coordinator in mid-2006 to support and coordinate the process of curriculum development and implementation in Fiji has enabled progress to be made in the revision of the syllabus for Forms 1-4 and the development of support materials.

Pacific Stars Life Skills

Tonga was the only country to meet the target of 20% of youths participating in CBLS prior to 2005. Between 2005 and 2006, Tuvalu met this target and Kiribati was able to reach nearly 18% of its young people.

Although UNICEF set a goal of reaching 20% of youth in the Pacific with life skills, there was no link between the size of the youth population in a given country and the number of LS Youth Trainers trained, making the achievement of this goal in countries with larger populations unlikely.

The Life Skills Training of Trainers is too short to develop the needed competence among youth trainers; and the content tends to be “generic” rather than specific and does not reflect the integration of the projects. Participants from too many different potential partners have been involved in the training in some countries making follow up difficult.

Learner needs have not played a significant role in decisions about the design of the life skills community-based education, particularly the 3-day, 15 hour workshop.
The difficulty and length of time it takes for CBLS funds to be obtained from UNICEF remains a major barrier to the implementation of life skills activities on the ground. While waiting, trained youth get jobs, lose their enthusiasm or become lost to follow up and may well forget what they learned in the training.

**AHD Community Education, including Peer Education**

Community based education tends to be delivered in a limited number of ways, typically through workshops of one to five days in length, which are not ideal for learning.

AHD Coordinators and peer educators received some life skills training and most expressed their enthusiasm for adding life skills to their education activities.

Training, mentoring, and support for peer educators are inadequate in many project countries. Peer educators’ capacity and knowledge vary greatly. While most have correct basic knowledge, their knowledge and understanding is not very deep or nuanced.

**Adolescent Health and Development Education (ARH and Life Skills)**

The lack of competent AHD Training of Trainers in country severely limits the possibility of developing solid capacity in AHD including life skills education in countries.

Well-selected NGO partners can contribute significantly to the delivery of the community based education.

Teaching and facilitation skills are not strong. Participatory methods are used intermittently, but education is not yet learner-centred and the experiential learning cycle is usually not fully applied.

Gender and rights are largely missing from the programming, training and materials and hence not adequately addressed in education activities.

**Education Materials and Resources**

The project produced a number of good materials which are in high demand, however, current materials do not sufficiently integrate life skills and AHD issues. The revised life skills training manual gets mixed reviews and still has considerable weaknesses.

The project has not provided many excellent resource materials readily available in English which could enhance the knowledge and work of programme implementers. Some materials provided are not in a user-friendly format.

**Media and Communications**

The cinema-based behaviour change ad campaign on the prevention of teenage pregnancies in Fiji exemplifies how communications activities can be strengthened by audience research, pre-testing, piloting, and impact assessment (i.e., by being research or evidence-based). The UNICEF sponsored radio magazine in the Solomon Islands also serves as an example of audience research and evaluation in communications work.
Strengthened ARH Services

Youth Clinics imbedded in clinics run by NGOs and in-schools were generally the most successful of the modalities tried. Community based youth clinics in particular can be very successful.

Many youth centres and AHD information and counselling rooms are underutilized and lack resources and regularly scheduled activities compelling or interesting for youth.

The integration of YFS into existing health services has been the least successful approach to youth service provision to date. Few youth access these services and anecdotal evidence suggests that those who do are already pregnant or have STI symptoms. Nonetheless, making government health services more youth friendly is vital since it is the only way to achieve widespread sustainable access to services for youth over the long term.

Although criteria for youth friendly services are generally well-known, there are no agreed upon standards for what would officially constitute a YFS globally or in the Pacific.

Insufficient attention has been paid to reducing adolescent pregnancy, including the promotion of family planning and emergency contraception.
List of Recommendations

Strengthening Project Management and Delivery

Management Structure and Staffing
- That the size of the staff and the size of the project be brought in line with each other to improve implementation and reduce work overload. Careful thought needs to be given to prioritising project components in close consultation with countries and partner agencies.
- That priority be given to increasing technical assistance staff, dependent on funding.
- That Assistant AHD Coordinators positions be established at least for large, priority countries, as funding allows.
- That the process for recruiting, handing over, orienting and training new Coordinators be strengthened and in particular, that SPC, UNFPA and UNICEF develop minimum recruitment standards for the AHD coordinator position.

Budget
- That SPC should continue to provide direct funding to support the project implementation.

Cross-cutting Programme Issues

Programme Design, Strategy and Planning
- That assessment and strengthening capacity and project implementation be the primary focus during the next programme cycle rather than expansion and up-scaling.
- That the project undertake strategic planning for the next programme cycle, both regionally (with country consultation) and in country (with technical support). For example, if the project intends to reach 10-20% of youth with quality programmes, the path to reaching this goal and related sub-objectives should be clearly laid out.
- That project implementers in-country identify a limited number of priority interventions, and focus on consolidating, strengthening and assessing them and ensuring the depth, intensity and quality needed to have an impact.
- That strategic plans and work plans be detailed and specific (particularly in terms of how post training follow up and monitoring will be done).

Technical Assistance and Capacity Building
- That the project focus on building stronger, deeper capacity and expertise and the process for developing capacity be revised to enable this. This would include not only more weeks of training for most capacities (not necessarily all at the same time, but also not spread out over a very long period), but also more immediate-term follow up, with coaching including observation and feedback, and where feasible, trainee support groups;
- That the length of training be determined based on a logical assessment of how much is needed for specific content and skill areas and adjusted over time based on the competence level observed during follow up.
- That ‘cascade training’ be used with great caution and that the number of levels between the initial or ‘Trainer of trainers’ and the community youth or end-recipient be limited;
That standards be developed for critical skill areas (i.e. those essential for the success of the project interventions such as education and counselling) and trainees’ knowledge and competence be assessed before they receive certificates.

That a regional certificate course be developed for youth educators in AHD (which should include life skills).

**Level of Integration**

- That all components of the project be fully integrated within an equitable partnership among the three agencies, including fund-raising and/or financial contributions;
- That SPC coordinate and implement all aspects of the project (including CBLS, if it is continued as a separate activity) at the country level.
- That agency conditions and other constraints to full integration as well as options for managing the project in country be openly discussed and addressed at the various levels of the project and a plan be developed for phasing in full integration, which addresses how the constraints will be dealt with.
- That the PMC and PAC decide on components of the project that require direct management and/or implementation by UNFPA or UNICEF.

**Record Keeping**

- That a set of standardized record-keeping requirements and summary templates be developed and tested for the activity, country and regional levels in consultation with in-country and regional staff.
- That training in their use be provided (including how to fill them out and how to use them for planning and assessment).
- That their use be monitored by AHD Coordinators and by regional partners and problems with them noted and addressed.
- That such collated data be included in every project report.

**Monitoring**

- That monitoring of project activities, particularly after training, be given greater importance in the next programme cycle and include observation and constructive feedback and guidance.

**Research, Assessment and Evaluation**

- That an assessment be made of the most critical evidence gaps for the project and efforts made to fill these to the extent possible given available resources.
- That operations research capacity development for AHD Coordinators be continued as well as funding and technical assistance for them to undertake additional operations research projects, particularly those which provide information about the quality and impact of project activities.
- That strategies and modalities used to date be critically assessed in terms of their impact on youth in the general population and their cost-effectiveness and strengthened based on this assessment before any further expansion takes place.
- That a comprehensive monitoring and evaluation framework be developed and impact evaluation be conducted in the next phase of the project, including at least the collection of baseline and endline data.
Strengthened Life Skills Based ASRH Information and Education

**Family Life Education (FLE)**
- That a situation analysis of the current status of sexual and reproductive health (SRH)/FLE education in the curricula and teacher training institutions be undertaken to develop a strategic plan for SRH/FLE development including determining the priority countries for project support.
- That countries be selected for work on SRH/FLE based on the following criteria: the interest and commitment of the Ministry of Education, the status of curriculum development and teacher training development, the dynamism of the staff responsible in the curriculum development unit, the extent to which children and youth attend primary and secondary school, and the general level and capacity of teachers.
- That all project work on FLE cover all three learning domains (cognitive, affective and behavioural); use interactive teaching and learning methods for all content to develop critical thinking skills; enable learners to observe and practise skills over sufficient time for them to be imbedded; integrate a gender perspective into all content and, as far as possible, be rights-based.
- That efforts to integrate life skills and to integrate SRH into curricula be combined.

**Adolescent Health and Development Education (Integrated Life Skills and AHD)**
- That a limited number of strong AHD partners are strategically selected and contracted first; and training provided thereafter, so that community based activities can begin immediately.
- That NGO partnerships be a key implementation modality for community based education activities in particular. NGO partners should be selected in each country based on the strategy and their mission and capacity.
- That a small core group of in-country Trainers of Trainers in AHD education (which fully joins the life skills and AHD components) be developed and maintained, the number of which should be based on an assessment of the in-country needs and the strategic plan, including its objectives, in consultation with partners. These Trainers of Trainers should primarily be based in and employed by the project’s key implementing partners to ensure greater sustainability and not increase or foster dependence on project staff.¹
- That all trainers and educators’ capacity be further developed, particularly their skill in using learner-centred, empowering methodologies, including the experiential learning cycle.
- That the position, titles, training, roles, resources and activities of the CBLS youth trainers and the AHD peer educators be merged and their training and roles and be reconceptualised to be more skilled and longer term with the conditions to enable this. (Note: school-based peer educators are not included in this recommendation.)
- That contracts include funds to pay the salaries of AHD youth educator positions in NGOs and other agencies as needed and efforts be made to keep these youth educators employed as such for at least five years.
- That a greater variety of models for delivering education be explored and promoted and that education programmes be adapted to the learners needs and to particular target audiences (i.e. not “one-size fits all”).
- That activities reinforcing gender stereotyping and roles (such as teaching girls cooking, sewing and flower arranging) not be supported.

¹ Note that it may not make sense to develop Trainers of Trainers in countries with very small populations.
Education and Resource Materials

- That the current life skills manual not be formally published as a ‘final’ document, but that bound photocopies be provided to those who need it.
- That a flexible resource package be developed that merges ARH and life skills; incorporates more on behaviour change, gender, rights and empowerment; and includes greater variety of lesson plans and resources, such as reference material.
- That high quality existing resources (e.g. manuals, reference books, curricula) from around the world be procured and provided appropriately to all key educators or education partners and curriculum developers for adaptation and reference.

Youth Media and Communications

- That the processes used in the Fiji cinema ad campaign and the Solomon Islands radio magazine programme be used as a model for strengthening existing media work and applied, with appropriate technical assistance, particularly to on-going, long-term media programmes.

Strengthened ARH Services

- That the reasons for the low usage of youth centres be systematically assessed before solutions are tried out; and solutions which are applied have a clear value to youth in terms of their development and health.
- That the provision of project funds to support school-based clinics be well-justified, limited to schools which met specific requirements (listed in the main report), and generally limited to non-recurring costs.
- That the project establish a minimum set of services as a requirement for support, which must include RH services (at least the provision of contraceptive methods appropriate for adolescents, including condoms).
- That a thorough assessment be done of the needs and problems in developing YFS from the perspectives of the management and administrative staff of the MOH and health facilities, the direct service providers, and the youth.
- That a Youth Friendly Service Initiative and Package be developed and tested, which would designate services as ‘youth friendly’ if they verifiably met established criteria.
Introduction

This report presents the results of a review of ‘Improving Adolescent Health and Development in the Pacific Region,’ a joint project among the Secretariat of the Pacific Community (SPC), UNFPA and UNICEF. The review was undertaken to evaluate the achievements of the project, examine strengths and weaknesses and propose changes. It also aimed to assess the level of integration achieved between the Adolescent Reproductive Health (ARH) and Pacific Stars Life Skills (PALS) components and make recommendations to increase the synergy and sustainability of the joint Adolescent Health and Development (AHD) project.

Given the complexity and regional nature of this project, which covers many countries and circumstances, many different and changing implementers, implementation modalities and activities, it has not been possible for this review to examine every aspect of all of the different elements or even to visit all the countries. We have done our best to familiarize ourselves with the project and its nuances and to identify issues which seem both relatively common and important, recognising that in most instances there are exceptions. We have had to generalize and thus wish to emphasize that not every issue raised applies to every country, activity or person involved.

Where quotes are used, they represent the words of one interviewee and are indicated as such. They have been included only when they reflect opinions expressed by others as well and with which the reviewers concur.

Methodology

The review used a combination of methodologies. Four of the fourteen project countries – Fiji, Kiribati, Solomon Islands, Tonga – were visited and looked at in more depth; another six countries were reviewed through documents and telephone interviews with the Adolescent Health and Development Coordinator (Cook Islands, Federated States of Micronesia (FSM), the Marshall Islands, Samoa, Tuvalu, Vanuatu); and one country, Nauru, was reviewed through a telephone interview with a life skills (LS) youth trainer. The other three countries, Tokelau, Niue, Palau were not reviewed since project activities there have been very limited.

Interviews were also conducted with key regional staff from the three partner agencies and, in the four countries visited during the review, with in-country staff, local project partners, government officials, particularly from Ministries of Health, Education and Youth, and young people, particularly those trained as peer educators or youth trainers in the project. In a few cases, group discussions were held rather than individual interviews. In addition, a number of youth centres and clinics, both for youth specifically and for the general public were visited; and some education sessions were observed. Interviews and observations were supplemented with an extensive review of documents (see Annex G for a list of documents consulted).

Background, Aims and Strategies of the Project

The AHD Project, a multi-country programme in the Pacific region, aims to promote the health and development of Pacific youth by providing information, education, life skills
training, and services to meet adolescents’ needs. It emphasises responsible behaviour and practices to prevent teen pregnancy, sexually transmitted infections (STIs), including HIV and AIDS, as well as other related youth health issues.

Prior to the initiation of the joint project in 2005, UNFPA had supported a regional Adolescent Reproductive Health (ARH) project from 2001 in collaboration with SPC and nine Pacific Island countries. This project was the region’s response to the 1994 International Conference on Population and Development (ICPD) Plan of Action to address sexual and reproductive health needs of adolescents. Using extensive partnerships, the project created an enabling environment and increased support for the implementation of ARH activities; increased awareness, information and education among young people and influential groups; and explored a variety of approaches to providing accessible ARH services. The project worked with stakeholders and communities and involved both government and non-governmental organisations (NGOs). This multi-sectoral approach helped to increase community receptiveness and support for adolescent reproductive health work in the region.

In 2002, UNICEF Pacific initiated the Pacific Stars Life Skills (PSLS) project to improve adolescent health and development through informed decision-making and positive self-esteem. The project focused on building the skills young people need to manage their health, with a primary focus on mitigating the impact of HIV and AIDS on young people. Designed as a community-based project, the PSLS’ goal was to reach 20% of youth in the region. Between 2002 and 2004, UNICEF conducted life skills training of trainer workshops in eight countries to enable selected young people to facilitate community-based life skills workshops. An evaluation of the PSLS project in 2004 recommended revisiting the training component and integrating the project with the UNFPA-SPC ARH project.

In 2005, UNICEF approached the ARH project about possible integration. Realising that their separate project activities focused on the same target groups and shared the same essential long terms goals, the three agencies decided to combine their efforts through the implementation of the current joint project on adolescent health and development. This merger also intended to enable the agencies to maximize the impact of limited financial and human resources. A joint project document was signed by the agencies later that year.

The joint AHD project has three key strategies: 1) strengthening adolescent health information through life skills based education; 2) expanding youth-friendly services; and 3) strengthening project management and delivery.

**Structure of the Report**

Following a short introductory presentation of some of the major achievements of the project, the report is structured to a large extent around the three core components of the project. The first section focuses first on project management and delivery at the regional and country levels. It reviews and discusses: the management structure and staffing; programmatic priorities, project objectives and outputs; and the budget.

The second section considers “cross-cutting” programme implementation issues, that is, issues which affect more than one or all programme areas. These include: programme
design, strategy and planning; technical assistance and capacity building; the level of integration; record keeping; monitoring; and research, assessment and evaluation.

The third section reports on the life skills based adolescent sexual and reproductive health (ASRH) information and education component of the project. It covers: family life education; Pacific Stars life skills; and AHD community education, including peer education; parent-child education and communication; education and resource materials; and youth media and communications.

The fourth section addresses the ARH services component of the project, including: youth centres; youth clinics; school based clinics; youth services integrated into existing health services; services for adolescent mothers; and general issues related to youth friendly services.

The report concludes with a short section on gaps and a list of lessons learned. The recommendations are dispersed throughout the report in the sections to which they relate. A complete list of all the recommendations is found at the end of the executive summary. Reports on the countries visited during the review are found in Annexes B, C, D, and E.

**Findings and Conclusions**

**Major Achievements**

Overall, the AHD project has achieved some level of success against many of its set outputs as described in the log frame. Considering the objectively verifiable indicators, for example, the number of communities covered with outreach programs by peer educators; the number of life skills trainings of trainers (TOTs) conducted; the number of ASRH integration workshops conducted for service providers to name a few, it is clear that some progress is being made, even though not all can be quantified easily. We note that this is not the case for all outputs and some were not pursued for various reasons and that meeting an output is not equivalent to demonstrating impact.

Ongoing challenges common to developing small island states have been encountered and will continue to be challenges in the future. These ongoing challenges include: the insufficient or lack of staffing or personnel; the lack of positions in government structures; limited funding allocations for health programmes including AHD; and limited or lack of infrastructure for service expansion. Some of these challenges are long term in nature and beyond the capacity, capability or scope of the AHD project to address by itself, but the project can meet some of these in part by ensuring that adequate resources are allocated for staffing and clinic infrastructure support (equipment, refurbishment, etc.).

Major Achievements of the project include:

- The AHD Project is leading the way in collaborative programming in the Pacific.
- Project implementation in Tonga demonstrates how UN agencies and Governments can work together effectively with NGOs, including having an NGO in the lead role, providing governments with alternatives for project implementation.
The project has generated greater general acceptance and government recognition of the importance of addressing AHD issues.

The project has used a large variety of different modalities for advocacy, education, communication, and service provision to young people which can now be evaluated for their effectiveness.

Over 500 Life Skills Youth Trainers have been trained since 2002. In 2006, seven Life Skills Training of Trainers workshops were conducted for 230 young people from ten PICs.

More than 9,500 young people participated in a community-based life skills programme in 2005-2006. In Tonga and Tuvalu, 20 percent or more of young people have participated in the programme since 2002.

The addition of life skills has strengthened ARH education. Many AHD Coordinators and peer educators received life skills training, expressed enthusiasm for adding life skills to their education activities, and had begun doing so.

The Ministers of Education endorsed the Forum Secretariat to work collaboratively with UNFPA and other partners to support curriculum development on sexual and reproductive health at the Pacific Islands Forum in September 2006.

The Ministry of Education in Fiji has agreed to make two periods of FLE per week compulsory starting in 2009.

In Fiji, the FLE syllabus for Forms 1-4 has been developed and the development of support materials is underway for Forms 3-4.

The project has produced a number of good materials, including the ARH manual and the Adolescent Sexual and Reproductive Health Research Methodology Manual for the Pacific.

The Fiji cinema ad campaign, while limited in reach, made people think about teenage pregnancy and resulted in some young people expressing their intention to practise safer sex. The campaign also demonstrated the benefits of the use of audience research and input, pre-testing, and impact evaluation in media work.

Fifty-seven percent of youth surveyed had listened to the UNICEF supported radio magazine programme in the Solomon Islands, ‘Youth of Today, Leaders for Today,’ at least once, with 7 out of 10 of those having listened more than one. Eighty-eight percent of respondents who had heard the show thought it was interesting or very interesting.

Fourteen Youth Centres and/or Youth Clinics have been initiated or further developed with support from the project, including some school-based clinics.
Strengthening Project Management and Delivery

Regional Management Structure and Staffing

Secretariat of Pacific Community (SPC)

The AHD project is largely implemented by SPC Suva on behalf of both UNFPA and UNICEF. SPC was selected to implement the ARH project in 2001, after the New Zealand based organisation originally identified to undertake the implementation, proved not to have the experience and ability to do so. SPC was selected because they had a proven track record implementing regional projects and extensive programme experience in all Pacific Island Countries. Given the experience they have gained with AHD and the different project elements over the last six years, they are at present the strongest partner in the Pacific region to implement a project on adolescent health and development.

At present, SPC has four regional staff working on the project full-time: an Adolescent Health and Development Advisor; a Life Skills Coordinator, a Family Life Education (FLE) Coordinator (based at the Ministry of Education in Fiji) and a Project Assistant. The AHD Advisor is responsible for project management and coordination and the provision of technical assistance. The appointment of a manager well connected to and knowledgeable about the Pacific is positive and has facilitated communication and networking with the country-based AHD Coordinators and government staff. The project is in the process of hiring an Adolescent Health Coordinator to assist the Advisor with coordination and the day to day management of the program at the regional level.

The management of the life skills component of the project is split between SPC and UNICEF. The Life Skills Coordinator, who was appointed at the end of 2005, manages the training component and is responsible for conducting life skills training of trainers (LS TOTs) in all project countries.

As the only health programme managed out of SPC’s Suva base, the AHD project has not been well-integrated with SPC’s other health programmes, such as its 2nd Pacific Regional HIV/AIDS Strategy, which are managed out of their Head Office in Noumea, New Caledonia. The organisation is committed to better integration of its health programmes and is considering moving more of its regional health programmes to Suva. To strengthen integration of the AHD project with its health programme, SPC intends to: develop a joint work plan for the AHD and HIV programme with the two coordinators responsible for ensuring the synchronisation of project activities in countries; establish a Project Advisory Committee; and establish a joint programme management committee at the national level for all related programmes. A new project focused on youth issues and development within the Human Development Programme has the potential to complement AHD project activities for youth at the community level.

UNICEF

UNICEF’s Life Skills Project is part of its Adolescent Development programme and has three components: the Pacific Stars Life Skills (PSLS) community education; the integration of life skills into school curricula; and communications. While SPC implements the training component of PSLS, UNICEF has retained the community based education component of life skills that follows the training. It is managed by UNICEF’s Life Skills Project Assistant based in its Suva office who follows up on the life skills training of
trainers to elicit proposals from the organisations where the LS Youth Trainers are based and provide them with contracts to conduct Community Based Life Skills (CBLS) activities. UNICEF is responsible for following up on the contracts made and monitoring quality. The curriculum component has done an assessment with the Institute of Education at the University of the South Pacific (USP), and the communications component supports youth radio magazines in the Solomon Islands, Tuvalu and Fiji. A campaign on two life skills, decision-making and self-awareness, has been developed and is about to be launched. UNICEF also provides technical assistance to the joint AHD project.

The location of staff managing the same project component in two different agencies and offices with different bosses has served to create unnecessary, detrimental divisions in the management of the implementation of life skills. In some cases, the management responsibilities outlined in the project agreement were not respected; for example, SPC has not been allowed to plan the schedule of the LS TOTs. The review noted insufficient coordination and information sharing; unclear channels of communication; ambiguous boundaries between UNICEF and SPC in the supervision of the SPC Life Skills Coordinator; and insufficient means for staff implementing the project at a regional and national level to provide valuable input that would improve the implementation. These issues have affected both quality and the rate of implementation of life skills CBLS to date. The review found that having the management of the CBLS funds at UNICEF did not improve the processing of CBLS proposals or prevent very lengthy delays in providing funds and implementing activities after training.

**UNFPA**

UNFPA channels nearly all of its funding for the project through SPC. It implements the cinema advertising campaign using other resources. UNFPA provides technical assistance, for example, to the operations research component, and guidance on adolescent reproductive and sexual health to the project and monitors its implementation through country mission visits.

The project also has a number of different committees which provide functional and organisational links among the agencies at all levels, including decision-making, policy, managerial and operational. They are intended to enable the agencies to oversee and provide guidance to the project at the regional and national levels.

**Project Management Committee (PMC)**

An interagency Project Management Committee (PMC) consisting of representatives from UNFPA, UNICEF and SPC was intended to meet quarterly to monitor and review the progress of the project and address any implementation issues. The PMC however did not meet at all until the end of 2006. Instead, there were meetings between UNFPA and SPC and between UNICEF and SPC, illustrating the lack of cohesion within the project. The lack of meetings of the PMC throughout the critical initial two years of the joint project -- during which time there were many wrinkles to iron out and some serious issues which needed addressing -- was a serious oversight. It undoubtedly contributed to the insufficient coordination, communication and limited merging of ARH and life skills activities.

**Project Advisory Committee (PAC)**

A Project Advisory Committee (PAC) comprised of representatives from UNFPA, UNICEF, and SPC met once or twice a year. There were to be representatives from several
project countries at these meetings but this has not occurred. At its meetings, the PAC considered project accomplishments, implementation issues and constraints, and discussed how to move forward. Although a number of the issues outlined in this report have been raised previously at PAC meetings and in reports many have remained insufficiently addressed, causing frustration for the staff.

In-Country Project Management

Adolescent Health and Development Coordinators

Implementation at the country level is coordinated and managed by government or NGO-based AHD Coordinators, appointed by the countries’ Ministries of Health. They are an integral part of UNFPA-supported National Reproductive Health Projects of the Ministry of Health and, as such, of the government’s public health programme. The AHD Coordinators are accountable to the Directors/Managers of the National RH Project or to the Director of Public Health in each country. They also report to the SPC-based AHD Advisor on a regular basis. Many also have other duties within the Ministry of Health or NGO. The AHD Coordinators reported that their relationships and communication with the SPC project staff in Suva were strong. During the review, no particular differences in implementation were noted among the Coordinators based on the source of their salary.

The capacity of the person in the position of AHD Coordinator is one of the key factors in the level and quality of project implementation in country. When the Coordinator is not qualified, interested and active, the project suffers. The process for recruitment for Coordinators varies across countries, but SPC’s involvement in these critical recruitments has been limited so far even when the salary of the position is paid by the project, despite requesting to have some input. When an AHD Coordinator changes, the Ministry of Health is responsible for ensuring a smooth transition. However, in several cases, there was no handover between a former Coordinator and a new one. Although it occurred for different reasons in the two cases which came to light in the review, one result is a loss of programme continuity, which in turn may result in lost capacity and momentum. In both of these cases, for example, the AHD Coordinators could not tell the reviewers what had happened in the project in their country prior to their employment. In one, at the time of the review, the new Coordinator appeared to be planning project activities with few, if any, linkages to what the former Coordinator had done.

Given the vital importance of this position to the project, the process for recruiting, handing over, orienting and training new Coordinators needs to be revisited during the next programme cycle. SPC, UNICEF and UNFPA should have input into the interview process. This could be done by developing minimum recruitment standards for all countries, e.g. a minimum set of requirements for the post, a standard process for interviews with a core set of questions to be asked and possibly a written test. In addition, the project should ensure that an effective performance appraisal process is in place, particularly for those Coordinators funded by the project and SPC should be asked for input. SPC should assist governments to ensure that the handover to a new Coordinator is properly done.

Although each Coordinator manages the project somewhat differently, many also play a large role in the actual implementation of activities. These activities can range from serving as a trainer to personally conducting community based education or providing clinical services. The latter occurs for a variety of reasons, usually legitimate and
understandable. Nonetheless, several issues arise when the AHD Coordinator plays a major role in the direct implementation of activities. First, it limits the number of activities that the project can effectively implement. Second, the project becomes overly reliant on the capacity and continued involvement of this one person. Finally, greater in-country capacity is not developed.

The Federated States of Micronesia, where the AHD Coordinator is the nurse who provides services and education at three school based clinics, the main project activity, is emblematic of the effect of using the AHD Coordinator as the main implementer of project activities. On the one hand, the services have benefited from her dynamism, capacity and passion. On the other hand, as long as she is the primary implementer, the number of other activities undertaken by the project has been restrained by the sheer limits of her time. An important next step for AHD Coordinators who are primary implementers is to train and build the capacity of others who can run the activities under their supervision. If the project grows in the next programme cycle, this will be essential.

It is not realistic to expect the AHD Coordinators to coordinate, provide technical assistance and training, as well as to follow up and monitor all aspects of a project with so many different strands of action. The scope of the project activities requires many complex competencies (for example, teaching, counselling, clinical service delivery, youth development, communications/media, advocacy/policy, management, and financial accounting), all of which one person is unlikely to possess. Many have higher education in one of these areas, however, it should not be assumed that they will be able to provide quality technical assistance in all other areas. In addition, in large Pacific Island countries (PICs), the job of the AHD coordinators is more than one person could do, particularly if they are to follow up with trainees after training or undertake monitoring of activities. Consequently, in most countries, some tasks have inevitably fallen through the cracks despite the best efforts of the Coordinators. For example, training follow up has been delayed or forgone and monitoring has often been minimal or done remotely, although it is critical to capacity building and programme quality. Additional responsibilities have been assigned to AHD Coordinators from time to time, seemingly without an assessment of whether they can take it on both technically and in terms of time, as was the case when the projects joined and they were given a new title and additional responsibilities, but no additional resources, staff or orientation.

Project Coordinating Committees (PCC)
Each country should have established a Project Coordinating Committee (PCC) whose members are representatives of key stakeholder and partner agencies as well as the AHD staff. The PCC is to meet on a quarterly basis to monitor and review project implementation, address issues and provide direction on project focus as appropriate. In Vanuatu, Solomon Islands and Kiribati, the PCCs have shifted to focus on coordination among projects within reproductive health (RH) or public health and away from specifically reviewing the progress, issues and future directions of the AHD project. For example, in Vanuatu, the purpose of the PCC is “to collaborate on relevant overlapping issues pertaining to RH, STI/HIV, ARH and Acute Respiratory Infections/Integrated Management of Childhood Illnesses (ARI/IMCI) programmes” and the committee includes the STI/HIV/AIDS Programme Coordinator, Reproductive Health Programme Coordinator, the ARI Coordinator, and recently, the TB and Leprosy Coordinator and Expanded Programme on Immunization (EPI) Coordinator. While this coordination is undoubtedly a
good idea, it is not specific to the AHD project and does not replace the need for a group or body which undertakes coordination, problem solving and other tasks specific to the AHD project (i.e. the tasks outlined above which were originally assigned to the PCC). It was suggested that, in addition to the new model of the PCC, an AHD Team be established in each country. In the reviewers’ opinion, it is primarily essential to have a group which meets to discuss issues related to AHD, and this project in particular, whether or not there is a broader coordinating group. It should be noted that while basic progress can be reported on, effective project monitoring cannot be done in a meeting.

Position of AHD in Government Programmes

The AHD project has been well received by governments and their support has been important in creating an enabling environment for the implementation of the AHD project. Governments, however, vary in the level of their support. Where government support is strong, for example in FSM and Tonga, it has contributed to the successful implementation and expansion of project activities. Ministries of Health (MOHs) in the region generally view AHD as a part of their Public Health programmes, with some seeing it as a part or extension of Maternal and Child Health (MCH), a component of Primary Health Care (PHC). Ideally, governments would have Strategic and Corporate Plans that clearly reflect and identify activities for AHD, rather than burying it within MCH or RH. MOH communication with SPC about the project is an area which needs improvement. In many countries, other government Ministries, such as those for education, youth, and women, are also active partners in project implementation.

One indicator of government support is the extent to which they have provided funds for positions and activities. The AHD Coordinators have been consistently fully government-funded in three countries (Fiji, Cook Islands and Tuvalu), have sometimes been government funded in some countries (Kiribati, the Republic of the Marshall Islands (RMI) and Solomon Islands) and are partly government funded in one (FSM). The aim to get more governments to take over the salary costs of the Coordinators needs to be strongly pursued in the next programme cycle. In Fiji, the government has allocated funds to AHD in the national budget and in Tonga, the government has provided an annual grant to the NGO which has been the primary implementer of life skills activities.

General Staffing Issues

The size, diversity, ambition and geographic reach and spread of the current project are too great for the current level of staff to be able to manage. With only four full-time regional staff, the project is considerably understaffed at the regional level. Although the staff are dedicated and work very hard, given their huge responsibilities it is not humanly possible for them to meet the programmatic needs. In fact, they are at risk of burnout and understaffing has contributed to many of the issues outlined below, such as insufficient technical assistance visits to project countries and follow up to training. The addition of the regional Adolescent Health Coordinator will help to alleviate the problem in some regards, however, one additional staff will not be sufficient to address the needs. Since project staffing at the operational level is a major factor in the quality and timely implementation of the project components and hence its overall achievements, an analysis should be undertaken of the staffing needs of the project to determine if new positions are needed and which ones. The management structure should also be assessed and refined to ensure good project accountability.
It was repeatedly stressed to the reviewers that insufficient in-country capacity in the competence areas required by the project is a major impediment to the depth and quality of implementation and to long-term sustainability. Indeed, building strong capacity is an essential, non-negotiable foundation for building robust programmes. Given the number of countries and the range of capacities which need to be strengthened, it is not sufficient to have only two regional technical staff for the project. Even having one staff person dedicated to building one capacity is not enough in this region, as the experience of the SPC-based Life Skills Coordinator clearly shows. At present SPC’s technical staff can visit and provide on the ground training, guidance and technical assistance at most once a year, which is insufficient to build strong capacity. Either the input needed for quality capacity to be built has been underestimated or it has been limited due to insufficient resources or both. Building strong capacity will require not only training, but repeated follow up during which observations, coaching and further technical input can be provided. Therefore each country in which a given capacity is being built needs to be visited at least twice, and preferably three times in a year, by the same technical staff person until on the ground capacity is strong. If the project is to become more effective and sustainable, this is a ‘corner’ that cannot be cut.

If the current level of funding and staff is maintained, the project should be considerably streamlined, as well as focused and structured in a way that makes it more feasible for the current staff to manage and implement the project effectively and thoroughly. This option would require reducing the areas of project intervention and result in slower progress towards objectives. If the budget is increased, it is recommended that priority be given to increasing in-country technical assistance for the reasons outlined above. For capacity to be built across the entire region, at least two technical staff would be needed in a given programmatic area, and even so, it is likely that the countries covered would need to be prioritized and phased in overtime. This may, understandably, seem unfeasible. An initial approach may be to do a more in-depth assessment of which capacities are most needed in which countries and to prioritize, either capacities or countries or both. The review noted that technical staff are particularly needed to strengthen AHD education and training capacity; counselling capacity; and communications capacity; however all areas of intervention should be assessed. Additional options for consideration include using long-term part-time consultants for technical areas that are needed in fewer countries; and seeking youth ambassadors and international volunteers for some needs in country. The development of regional certificate courses or use of existing ones would be a more general way to address some needs in the region. For example, the USP offers a Certificate in Basic Counselling, some of which can be done through distance or flexible learning.

The AHD Coordinator’s role and responsibilities should be evaluated on a country by country basis. In particular, their role in the implementation of CBLS needs to be clarified as soon as possible. Where necessary, plans should be developed for gradually shifting Coordinator’s away from intensive direct implementation of activities, particularly education and service delivery to youth. For large countries or those that are a priority, hiring an Assistant Coordinator should be considered if funding allows. Assistant Coordinators should ideally have skills complementary to the AHD Coordinators (e.g. one with education skills; one with service delivery skills)

Recommendations
➢ That the size of the staff and the size of the project be brought in line with each other to improve implementation and reduce work overload. Careful thought needs to be given to prioritising project components in close consultation with countries and partner agencies.

➢ That priority be given to increasing technical assistance staff, dependent on funding.

➢ That Assistant AHD Coordinators positions be established at least for large, priority countries, as funding allows.

➢ That the process for recruiting, handing over, orienting and training new Coordinators be strengthened and in particular, that SPC, UNFPA and UNICEF develop minimum recruitment standards for the AHD coordinator position.

Programmatic Priorities, Project Objectives and Outputs

The three key outputs which the joint project proposed to achieve – strengthening adolescent health information through life skills based education; expanding youth-friendly services; and strengthening project management and delivery – are well chosen and in line with international and regional policy and planning briefs and frameworks, such as ‘Investing in our future: A framework for accelerating action for the sexual and reproductive health of young people,’ a joint commitment of UNFPA, UNICEF and WHO.² The companion policy and planning brief noted that ‘major health threats still persist, most notably teenage pregnancy, often arising from the unmet need for contraception; sexually transmitted infections (STI), including HIV and AIDS; and sexual violence and exploitation.’³ It also supports the commitment of the international community to intensify linkages between sexual and reproductive health and HIV and AIDS at the policy and programme level as expressed in the 2005 UNAIDS policy position paper ‘Intensifying HIV prevention,’ which builds upon the ‘New York Call to Commitment: Linking HIV and Sexual and Reproductive Health.’

The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children, the result of a high level consultation convened by WHO and UNFPA in May 2004 which considered the evidence of the role that family planning (FP) can play in preventing HIV in women and children, concluded that the United Nations General Assembly Special Session’s (UNGASS) goals on the reduction of HIV infection in infants could not be met solely by the prevention of maternal to child transmission (PMTCT). It stressed the need for a comprehensive approach including the prevention of unintended pregnancies through family planning and, thus, recommended the forging of closer programmatic links between family planning and HIV prevention programmes.⁴ In line with this commitment, greater

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emphasis needs to be placed on family planning and the prevention of teenage pregnancy in future AHD projects.
### Table 1: Snap analysis of project budget 2005 - 2007

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Over the three years from 2005-2007, UNFPA contributed 53% of the project budget, distributed across the different components; UNICEF contributed 39% towards the education and management components; and SPC 8% across all components. In 2005 and 2006, SPC made an in kind contribution of $110,000 to the project, based on an estimate of the personnel cost and office space and facilities used, and acted more as a contracted implementer, than a full partner. SPC began providing direct funding in 2007, when it contributed 14.8% of the total budget.

Most funding was allocated for work on education (37%) and management (49% which includes some technical assistance for different components). Funding allocated to services has been considerably smaller than for education or management, accounting for only 14% of the total budget.

**Recommendation**

- That SPC should continue to provide direct funding to support the project implementation.

**Cross-cutting Programme Issues**

In the next section, the report discusses issues which apply to all components of the project, including those related to programme design, strategy and planning; technical assistance
and capacity building; the level of integration; record-keeping; monitoring; and research, assessment and evaluation.

**Programme Design, Strategy and Planning**

Programme planning meetings occur annually and there are work plans for the project as a whole as well as by country. In addition, there is a log frame for the project which lays out its overall goal, outcomes, outputs, activities and indicators. In terms of the broad programme priorities, the strategy is strong, as noted above. However, detailed strategic planning which lays out how the project intends to build towards the achievement of its set objectives over time has not been done. Consequently, to the outside observer, many activities appear to be more randomly dispersed and ad hoc than strategically planned and cohesive.

All project components would benefit from greater attention to strategy particularly given limited resources. The life skills component, for example, aims to reach 20% of Pacific youth, with a particular focus on reaching high risk youth. However, no strategy has been laid out at the regional or national level for how this will be achieved (i.e. what capacity is required, among how many trainers, who would reach which youth and at what rate, with what programme, requiring what level of resources, over what period of time?). For other education, strategic thinking and prioritizing is also needed. A strategic plan, if well done, would be useful as well for ensuring that goals, objectives and activity plans are feasible; determining what level of human and financial resources are needed; and ensuring that countries have a plan for building the programme not just doing activities.

Most countries need technical assistance and critical feedback when developing strategic plans and annual workplans. There should therefore be considerable discussion and interaction with them to ensure that these plans are in fact strategic, feasible and focused on quality programme building. Plans also need to be more detailed than they are at present; for example, the specifics of training follow up should be outlined to ensure that what needs to be done is clear and feasible.

The project has been very ambitious in trying to reach a large range of audiences with education and information and trying to implement services in a wide variety of locations and ways. On the plus side, in doing so, it has been able to test a large variety of modalities for providing youth with education and services in the Pacific. On the down side, the project is trying to do too many things for the number of staff, the size of the budget and the still insufficient country-level capacity. The project would benefit from focusing and ensuring that its plans are realistic and feasible given the staff and financial resources and the requirements for building a quality programme.

While the reach of activities may be broad and varied, it is unclear whether the quality, depth and intensity of the interventions are sufficient to have the intended impact. Impact could not be assessed in the current review for any component of the project, but for many activities, it appears that what youth, the ultimate end beneficiaries, receive is often limited, and, hence, the impact on their behaviour and outcomes is also likely to be limited. For example, in Fiji, peer educators go with the health team on school visits where they offer one period of education to certain classes per year (often covering material already in the school curriculum).
Having tested a significant range of modalities in the Pacific, the project is now at the stage where it needs to assess the impact of these different modalities on youth to separate out those which are working well, those which need adjustment, and those which are not worth continuing or are not priorities. Cost effectiveness should also be looked at. Such assessments would assist countries to make strategic decisions and to prioritize and focus their activities by enabling them to select those modalities which are most effective and best suited to their situation and target youth populations, based on evidence. This prioritizing is essential given limited human and financial resources.

UNICEF has raised the issue of whether the project design should be shifted from one that is “a regional programme implemented in countries” to one that is “a country-led programme supported by regionally located technical support.” The latter would be more complex yet for the UN agencies to administer and would require more technical and management capacity than currently exists in most countries. At present, the programme is adapted to some degree to the country situations and therefore is not identical across all the countries, which is appropriate. Further adaptation to the country situation is encouraged through country-level strategic planning which focuses the project on specific in-country needs and priorities. Building greater capacity in country is a critical step toward shifting more responsibility to the country level, and thus is the primary recommendation for the next programme cycle rather than a major shift in the structure, management and implementation modalities.

Recommendations

- That assessment and strengthening capacity and project implementation be the primary focus during the next programme cycle rather than expansion and up-scaling.
- That the project undertake strategic planning for the next programme cycle, both regionally (with country consultation) and in country (with technical support). For example, if the project intends to reach 10-20% of youth with quality programmes, the path to reaching this goal and related sub-objectives should be clearly laid out.
- That project implementers in-country identify a limited number of priority interventions, and focus on consolidating, strengthening and assessing them and ensuring the depth, intensity and quality needed to have an impact.
- That strategic plans and work plans be detailed and specific (particularly in terms of how post training follow up and monitoring will be done).

Strategic plans should lay out clear goals for priority sub-groups of youth and geographic reach; have selected and justified priorities; and detailed staged plans achieving them. Future interventions and activities should be selected among current ones based on evidence of their effectiveness. Ensuring quality and depth and building capacity and programs need to be considered in the strategic plans. Project partners in country should be identified based on their fit with the strategic plan among other things.

Technical Assistance and Capacity Building

In general, those involved in the programme said that capacity building, which has been largely equated with training, has been inadequate for building the knowledge and skills they need (for all programme areas, including peer education, life skills, ASRH counselling and education, youth friendly services, etc.). Trainings have generally been too short to really develop the needed understanding and competence according to the trainers, those
trained and the reviewers’ experience. For example, a two-week training to become an AHD peer educator or a LS youth trainer is insufficient to develop the needed knowledge and skill to deliver life skills or AHD education or counselling to others.

In addition, the use of cascade training, a strategy of questionable effectiveness, means that training, workshops and/or education are frequently conducted by those who have just been trained and hence lack expertise and experience themselves. As elsewhere in the world, since much expertise is lost at every level of the cascade, its use raises serious concerns about the quality of what is received at the end of the line. When inadequate initial training and the cascade model are combined, the problem becomes even more acute. Hence the combination in the project of relying primarily on short training or workshops to build capacity and using some trainers with limited experience and expertise is likely to have resulted in relatively low capacity among those trained; and this in turn puts the quality and effectiveness of subsequent activities in jeopardy. As an experienced observer of a workshop conducted by a newly trained young person said, ‘I do not want to judge, but….’

The heavy schedule of training and workshops on a large range of topics for trainees from a very wide geographic area undertaken by few staff means that it has not been feasible to follow up, support, coach or monitor trainees effectively afterwards. The follow up which does occur is often too long after the training to effectively encourage the use of the training and further develop capacity. Although this could not be thoroughly assessed, it seems that quite a few trainees have yet to use the training they have received. For example, many life skills youth trainers had not yet conducted workshops nine or more months after training. In Solomon Islands, many of those trained could not be located or had since found work elsewhere. In Fiji, at a health centre, those interviewed thought others working at the health centre had been trained, but they were uncertain who, clearly indicating that those trained were not actively working on making the services more youth friendly. As the staff of an NGO put it, ‘A lot of money is being spent, training is done, the trainers go back and what happens? If there is no follow up plan, they might as well forget about it.’

Standards for assessing trainees are lacking. Attendance at a training is equated with a participant having mastered the knowledge and skills taught. Thus, individual understanding and capacity are not assessed before certificates and titles and even positions (for example, peer educator positions) are bestowed.

An assessment needs to be done of the current technical, management and administrative capacity needs, which should include a critical assessment of the current level; and of who needs capacity, in what, at what level. Based on this assessment, the strategic plan should include a justified plan for how the needed capacity will be built, including how trainings will be delivered and followed up. One option would be to develop regional certificate courses with set standards within an institution, for example, at the University of the South Pacific or the Fiji School of Medicine. In addition, the project could consider recruiting from among graduates of existing programmes where there is a match with the project’s needs and could inform project implementers of capacity building opportunities offered elsewhere through the AHD info-share or other means.

Although training to build capacity may need to occur initially on a regional level, the focus should be on developing the depth and strength of capacity that could eventually enable
high quality training to be done in country so as not to foster dependence on external assistance (taking into consideration that for very small countries, this may not make sense).

**Recommendations**

- That the project focus on building stronger, deeper capacity and expertise and the process for developing capacity be revised to enable this. This would include not only more weeks of training for most capacities (not necessarily all at the same time, but also not spread out over a very long period), but also more immediate-term follow up, with coaching including observation and feedback, and where feasible, trainee support groups;
- That the length of training be determined based on an logical assessment of how much is needed for specific content and skill areas and adjusted over time based on the competence level observed during follow up.
- That ‘cascade training’ be used with great caution and that the number of levels between the initial or ‘Trainer of trainers’ and the community youth or end-recipient be limited;
- That standards be developed for critical skill areas (i.e. those essential for the success of the project interventions such as education and counselling) and trainees’ knowledge and competence be assessed before they receive certificates.
- That a regional certificate course be developed for youth educators in AHD (which should include life skills).

**Level of Integration**

The 2005 project document notes that the projects were joined because the project activities focused on the same target groups, were complementary (and in certain areas duplicative, for example, in the provision of HIV education), and in some countries used the same young people as resources (some Life Skills trainers, for example, also undertook work on ARH). It was thought that joining the projects would make both more comprehensive and more effective and enable them to share resources, and thus maximize their impact. The joint project was intended to localise the life skills training of trainers in country because experience had indicated that its impact would be greater if conducted by local facilitators in familiar surroundings and using the local vernacular.

One of the key tasks in the terms of reference for this review was to evaluate the level of integration achieved between the ARH and PSLS components and propose strategies to move towards a more synergised and sustainable joint AHD project. By all accounts, the ARH and PSLS components of the project are not well-integrated. Indeed some in-country interviewees in implementing organizations reported that to them AHD and life skills are two completely separate projects. The review findings confirm that there has only been a minimal level of integration.

A key omission at the beginning of the joint project was not assessing in detail what it would mean to merge and developing a plan to address potential constraints and the impact on management, staffing, staff capacity and workload, as well as to integrate resources such as manuals, training packages, etc.
At the international agency level, the agencies have not been working together as equal partners on all aspects of the project. For example, SPC’s involvement has been more like that of an agency contracted to implement the project rather than a full partner in all respects and UNICEF’s technical involvement has been largely on the life skills component. In 2005-2006, budget allocations for project components, substantive involvement, technical assistance input and fund-raising remained largely separate. This divide has started to shift in 2007, with SPC providing direct funding and UNICEF providing support for project areas beyond life skills.

The ways in which the projects have merged include:

- The Life Skills Coordinator and training of trainers component are based within the AHD Project at SPC.
- The SPC Life Skills Coordinator and UNICEF’s Life Skills Project Assistant undertook a few joint in-country trainings and visits; however, this was discontinued at the request of SPC.
- The AHD Coordinators received a one-week training on using the revised life skills manual, are in-country focal points for life skills in some countries, and have been involved in organising life skills TOTs;
- The AHD staff report increasing the amount of life skills in their on-going trainings and work to some degree, the exact extent of which could not be determined;
- In some countries quite a few of the peer educators from the former ARH project attended the life skills TOT and some report including more life skills in the education they provide, though, again, the extent of this could not be determined;
- Some LS Youth Trainers invite peer educators from the former ARH project to conduct reproductive health sessions for their community based workshops (however still as a separate subject);
- A few AHD partners sent a staff or volunteer to the life skills TOT and at least one had a five day workshop conducted by LS Youth Trainers.

To date, however, the two components remain separate in nearly all ways, with mostly distinct staff, management, financial resources, manuals, training, activities, and to some extent partners. The life skills component, for example, has only shifted its content to incorporate ASRH issues beyond HIV and AIDS to a very limited degree. The current division in the management of the life skills component has proven to be problematic and is ‘the most contentious issue in the joint project.’ It has contributed significantly to the limited actual integration in the joint project by establishing a structure that ensures the maintenance of life skills as a largely separate activity. Given that the resources and implementation are still largely separate, even when the implementing partners on the ground are the same, the benefits that the merger was originally intended to produce have yet not materialised.

UNFPA, UNICEF and SPC staff, in-country Coordinators, and project implementers have to a large extent expressed a desire for the project to fully integrate all components and for there to be a full partnership among the three agencies. There are, however, a number of constraints, which include: expressed conditions for agreeing to fully merge resources and programmes; differences in organizational culture, style and operating procedures; lack of a common understanding of the meaning of ‘integration;’ UN agency ‘brand’ identity and competitiveness; possible differences in programmatic and country priorities, targets and ambitions; differences in available resources; and personality conflicts. Nonetheless, most
of those involved believe that it is essential to find ways to overcome these constraints, particularly given the movement towards ‘one UN.’

The process for fully integrating should be carefully planned and implemented in phases. In addition to ironing out the conditions for merging and developing a joint plan, the initial phase might include joint assessments (for example, of the technical assistance needs or of the quality of the education/training delivered by AHD peer educators and LS youth trainers and the impact on the recipient); joint planning and fund-raising for the next programme cycle; the development of a single resource package which encompasses and merges ARH and other AHD issues with life skills; developing the capacity of the current LS youth trainers and AHD peer educators to create one type of youth trainer/educator (i.e. building the ARH capacity of LS trainers and the LS capacity of AHD peer educators); and the joint development of a Youth Friendly Services (YFS) certification initiative/package, among other things.

On the issue of funding for community based life skills, the major concerns about merging expressed were 1) SPC’s capacity to manage the process given already overloaded staff; and 2) the need to avoid both UNICEF and SPC taking an administrative cut from the same grant. Modalities for overcoming these constraints need to be discussed and agreed on. Some options include ensuring that SPC has sufficient staff to manage the process; or, if this should prove impossible, seconding UNICEF CBLS staff in Suva to SPC (recognizing that we recommend that CBLS be phased out as a separate component as life skills is transitioned into AHD education). Regarding the issue of administrative costs, solutions could be negotiated among the partners and/or with the donors. Joint fundraising would presumably eliminate this issue.

**Recommendations**

- That all components of the project be fully integrated within an equitable partnership among the three agencies, including fund-raising and/or financial contributions;\(^5\)
- That SPC coordinate and implement all aspects of the project (including CBLS, if it is continued as a separate activity) at the country level.
- That agency conditions and other constraints to full integration as well as options for managing the project in country be openly discussed and addressed at the various levels of the project and a plan be developed for phasing in full integration, which addresses how the constraints will be dealt with.
- That the PMC and PAC decide on components of the project that require direct management and/or implementation by UNFPA or UNICEF.

**Record Keeping**

Basic record keeping enables a project to report on the extent to which project activities have reached a given audience during a given period (however, they in no way indicate quality, results or impact and do not replace monitoring, assessment or evaluation). Record keeping was highly varied, with some being extremely detailed and others very cursory; the quality was mostly dependent on the person responsible. In the countries visited, in Fiji, Solomon Islands, and Tonga, there were records on outreach and educational activities,

\(^5\) An equitable partnership being one in which all partners have a stake in and recognized contribution to make to all components of the project (for example, UNICEF to services for youth and UNFPA to life skills. It is characterized by fairness, rather than strict equality (for example in the size of monetary commitment).
trainings and workshops, clients seen, and so on, which were kept by clinic staff, peer educators, youth trainers and partners. However, in Kiribati, the records were more poorly kept and it was difficult to obtain records of services at clinics or youth centres, of condom distribution, and of the number of youth reached in community outreach programmes, for example.

At the country level, however, summary records on service provision and the reach of project activities undertaken at the clinics, schools and in the community are often relatively poorly kept. In most countries and across the project, except for the life skills component, records were not collated by month, year and/or project cycle, making it difficult to easily access summary data on the level and reach of project activities. It was possible to obtain basic collated information about the life skills component, but in some instances, information from different sources conflicted, which indicates a different sort of problem with record keeping, possibly lack of clarity about what constitutes “reaching” someone. The lack of collated data on project activities and reach is a very serious gap which needs to be addressed urgently. Every partner, AHD Coordinator, and SPC should be able to easily provide such information and these data should be included in every report.

A set of standardized record-keeping requirements and summary templates should be developed and tested for the activity, country and regional levels and project implementers trained in how to fill them out and use them subsequently in planning and assessment (note that these should not replace reports of activities such as workshops or other current narrative reports). These should be made an integral part of in-country monitoring of implementing partners by AHD Coordinators and regional partners. Summary records should include information that would indicate what was provided and to whom in sufficient detail for it to be useful for planning and assessment (in other words it should provide more information than only numbers reached). In terms of the population reached, collated records should include at least gender, age, and marital status. For services, they should also include at least the type of facility, reason for visit; whether new or repeat client; whether referred or walk in; and the visit outcome (for example, if referred onward). For education activities, they should also include at least number of participants (with the break down indicated above whenever possible), the topics covered, and the length of activity. These should be developed so that they can be easily collated in country and regionally. They should be collated quarterly, annually and over a project cycle, at both the country and regional level. Reports should be sent to supervisors in country, relevant Ministries and partners, as well as to SPC Suva, UNICEF and UNFPA.

**Recommendations**

- That a set of standardized record-keeping requirements and summary templates be developed and tested for the activity, country and regional levels in consultation with in-country and regional staff.
- That training in their use be provided (including how to fill them out and how to use them for planning and assessment).
- That their use be monitored by AHD Coordinators and by regional partners and problems with them noted and addressed.
- That such collated data be included in every project report.

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6 Collating records could be done in most countries but in most, it had not already been done and it was not possible for the reviewers to do it within the time frame of the review.
Monitoring

Numerous monitoring mechanisms are used by the project at different levels and the information gathered is used to refine workplans and to plan and direct project activities annually. These mechanisms include: weekly AHD info-share via email with the ten main project countries, UNICEF and UNFPA; quarterly reports using a Workplan Monitoring Tool sent by the project countries; annual reports from the project countries and SPC; detailed mission reports from Regional Advisers and UN agency staff (eight in 2006, three so far in 2007,) and the SPC Life Skills Coordinator and UNICEF Life Skills (eight mission reports in 2006 and three so far in 2007 and eight Life Skills Training Reports); supervisors’ reports from countries; Project Management Committee meetings as well as numerous meetings between SPC and UNFPA and UNICEF; six monthly Project Advisory Committee meetings; Annual Review and Planning Meetings by stakeholders and partners in country and at the regional level; and in-country Project Coordinating Committee meetings. In country, the AHD Coordinators monitor project activities through email and visits, but, as noted, often do not have sufficient time to thoroughly monitor all activities. Because emails, written reports, checklists and meetings cannot monitor the quality of activities, they provide only a minimal level of monitoring and need to be supplemented by visits which include observation, followed by discussions of strengths and weaknesses, problems or challenges and guidance on ways to overcome these.

Recommendations

- That monitoring of project activities, particularly after training, be given greater importance in the next programme cycle and include observation and constructive feedback and guidance.

Research, Assessment and Evaluation

General Research on Adolescent Health and Development

The general lack of research about AHD issues has meant that most project activities have been planned and implemented without an evidence-based understanding of the problems they are trying to address. While the reviewers recognize that research capacity is still weak in the region and difficult to develop quickly, the project would benefit greatly from having more quantitative and qualitative evidence about AHD issues on which to base its activities. A deeper understanding of adolescent pregnancy, for example, is key to developing effective strategies to address it.

Assessment

During the last year, operations research was initiated, which is a very positive beginning in the area of on-going assessment of project activities. A five-day training enabled AHD coordinators to design and plan an operations research project on an aspect of their work. UNFPA developed a manual, ‘Adolescent Sexual & Reproductive Health Research Methodology Manual for the Pacific,’ for use during the training and afterwards, which is both comprehensive and easy to use. The training was well-followed up and AHD Coordinators came to a second workshop to analyze their data. See the table in Annex A for a summary of the operations research being undertaken. Many coordinators indicated that the results of their research were illuminating and quite useful in identifying weaknesses in the project of which they were previously unaware. It is expected that they
will use their findings to improve related project activities but this should be followed up to ensure it occurs. Given that research is a very complex skill to master well, further capacity development of the AHD Coordinators is still needed in this area, particularly on data analysis and research report writing and should be undertaken prior to training others.

Evaluation

A critical gap in the project design is the lack of on-going assessment and impact evaluation, an issue raised by many. Because of this gap, the review cannot report systematically and accurately on the quality or impact of any of the project activities on the key indicators. Although the 2005 project log frame states that the means of verification to assess some indicators would be ‘sample surveys of adolescents in selected coverage areas,’ ‘knowledge, attitude and practices studies on sexual and reproductive health behaviour,’ for example, no surveys were planned or conducted. Although this review is a kind of assessment, it was not designed to gather data to assess impact. As noted above, before considering any expansion at this point in the AHD project, it is critical to assess the actual impact on the end beneficiary of the different approaches and modalities tried over the last five plus years in the project. As one interviewee said, ‘We need to know our successes and failures rather than doing the same old thing year after year.’

Since neither baseline nor midline data were gathered, project data to measure changes in youth use and perception of services or in their life skills, sexual and reproductive health (SRH) knowledge, attitudes and behaviour, among other things, are not available. Data collected through regular or planned surveys or data collection processes, such as the second generation surveillance surveys which will be implemented in ten PICs in 2007-2008 or the Demographic and Health surveys being led by SPC, and through Ministries of Health, should be used, where possible, to monitor general trends in end line indicators, such as rates of STI and HIV infection and teen pregnancy. However, in many countries, there are problems with these data, for example, rates of teen pregnancy may not be available over time to monitor changes, data may not be disaggregated by marital status or by the ages of interest, or questions of particular importance to the project may not be included. While these data will give an indication of national trends, they will not provide very accurate information about the impact of the project activities themselves. For example, if HIV infection rates among adolescents continue to rise, one cannot conclude that the project activities have had no impact on young people (rates may be going up more slowly than they would have or may simply be attributable to more young people getting tested and not indicate an actual rise in infection rates).

The Health Behaviour and Lifestyle of Pacific Youth Survey conducted in 2001 in 3 Pacific Island Countries might serve as proxy baseline data for some indicators since project activities began shortly after they were done. One means for obtaining some comparative data might be to repeat this survey to assess changes in the adolescent health indicators measured. One serious limitation, however, is that the questions on sexual behaviour and reproductive health were not asked of in-school respondents in all three countries, which means that there would be crucial gaps in the baseline data if these surveys were used. The potential usefulness of repeating these surveys should be assessed to see if it would be worthwhile to do so. If funding is available and if sexual behaviour and reproductive health questions could be included for all respondents, conducting such surveys every five or ten years to monitor basic adolescent health and development indicators could be considered. This would also serve to establish a regional longitudinal data base on AHD status.
A comprehensive monitoring and evaluation framework should be developed and plans made to actually gather the data necessary to assess the impact activities. In order to measure impact, the project will need to gather at least baseline and endline data over a reasonable period of time (i.e. one in which an impact could be expected to occur), most likely in several different ways. For example prior to trialling the FLE curriculum in Fiji, the project should consider undertaking a baseline survey of the ASRH knowledge, attitudes and behaviours it intends to change among students. Targets for change in key indicators (distinct from targets for outputs or activities) for each country and the region need to be set once baseline data have been collected. Data on these indicators should be compiled for feedback to all partners and for use in future planning.

**Recommendations**

- That an assessment be made of the most critical evidence gaps for the project and efforts made to fill these to the extent possible given available resources.
- That operations research capacity development for AHD Coordinators be continued as well as funding and technical assistance for them to undertake additional operations research projects, particularly those which provide information about the quality and impact of project activities.\(^7\)
- That strategies and modalities used to date be critically assessed in terms of their impact on youth in the general population and their cost-effectiveness and strengthened based on this assessment before any further expansion takes place.
- That a comprehensive monitoring and evaluation framework be developed and impact evaluation be conducted in the next phase of the project, including at least the collection of baseline and endline data.

**Strengthened Life Skills Based ASRH Information and Education**

This section presents the findings specific to the project’s first output, strengthened life skills based ARH Information and Education. It first discusses work on family life education (FLE), then Pacific Stars Life Skills, followed by AHD community education, including peer education, parent-child education and communication and education and resource materials. Finally, it reviews youth media and communication work undertaken by the project.

**Family Life Education (FLE)**

- Project funding: Introduction of FLE in Tonga, Samoa and Vanuatu –$10,000 – 2006
- 2006 Work plans review: Not reflected for Tonga

The project has opted to use the term “family life education” to refer to education which addresses a variety of health and sexuality related topics and life skills.\(^8\) It should be noted...

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\(^7\) Whether it should be the AHD Coordinators’ role to undertake operations research could be debated; however, since the process of training them has already been initiated and it is a useful skill for them to have to assess and guide the improvement of activities, we recommend that the training process for them be completed before any training of others is considered.

\(^8\) This type of education, which varies widely in content, may also be referred to as reproductive health education, sexuality education, sex education, health education, and sometimes population education. It may also be undertaken within health promotion programming.
that while many project countries use this term, some use other terms for education on the same basic content. The project has approached the provision of SRH/FLE/LS education in the schools in a variety of ways, including AHD staff or non-school-based peer educators providing education directly in the schools; developing in-school peer education programmes; providing after school education; training teachers with the intention that they would integrate the subject into their classrooms; and working with curriculum development units in the Ministry of Education on the development or revision of official curricula covering these topics. Of the various strategies, the latter, while a complex, long-term one, is the one which will ultimately achieve the greatest reach and sustainability. It should be the primary focus of in-school education activities rather than ad hoc, piecemeal activities in schools. Working with teacher training institutions to support and/or ensure the development of pre-service education for teachers is an important complementary strategy to curriculum development.

In quite a few countries in the region, a small amount of the usual content of a family life education curriculum is part of the school curriculum, often integrated into various subjects, such as biology, social studies, religious education and home economics; for example, human reproduction is usually covered to a limited extent in biology. However, the contents and details vary from country to country and the where it exists as a separate subject, it is often not compulsory so implementation varies by school. Overall, life skills based SRH education is not taught systematically or thoroughly.

A review of the Fiji Family Life Education curriculum in 2004 strongly recommended the revision of the seventeen year old curriculum to strengthen its focus on ARH and life skills and working to make FLE compulsory in primary and secondary schools. Taking up these recommendations, the project has focused on piloting the process of integrating Family Life Education (FLE) into school curricula in Fiji. Although it had been planned for many years, the Fiji curriculum revision stalled for a variety of reasons, including the lack of expertise on family life education in the Pacific, issues with staffing, and the need for the revision to be timed appropriately within the evolution of the national curriculum framework. During the last year, the project has provided support for a FLE Coordinator, curriculum mapping, material writing and training. The hiring of an FLE Coordinator in mid-2006 to support and coordinate the process of curriculum development and implementation has worked to jump start the process and the review found that steady progress is being made: the syllabus for Forms 1-4 has been developed, support materials are currently being written for Forms 3-4, and these materials will be trialled in schools. A major achievement has been getting the Ministry’s agreement that two periods of FLE per week will be compulsory starting in 2009. Three weeks of technical assistance was provided by an Australian expert in early 2007, with additional assistance planned. While it was the project’s intention that Fiji’s curriculum could be shared across the region, the review found that Fiji is not necessarily considered to be a leader in curriculum reform by other MOEs in the region, hence some may not see it as a model. In this area of education, compromises often need to be made in the content based on what a given Ministry and its staff will accept. Therefore, rather than deciding a priori that the Fiji curriculum will be a “model,” this should be decided only after it has been developed, based on its content and quality.

In addition to the work in Fiji, workshops to introduce the concept of FLE and gauge stakeholder response were conducted in Tonga, Samoa and Vanuatu in 2006. A significant
development related to this strategy occurred at the meeting of the Ministers of Education at the Pacific Islands Forum in September 2006 where, at the urging of the Vice President from Fiji, the Ministers endorsed ‘the Forum Secretariat to work collaboratively with UNFPA and other partners to support curriculum development on sexual and reproductive health.’ This endorsement provides an important opening which for work on curricula.

Most countries regularly review their curricula and some, such as the Solomon Islands, are currently in the process of a major overhaul of their primary and secondary school curricula. Work to include FLE education is best integrated into this process through the Curriculum Development Units (CDUs) of Ministries of Education (MOEs). In some countries in the region, such as Tonga, ongoing curriculum review work is being funded by NZAID and the World Bank, so work on FLE curriculum should also be synchronised and integrated with those efforts.

At present knowledge about the current status of FLE in the official curriculum in different countries across the region is incomplete (See Table 2 for the status in the countries visited). In order to develop a strategy to capitalize on the Ministers’ endorsement, a more in-depth understanding of FLE in the different countries across the region is needed, including: the current status of the topics covered by FLE; the quality of existing curricula and materials; in-country interest and commitment; and plans for curriculum review or development.

Table 2: Status of Family Life Education in Countries Visited

<table>
<thead>
<tr>
<th>Countries</th>
<th>Family Life Education in Schools</th>
<th>2006 Report</th>
<th>2007 Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji</td>
<td>FLE syllabus development for Forms 1-4 started with project support.</td>
<td>Continuation of syllabus development and beginning of materials development for Forms 3-4.</td>
<td></td>
</tr>
<tr>
<td>Kiribati</td>
<td>Teacher capacity and skills lacking. Need to strengthen teacher training.</td>
<td>In Phase 1 of FLE development. Need support for Phase 2-4 (see details in Annex C).</td>
<td></td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>Curriculum developed. Teacher skills need strengthening.</td>
<td>In the process of being integrated into primary and secondary school health education syllabi. Part of MOE curriculum overhaul; not a project activity.</td>
<td></td>
</tr>
<tr>
<td>Tonga</td>
<td>FLE to be developed and incorporated.</td>
<td>NZAID funded review of curriculum for G1-8 underway. Inclusion of FLE under consideration.</td>
<td></td>
</tr>
</tbody>
</table>

One component of UNICEF’s Life Skills work is focused on ensuring that life skills are integrated into formal school curricula. In July 2006, UNESCO, UNICEF, the South Pacific Board for Educational Assessment (SPBEA), the Government of Vanuatu and UNESCO Vanuatu NatCom hosted a workshop to draft regional benchmarks for literacy, numeracy and life-skills. The intention is for these benchmarks to be used as the basis for monitoring the quality of education at the country level. UNESCO, UNICEF, SPBEA and the Pacific Regional Initiatives for the Delivery of Basic Education (the PRIDE Project implemented by the Institute of Education at USP) will collaborate on monitoring their use nationally and regionally.

A quality FLE curriculum will cover all three learning domains, i.e. cognitive, affective and behavioural. As such it would include education in life skills, i.e. those psychosocial competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with and manage their lives in a healthy and productive manner. In addition, it should use interactive teaching and learning methods for
all content (not just that which is skills related); provide opportunities for learners to observe and practise skills over sufficient time for them to be imbedded; and, as for all education, it should be appropriate to the age, experience and culture of the students. Hence, FLE curricula should be consistent with the ‘life skills based approach’ as articulated by UNICEF.

Research has found that ‘while some programs attempt to teach life and social skills generically… effective programs teach children to apply skills to specific behaviours;’ that ‘content of relevance to young people (for example, sexuality, substance use, nutrition and fitness, or interpersonal conflict) provides a context for learning skills;’ and that skills are not automatically and consistently applied to every problem or social task encountered, [but] rather, to produce a meaningful effect on development or behavior, adolescents need to practice and apply learned skills to “specific, relevant social tasks.” Given these findings and the difficulty of getting hours allocated and curricula and materials developed and integrated, in order to get both FLE or ASRH education and life skills into school curricula, the sensible approach would be to combine these efforts.

**Recommendations**

- That a situation analysis of the current status of SRH/FLE education in the curricula and teacher training institutions be undertaken to develop a strategic plan for SRH/FLE development including determining the priority countries for project support.
- That countries be selected for work on SRH/FLE based on the following criteria: the interest and commitment of the Ministry of Education, the status of curriculum development and teacher training development, the dynamism of the staff responsible in the curriculum development unit, the extent to which children and youth attend primary and secondary school, and the general level and capacity of teachers.
- That all project work on FLE cover all three learning domains (cognitive, affective and behavioural); use interactive teaching and learning methods for all content to develop critical thinking skills; enable learners to observe and practise skills over sufficient time for them to be imbedded; integrate a gender perspective into all content and, as far as possible, be rights-based.
- That efforts to integrate life skills and to integrate SRH into curricula be combined.

**Pacific Star Life Skills (PSLS)**

- Project funding of $130,000 for 2 years.
- Work plan review: Training of Trainers (TOT) for 8 Countries achieved as planned with 2 countries scheduled for 2007; Refresher training initiated and ongoing

*Pacific Stars Life Skills Training*  
While no LS TOTs were conducted in 2005, in 2006, seven were conducted. Table 3 summarises the LS TOTs and participants in 2006.

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10 Please refer to the section on Technical Assistance and Capacity Building for general concerns in this area capacity building which apply to life skills capacity building activities as well as others.
Although UNICEF set a goal of reaching 20% of youth in the Pacific with life skills and the 2004 review stated that “a country’s demographic profile should determine the number of youth trainers trained in each country,” there has still not been a link between the size of the youth population in a given country and the number of LS Youth Trainers trained. Consequently, the achievement of this goal in countries with larger populations is unlikely (see Table 4 below).

Table 3: Life Skills TOT Participants in 2006

<table>
<thead>
<tr>
<th>Country</th>
<th>No. Trained</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji</td>
<td>29</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>FSM</td>
<td>24</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Kiribati</td>
<td>29</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Nauru</td>
<td>30</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>Samoa*</td>
<td>22</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>26</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Tonga</td>
<td>19</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>21</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>30</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

*Includes 3 participants from Tokelau. Source: AHD Annual Report 2006

Table 4: Cumulative Total of Life Skills Youth Trainers by country compared to Youth Population

<table>
<thead>
<tr>
<th>Countries</th>
<th>Females</th>
<th>Males</th>
<th>Total Youth Trainers*</th>
<th>Youth Population (15-24)</th>
<th>No. of Youth Per Youth Trainer (Ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federated States of Micronesia</td>
<td>25</td>
<td>22</td>
<td>47</td>
<td>25,500</td>
<td>543</td>
</tr>
<tr>
<td>Fiji</td>
<td>37</td>
<td>39</td>
<td>76</td>
<td>164,593</td>
<td>2,166</td>
</tr>
<tr>
<td>Kiribati</td>
<td>24</td>
<td>35</td>
<td>59</td>
<td>19,736</td>
<td>335</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>7</td>
<td>17</td>
<td>24</td>
<td>13,366</td>
<td>557</td>
</tr>
<tr>
<td>Nauru</td>
<td>19</td>
<td>11</td>
<td>30</td>
<td>1,986</td>
<td>66</td>
</tr>
<tr>
<td>Samoa</td>
<td>10</td>
<td>11</td>
<td>21</td>
<td>35,825</td>
<td>1,706</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>45</td>
<td>37</td>
<td>82</td>
<td>98,781</td>
<td>1,205</td>
</tr>
<tr>
<td>Tokelau</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>250</td>
<td>83</td>
</tr>
<tr>
<td>Tonga</td>
<td>38</td>
<td>19</td>
<td>57</td>
<td>21,901</td>
<td>384</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>24</td>
<td>22</td>
<td>46</td>
<td>1,678</td>
<td>36</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>35</td>
<td>52</td>
<td>87</td>
<td>45,347</td>
<td>521</td>
</tr>
<tr>
<td>Total</td>
<td>266</td>
<td>266</td>
<td>532</td>
<td>428,963</td>
<td>806</td>
</tr>
</tbody>
</table>

*Note: Not all are available for training or active. Source: UNICEF 2007 and SPC Population Projections 2006

It was not possible to observe the LS TOT during the review. According to SPC it gets exceptional reviews by participants and stakeholders agencies and many comments during the review support this view. During the review, however, several interviewees also commented that at times lecturing, albeit animated, was used in a life skills training they had observed, which is not a participatory or learner-centred method and is ill-suited to skills development. A number of other issues related to the training were raised, including by the Life Skills Coordinator himself. First, the TOT is by all accounts too short and lacks the depth to build the needed competence. In particular, there is no practical component.
which is absolutely essential for the development of facilitation capacity, an issue also
raised in the 2004 evaluation which recommended that “greater emphasis [be] placed on
participatory facilitation techniques in future youth training sessions.” In addition, LS
training of trainers has been done for varying lengths of time (ranging from one week to
two months for someone who is to provide a workshop to youth in a community) and a
variety of labels have been applied to those who were trained (including master trainer,
youth trainer, youth volunteer) which has created confusion about who actually has what
capacity. Although the 2004 evaluation recommended that the term ‘master trainer’ no
longer be used, the review noted that it is still being used in countries and by partners.

Given the present level of staff and number of partners in country, further capacity
development through follow up, support and coaching could not be done effectively in a
timely manner by the Life Skills Coordinator, the Life Skills Project Assistant or other
project staff. A few NGOs provided new Youth Trainers with follow up support and
coaching on their own initiative, for example, the Fiji Network of People Living with HIV
did so, but this was ad hoc and not widespread. Those who have observed the Youth
Trainers conducting training have expressed concerns about the quality of the training they
provide.

Second, the content of the training does not reflect the integration of the projects. Apart
from HIV, AIDS and STIs, the LS TOT covers AHD issues in only a minimal fashion,
although the LS Coordinator noted that in sessions where content is participant driven other
issues, such as sexual violence, often come up. The 2004 Life Skills evaluation noted the
need for greater emphasis on sexuality issues in the LS TOT but this has yet to happen. In
addition, as mentioned earlier, research has shown that teaching life skills generically has
not been effective, but rather to enable behaviour change, young people need to learn and
practice applying the skills to specific behaviours relevant to their lives.

Third, conducting the TOT workshops in English, which is not the mother tongue of the
majority of trainees, has affected their comprehension of the material. Although a local co-
facilitator has often been recruited to provide translation and interpretation of life skills
concepts and principles, they have at times experienced difficulties with translating terms
that have no equivalent in the local language, sometimes providing subjective
interpretations of the concepts which causes confusion. There may be a need to develop a
lexicon of key terms, which would include agreed upon terms and definitions in both or all
languages. Clearly, insufficient comprehension and/or confusion about the concepts and
material decreases the trainees’ competence to deliver community based education.

The AHD Coordinators are responsible for the selection of the trainees and staff report that
they have done an excellent job of identifying participants that meet the selection criteria
for the PSLS TOT, including youth representing a wide geographic spread. The 2004
evaluation stated that in Vanuatu “the project needed to involve different actors” and that
“greater success in reaching the target population with quality life skills education [would
be achieved] if [the project promoted] a deeper and more meaningful partnership between
the implementing partners and the UNICEF office in Suva.” Based on this, in some
countries, one or two trainees have been selected from each of a large number of potential
partners. While positive in some regards, such as potentially generating broader support for
community based life skills education, the down sides of this approach tend to outweigh the
benefits. These include: difficulty in following up with many potential partners and
managing the lengthy process to provide them with contracts to undertake CBLS; difficulty in following up with the trainees, particularly when they are from far flung regions of the country; and no critical mass of capacity being developed within a given organization which can make it difficult for those trained to develop proposals and conduct training and does not encourage partners taking on CBLS as a part of their own work. In addition, the potential partners do not seem to have been selected strategically. While having only one life skills partner may be concentrating the activity too much, having a large number of partners has not proven to be feasible. Hence, depending on the country and its strategy, it is likely that in most the number of partners should fall between the two extremes. In addition, the 2004 recommendation to develop a deeper and more meaningful partnership between the implementers and the project should be pursued, but this will only be feasible if the number of partners is moderate. A well trained, well maintained core group of partners and youth trainers would assure greater quality of facilitation skills and programme delivery than the model currently being pursued allows for.

The lack of competent AHD Trainers of Trainers in country severely limits the possibility of developing solid capacity in AHD including life skills education in countries. It is clear that most countries need to have one or more Trainers of Trainers on the ground, particularly given that it is preferable for the training and follow up to be done by the same person and in the local vernacular. It has been suggested that the AHD Coordinators become the in-country Trainer of Trainers and some work towards this has begun. Before taking this suggestion further, their workload and potential availability should be carefully assessed and compared to the country’s training needs. Having Trainers of Trainers, competent in ASRH and LS education, who are staff of the key partner agencies would be ideal as it ultimately decreases dependence on the project and also increases the likelihood of life-skills based AHD education becoming an integrated part of a partner’s programme.

**Life Skills Consortia**

The 2004 evaluation of the Pacific Stars Life Skills Project recommended the establishment of country-based Life Skill Consortia to enhance life skills training in the community. This review found that these consortia had not yet been established in any of the countries reviewed. UNICEF notes that it was decided at the 2005 annual review meeting that AHD Coordinators would call “stakeholder meetings” instead, however, this has not served a similar purpose. In one country, Tonga, the need for the consortium was not seen as urgent by the AHD Coordinator nor the LS Youth Trainers interviewed. By contrast, in the Solomon Islands, the UNICEF staff thought that it would be useful to establish a group of “training alumni” to reinforce, support and encourage the development of their capacity by sharing ideas and learning from each other, to promote their active participation in community based activities, to coordinate activities and to sustain enthusiasm. AHD Youth Educator Consortium (rather than a Life Skills Consortium) which brought those trained who live near each other together on a regular basis could be very beneficial for creating a sense of joint purpose and ownership.

The number of youth educators needed, the number of partners to engage and whether or not to have one or more youth educator consortia or training alumni groups should be decided on a country by country basis considering the country strategy and based on a written rational.
Community Based Life Skills Education

Table 5 shows the estimated number of youth who have participated in community-based life skills activities in 2005-2006, based on figures obtained from UNICEF Suva, and the percentage of the youth population (here defined as 15-24 years of age) who participated. Some information in this table varied depending on the source. In Samoa and the Federated States of Micronesia, although an LS TOT was conducted in 2006, at the time of the review, UNICEF had yet to provide support to an organisation to conduct CBLS activities.

Table 5: Community Based Life Skills Education in 2005-2006

<table>
<thead>
<tr>
<th>Country</th>
<th>2005</th>
<th>2006</th>
<th>Total</th>
<th>Population 15-24 yrs</th>
<th>% of Youth reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji</td>
<td>1,116</td>
<td>1,325</td>
<td>2,441</td>
<td>160,000</td>
<td>1.5</td>
</tr>
<tr>
<td>Tonga</td>
<td>600</td>
<td>680</td>
<td>1,280</td>
<td>20,000</td>
<td>6.4</td>
</tr>
<tr>
<td>Solomon</td>
<td>1,000</td>
<td>1,000</td>
<td>2,000</td>
<td>78,000</td>
<td>2.5</td>
</tr>
<tr>
<td>Kiribati</td>
<td>700</td>
<td>1,800</td>
<td>2,500</td>
<td>14,000</td>
<td>17.8</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>295</td>
<td>640</td>
<td>935</td>
<td>37,000</td>
<td>2.5</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>200</td>
<td>200</td>
<td>400</td>
<td>1,650</td>
<td>24.2</td>
</tr>
</tbody>
</table>

Source: UNICEF and AHD Evaluation 2007

Note: This table covers only the two years of the project under review and does not give a complete picture of the project since its inception in 2002.

According to Table 5, in 2005-2006, Tuvalu was the only country to reach the target of 20% of youths participating in CBLS (Tonga met this target prior to 2005). Kiribati was able to reach nearly 18% of its young people. As noted previously, reaching this target is a much greater challenge for larger countries such as Fiji and Solomon Islands, particularly given that they have not had significantly more people trained as LS Youth Trainers. Going beyond the sheer numbers reached, additional questions arise, including: Who are the young people reached (in terms of age, gender, marital status, vulnerability)? What exactly did they participate in? What did they receive? What was the quality of the education? What impact did it have on them?

Staff concerns about whether or not the life skills work will have an impact are well-founded. The life skills manual, training and support are geared towards providing a three-day intensive life skills workshop. However, a three-day workshop is not a particularly good way to learn multiple life skills (there are five skill units, some of which cover more than one skill, plus one knowledge unit). In addition to providing the learner with a lot of new content in a short condensed period, not ideal for learning already, it leaves no time for young people to practice and try skills out in their own lives and come back for reinforcement, further advice and development. That is to say it doesn’t meet the criteria of ‘spending sufficient time to imbed behaviours’ which is one aspect of UNICEF’s life skills based approach. In the words of one experienced youth trainer, the training will provide participants with an ‘awareness of skills more than actually developing them.’ If the purpose of the project activities is for the learner to actually gain the life skills taught, this three-day workshop alone is unlikely to achieve that end.

There cannot be one globally predefined amount of time required to ‘teach life skills’ since it will depend on how many skills, which skills (since some are more complex than others and hence require more time) and at what depth as well as the level of the participants and
their pre-existing familiarity with the concepts. Hence, the amount of time required perforce will depend on the content, the participants and the desired outcome. The length of time for the PSLS curriculum has varied as much as from 9 to 50 hours. According to the responses received from UNICEF staff during this review, the current 15-hour, three-day workshop was decided upon principally because it is what is feasible, and, as such, seems to be more trainer- and project-centred than learner-centred. Greater weight needs to be given to learner’s needs and a realistic assessment of the time needed to actually learn the skills being taught in making decisions about the length of curricula and training or workshops. While feasibility is a consideration, decisions about education must be more heavily learner-centred and realistically linked to the desired impact. Consideration should also be given to enabling youth trainers to design workshops or education programmes flexibly. Some suggested that it might work better to implement stagger the education over a number of weeks, possibly running multiple trainings at the same time.

During 2005 and 2006, Community Based Life Skills activities were slowed by a number of factors: the manual being under revision, the need for training in the use of the new manual, and pace of in-country training given only one trainer for the region, hired at the end of 2005. In addition, the difficulties experienced providing CBLS funds to trainees’ organisations in a timely manner after the training hindered the life skills component in most countries. One contributing factor to this difficulty is that the links between the life skills training and the community based life skills education which is intended to follow it remain weak.

The general perception is that it is difficult to get CBLS funds from UNICEF. UNICEF staff also stated that the complexity and length of the process for obtaining funds remains a major barrier at present to the implementation of life skills activities on the ground. It is positive that, in response to these difficulties, some changes in the process were made. Currently, the LS Project Assistant attends the last days of the TOTs and works with trainees to develop proposals immediately. Once she returns to Fiji, however, there has been no one on the ground with the responsibility to follow up, provide guidance on the proposal submission process or other matters, or coordinate and monitor CBLS activities (with the exception of the Solomon Islands which has had a Youth Ambassador responsible for this since last fall). The extent to which the changes in the process for obtaining proposals will accelerate access to funds through UNICEF remains to be seen.

Some interviewees reported that the larger problem was the lengthy process of sorting out details and getting forms completed and signed after the proposal has been submitted, resulting in some proposals never being finalized, continuing delays and the loss of enthusiasm among organisations and youth. In the Solomon Islands, the UNICEF office reported that it needed a full-time staff person just to manage this process. One interviewee, for example, reported having to provide information on how many kilometres it is from one place to another and how much fuel costs per gallon rather than a justified but more summary transportation line item. The necessity of this is not clear to the reviewers and more important, budgetary scrutiny at such a level implies a lack of trust of partners which they feel. In addition, extremely tightly constructed budgets can strangle activities through their lack of flexibility to meet needs since plans sometimes need to be changed for legitimate reasons, prices change, currencies are devalued, and so on, rendering extremely detailed budgeting moot. Since the process is getting in the way of implementation and
fosters mistrust and disillusionment, both it and the requirements for the proposals should be looked at critically to determine their necessity.

A major impact of the delays, for some more than 9 months, is that during the time it has taken for a contract to be approved and funds provided, trained youth get jobs, lose their enthusiasm, motivation and interest or become lost to follow up -- not to mention forgetting what they learned in the training. Although figures are not available, it appears that a good number do not conduct any CBLS workshops. In the Solomon Islands, for example, the Assistant AHD Coordinator and UNICEF Australian Youth Ambassador undertook to establish a data base of Youth Trainers and were able to locate only 20 of the 68 (according to the Solomon Islands UNICEF Office) or 82 (according to the Suva UNICEF Office) Youth Trainers.

CBLS funds were provided to 16 partners in 6 countries (Fiji, Tonga, Solomon Islands, Kiribati, Vanuatu and Tuvalu) in 2005 and to 14 partners in the same 6 countries in 2006. The size of the contracts ranged from about $1,160 to just over $30,600 (only one partner received more than $20,000). Many of the contracts were for less than $5,000. The value of processing many small grants or contracts (e.g. those under $5,000), a very time consuming undertaking, should be reassessed since such small contracts are also likely to have a relatively small impact often without being much less demanding on staff time (i.e. the balance between effort and impact should be taken into consideration). Given that not all potential partners are able to handle larger contracts administratively or programmatically, we recommend focusing more on building partnerships with those who are stronger and better able to implement more substantial programmes.

The review was not able to systematically assess for all countries how many potential partners had youth trained compared to the number of partners who were provided with CBLS funds. In Solomon Islands, 10 organisations had young people participate in the LS TOT in September 2006. At the time of the review, UNICEF Solomon Islands reported that funds had been provided to one and that they were in the final stages of providing funds to two more organizations, which implies that seven of the organizations with Youth Trainers were not yet close to receiving funds, nine months after being training.

If, as suggested by UNICEF, some of those seven organizations have not submitted proposals out of a lack of sufficient interest this would make their selection for participating in the training questionable and reinforce the need to change the current process for selecting partners. The review found that the more commonly cited problem was the lack of follow up and inability to access funds after training which dash the hopes of the young people who were trained. Although they do not remain responsible for CBLS after the training, because the AHD Coordinators organise the TOTs and remain on the ground after the trainers leave, the LS youth trainers look to them for follow up support and to hold them accountable when it does not come through. Thus while the young people’s disillusionment hurts the reputation of the project and all agencies involved, it affects those on the ground the most.

There is evidence that well-selected NGO partners contribute significantly to the delivery of the community based education. In Tonga, the selection of one well-established NGO to conduct CBLS resulted in reaching the target of 20% of youths in 2004. In Solomon Islands, a group of staff from Save the Children Australia’s Youth Outreach Project were
trained in life skills in 2002-2003, following which they had a special agreement with UNICEF which paid the salaries of seven Youth Trainers. These Youth Trainers facilitated life skills education and were responsible for follow up and support to young people in the community. According to UNICEF in Solomon Islands, between November 2005 and November 2006, the youth outreach project was able reached 632 volunteers, and during the six months from June to November 2006, those volunteers reached approximately 4,970 young people per month with ‘life skills messages.’ (By contrast, UNICEF Suva reports that in Solomon Islands, 1,000 youth were ‘reached’ in both 2005 and 2006).

AHD Community Education, including Peer Education

- Project funding $22,000 for 2 years for 8 Countries (Tuvalu Excluded)

Prior to the 2005 merger, extensive awareness and education activities were undertaken as a part of the ARH project. The awareness and advocacy activities were so successful in creating an enabling environment that this is no longer needs to be a major focus of project activities in most countries. Evidence of this success can be seen in the broad level of acceptance of the need to address ARH, previously considered too sensitive and generally ‘unacceptable’ in Pacific Island cultures.

A large variety of education activities have continued to be conducted in most countries by AHD Coordinators, peer educators, NGO partner staff, and some nurses, teachers, counsellors and others. For youth, these have included in-school and out-of-school peer education; community-based youth training workshops; community based drama; workshops for young women; education integrated in sports activities; education at youth camps, retreats and forums; activities during national youth week programmes and international days, such as World AIDS Day and World Population Day; and education integrated into livelihood skills programs for girls. For adults, they have included: advocacy targeting churches and religious leaders aimed at getting AHD education included in church-based programmes and networks; and education for parents and community leaders to gain their support. As for other components, a clear set of meaningful targets and a strategy for reaching them have yet to be laid out for community-based education, so education tends to be scattered, ad hoc, and shallow.

As noted above, although records have generally been kept to some degree at the implementation level, the number and type of education activities undertaken by the project and the number of youth reached over the last two years has not been collated and it has not been possible to gather this information during the review. In addition to the sheer number of youth reached, information about who was reached (in terms of age, gender, marital status, vulnerability), with what education, of what quality and length, available to a varying degree at the implementation level, is also not available in collated form. The impact of these activities has also not yet been assessed by the project. As previously noted, these gaps in should be rectified in the next programme cycle.

Community based education tends to be delivered to youth in a limited number of ways, typically through workshops of one to five days in length, described by one interviewee as ‘bulk training.’ As noted, this modality, though often necessary in training, is not always ideal for learning since the learners have no time to absorb the material or to practise skills. Other options, including on-going courses, should be explored. At present, there is no
possibility for a young person seeking comprehensive reproductive health, sexuality or adolescent health education to do so.

It was observed during the review, that while participatory methods are used at least intermittently, teaching and facilitation skills need to be much improved. The education provided is not yet learner-centred and the experiential learning cycle, upon which the effectiveness of participatory learning is based, is often not followed through when participatory activities are used (while the ‘experience’ step is done, the processing, generalising and applying steps are not well facilitated or omitted). In terms of participatory activities, there seems to be a heavy reliance on small group work. Educators still spend considerable time talking rather than developing participants’ own thinking capacities. These weak teaching skills point to the urgent need to improve or add training for educators on methodology and facilitation and to follow up such training with coaching and support. All project education programmes would benefit considerably from improved facilitation and an infusion of creativity and new ideas about methodologies. Indeed, some project educators expressed their desire and need for such input.

Generally, the community-based AHD education has focused on creating awareness and providing information. A positive development during 2006 was that many AHD Coordinators and peer educators received some life skills training and most expressed their enthusiasm for adding life skills to their education activities, with some noting that they had done so. However, the exact nature and extent to which they are including life skills education in their work could not be assessed. Some youth educators specifically mentioned the desire to learn about behaviour change. As one said, they have done ‘awareness, awareness, awareness for many years. People are still the same.’ According to some interviewees while the term behaviour change communication (BCC) is being used, they have no background on BCC theory or implementation and have not changed their interventions.

Internationally, educational approaches are increasingly emphasizing the importance of incorporating rights, gender and empowerment in health education. Gender is a central factor in an individual’s control over their sexuality and reproductive health and in the development and use of life skills. The review found that gender and rights are largely missing from the programming, training and materials and hence also not adequately addressed in education activities. In fact, previous ‘girl-focused’ activities reinforced gender stereotyping and roles by teaching girls cooking, sewing, flower arranging and fabric dying, rather than promoting gender equality or girls’ empowerment and leadership. Activities reinforcing gender stereotyping and roles are not in line with the human rights based and gender equality approaches adopted by the UN and should not be supported.

**Peer Education**

Within the project, there are two main types of ‘peer educators.’ Most are full time, volunteer peer educators working in NGOs and health centres who typically receive a small stipend, many of whom are young but not actually peers of those they are educating. There are also some part-time student peer educators in schools.

The work of the full-time ‘peer educators’ is highly varied by country and even within countries. Their activities may include: education in the schools in conjunction with the school health team; education in communities; staffing AHD centres or rooms and
attending to visitors; provision of condoms and sometimes emergency contraception; provision of sessions or workshops on request at schools, youth camps, churches or other places; implementation of events on special days; provision of counselling to STI patients (some to patients of all ages), pregnant teens and cases of attempted suicides; provision of family planning and marital or relationship counselling; contact tracing for STI cases; training and working with school or community-based peer educators; and working with commercial sex workers.

**Peer Educator Training**\(^{11}\)

Most peer educators receive about two-weeks training which is widely and, in the reviewers’ opinion, appropriately considered to be very inadequate to prepare them for the complex tasks outlined above. Typically, peer educators receive at most a week’s refresher training per year after the initial training. On-going development of the peer educators’ capacity varies by country and location, but is limited for most. FSM provides an example of good post-training development: the AHD Coordinator works with all new peer educators, observing them and providing feedback until their capacity is at her standard. In Fiji, such mentoring only occurs in the Western Division (and not necessarily on all aspects of their jobs). The resulting quality of the peer educators is highly variable and has not been systematically assessed or controlled.

During the review many peer educators were interviewed and a few observed. While capacity and knowledge vary greatly by individual, overall, it was found that while they generally have correct basic knowledge, their knowledge and understanding is not very deep or nuanced. Some of their messages are unclear and/or clichéd, and some expressed negative attitudes and incorrect ideas which raised greater concerns about the quality of certain aspects of their work. Various comments, sometimes contradictory, were heard about the peer educators’ capacity from others, for example, on the one hand that they were too technical (e.g. talking about T-4 helper cells to young people) and on the other, that they did not know enough about HIV. These perspectives are likely dependent on which peer educators the person happened to know since their knowledge, particularly about HIV and AIDS, varies hugely. As for educators as a whole, their facilitation skills urgently need considerable strengthening.

While generally enthusiastic, many peer educators are also deeply frustrated. Issues frequently cited include: inadequate preparation for the job; lack of support, feedback and supervision; insufficient funds for activities or initiatives or uncertainty about budget allocations; insufficient encouragement or motivation (for some active discouragement) and skills development opportunities; lack of clients and visitors at youth centres and clinics; lack of or inadequate equipment and facilities (particularly computers and internet access); level of responsibility and work not reflected in amount they are paid; stipends insufficient for survival; uncertainty about the future of their positions; and last but not least, the non-resolution of long-standing problems raised repeatedly (we note that many issues found in this review were also found previously).

**Retention of Trained Young People**

The prevailing conventional wisdom is that it is inevitable that there will be a high turnover of trained young people (peer educators and LS youth trainers), requiring regular trainings

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\(^{11}\) Please refer to the section Capacity Building for general concerns which apply to all AHD education and peer educator capacity building activities as well as to other capacity building activities.
of new youth educators/trainers. This is necessarily true of part time in-school peer educators, who leave the school when they graduate. However, the review found that by and large the young people who were trained by the project like their jobs and would like to stay in them, but the conditions of their engagement were not conducive to their doing so. A major issue is that rather than employing youth trainers or peer educators, organizations use them on an ‘as needed’ basis or as ‘full-time volunteers’ who receive small stipends, insufficient for survival (unless their families can support them). The project need not assume that there will be a high rate of turnover or that these young trained educators cannot be retained; but better conditions of employment would be needed to do so. Retaining them would have considerable value if their capacities are further developed (which the reviewers believe is necessary to ensure the quality of their work), particularly given the general lack of capacity in the region. A better understanding of the reasons that the young people who left the work, were lost to follow up, or never used their training did so would be helpful in assessing how to retain them longer and the extent to which turn over is inevitable. Differences in the mobility of and opportunity for youth across the countries should also be analyzed and planned for.

For those young people working full-time, the exact reasons why they are generally considered volunteers rather than employees is unclear and may violate ethical labour standards. The reasons they are called ‘peer educators’ rather than ‘youth educators’ is also unclear since most do not primarily educate their own peers. The status and title of full-time volunteer peer educators should be re-evaluated, particularly if they are better trained, which is recommended. The idea of changing the level and title of young educators was discussed with quite a lot of supervisors and educators and got a positive reaction.

**Recommendations for Integrated LS and AHD Education**

- That a limited number of strong AHD partners are strategically selected and contracted first; and training provided thereafter, so that community based activities can begin immediately.\(^{12}\)

- That NGO partnerships be a key implementation modality for community based education activities in particular. NGO partners should be selected in each country based on the strategy and their mission and capacity.\(^{13}\)

- That a small core group of in-country Trainers of Trainers in AHD education (which fully joins the life skills and AHD components) be developed and maintained, the number of which should be based on an assessment of the in-country needs and the strategic plan, including its objectives, in consultation with partners. These Trainers of Trainers should primarily be based in and employed by the project’s key implementing partners to ensure greater sustainability and not increase or foster dependence on project staff.\(^{14}\)

- That all trainers and educators’ capacity be further developed, particularly their skill in using learner-centred, empowering methodologies, including the experiential learning cycle.

- That the position, titles, training, roles, resources and activities of the CBLS youth trainers and the AHD peer educators be merged and their training and roles and be reconceptualised to be more skilled and longer term with the conditions to enable this. (Note: school-based peer educators are not included in this recommendation.)

\(^{12}\) This will also reduce the number of people trained who ultimately never use the training.

\(^{13}\) Note that this does not mean there should be no partnerships with government agencies.

\(^{14}\) Note that it may not make sense to develop Trainers of Trainers in countries with very small populations.
➢ That contracts include funds to pay the salaries of AHD youth educator positions in NGOs and other agencies as needed and efforts be made to keep these youth educators employed as such for at least five years.

➢ That a greater variety of models for delivering education be explored and promoted and that education programmes be adapted to the learners needs and to particular target audiences (i.e. not ‘one-size fits all’).

➢ That activities reinforcing gender stereotyping and roles (such as teaching girls cooking, sewing and flower arranging) not be supported.

The recommendation to merge the role of youth trainer and peer educator is key to focusing, streamlining and consolidating the project activities to make them more manageable and to finally gaining the potential benefits of the joint project in terms of human, financial, material and training resources. By applying evidence from research on what makes AHD education for young people effective, it will strengthen both the former ASRH and the current LS education. Joining these roles will need to be carefully planned and phased in and consultation with countries and important current partners would be essential. Current AHD Peer Educators will need to be trained in life skills as a part of their certification process and LS Youth Trainers would likewise need to be trained in ASRH issues.

As a part of the process of focusing more on fewer, stronger partners, current AHD and LS partners would need to be critically assessed, particularly on their performance to date and all would not necessarily be retained. All partners would need to have AHD as one of their core focus areas in order for there to be the potential for sustainability. The shift to including more ASRH together with LS in AHD education may require negotiation with some partners who are not health-focused. It should be pointed out, however, that they are already implementing a programme with a health focus, given that the only knowledge content of the current life skills curriculum is HIV and AIDS.

In terms of salary support, the UN agencies report different levels of restriction and flexibility in terms of the length of time that they can support salaries in contracted agencies. In addition, with joint fund-raising, funds for contracting partners might go directly through SPC which is not governed by UN rules. If project support for salaries needs to be time limited, this limit should be clearly communicated to the partners and they should be assisted to source other funds. In terms of sustainability, NGOs are able to raise funds from a variety of sources and could thus raise their own funds. They will be more likely to do so if they are committed to the programme and supported to raise funds. Hence leveraging funds directly to NGO partners may be an area of technical support that needs to be added and certainly would decrease dependence on the project and contribute to sustainability. For government agencies, plans for transitioning salary support for positions should be negotiated up front.

Parent-Child Education & Communication

An attempt was made to initiate parent-child education activities in three countries, but AHD Coordinators found organizing parent-child workshops difficult. Ultimately the project provided only a small amount of support for this activity in Samoa, where mother-daughter education was already part of the Ministry of Women and Community Affairs activities.
While parents are recognized as children’s first sexuality educators and do need education and support in learning how to talk with their children and answer their questions, work to further develop education programs for this target audience should be postponed until already on-going education strategies are assessed, strengthened and solidified.

Education and Resource Materials

Overall, the project appears to have produced and procured from other sources a fairly limited number of materials. Although limited, many of the materials produced are good and demand for them remains high. Comments on the ARH manual were positive, including that the language is simple for the facilitator to follow. Some existing materials, such as the Young Person’s Guide among others, are available in inadequate numbers.

Life Skills Curriculum and Manual
The Life Skills Manual has gone through numerous revisions: it began as a 50-hour curriculum, which was criticized for being too long and the manual for being ‘too bulky;’ it was then revised to a 9-hour curriculum manual, which was considered too complicated; this curriculum was further revised by a consultant who expanded it, after which it was then cut by about half again, resulting in the current manual, with a curriculum designed to be delivered in approximately 15 hours. This revised life skills training manual got mixed reviews among staff and users. Some expressed no concern with using the revised manual, whereas others, including but not limited to those familiar with the original manual, felt that the revised manual was too complicated and difficult to understand and use, and to explain to others, especially youth. Quite a few of those interviewed who have the original manual mentioned that they still use it rather than the new one.

The review found a number of weaknesses with the manual. First, in order to learn skills, a learner needs to practice the skill with feedback in the learning environment and then in their daily lives and be able to get further input, corrections and guidance in the process. The manual contains an inadequate number of activities which provide skill practice whereas this should be a major emphasis of any life skills education curriculum. Second, it is not intuitive or user friendly. The presentation of some skills is confusing and lacks coherence. Third, because it is organized around and limited to providing a fifteen-hour workshop, it does not promote flexibility in implementation, and doesn’t allow for learning any skill in-depth. Fourth, AHD content has not been well integrated into the manual as a whole or into the skills sections. Even the HIV and AIDS session is at the end of the manual, rather than in the beginning where it could provide a context of relevance to young people and enhance their learning by enabling them to apply the skills to specific behaviours, increasing the likelihood of healthy behaviours being adopted.

Use of Existing Materials
Although SPC reports that in-country implementers have ‘abundant materials,’ this was not apparent during the review. Project Coordinators, trainers, educators, counsellors, and curriculum developers would benefit from using a broader range of information resources for ideas, as references and to increase their knowledge. Many excellent resource materials are readily available in English which could contribute a lot to the programme, particularly if training and/or coaching in their adaptation and use is part of more in-depth capacity building, recognizing that familiarity with resources does foster their use. Consideration should be given to the user-friendliness of the materials which are provided: many AHD/LS
educators have limited access to computers, printers, paper and the internet, thus expecting that they would print a fifty or hundred page manual, search on line, use a soft copy of a document, is unrealistic for many. In addition, many particularly useful or important materials are not available in soft copy or on line and would need to be purchased. A resource centre, possibly within a youth centre, where youth educators and teachers could borrow materials is an option that can be considered, though these would most likely be accessible only to those educators in major urban areas. See Annex F for a selected list of recommended materials.

Recommendations:
➢ That the current life skills manual not be formally published as a ‘final’ document, but that bound photocopies be provided to those who need it.
➢ That a flexible resource package be developed that merges ARH and life skills; incorporates more on behaviour change, gender, rights and empowerment; and includes greater variety of lesson plans and resources, such as reference material.
➢ That high quality existing resources (e.g. manuals, reference books, curricula) from around the world be procured and provided appropriately to all key educators or education partners and curriculum developers for adaptation and reference.

With regard to the second recommendation above, although the ARH Manual has recently been revised and mass produced, this need not be a problem per se. The development of a flexible integrated resource package would take time, and might be a set of materials, not a single manual. Thus, it would consider how to integrate and build on the ARH Manual.

Youth Media and Communications

• Project funding of $19,000.00 for 2 years
• Work plan review – 3 countries noted with specific requests

Some countries implemented media activities during the last two years, however, media activities have been generally limited by their high cost. The project has used radio, cinema ads, newspaper articles, community drama and a limited amount of television. For example, in the Solomon Islands, Wantok FM has continued to produce its radio drama programme, Dance with the Devil, which is focused on the issues of HIV and AIDS, STIs, teen pregnancy, violence and alcohol. Since April 2006, UNICEF has sponsored a half-hour pre-recorded youth magazine programme called ‘Youth of Today, Leaders for Today,’ on the Solomon Islands Broadcasting Corporation (SIBC, the national AM radio station) with the broad aim of communicating life skills to young people through issues relevant to them. To date, 44 radio magazines and six talk back shows have been aired, with 60 percent of those participating in the show being youth.

UNICEF also sponsored a training for youth producers of radio magazines from Tuvalu, Fiji, and Solomon Islands on integrating life skills into youth radio programmes as a part of its communication component. The training, conducted by UNICEF Nepal radio partners, was well-received, although critical follow up support for media activities is unclear to those trained. Some countries visited during the review expressed the desire to produce more intensive, on-going media programmes.
The main concerns found in the area of communications programming include: messages insufficiently linked to a research-based understanding of the problems being addressed; the lack of audience research and input; the lack of pre-testing; gaps in ensuring the content of media programmes is accurate; and the lack of impact assessment.

In most cases, given that no audience research or impact assessment has been done, it was not possible to ascertain if the audience is getting the intended messages, making the cost difficult to justify. Two outstanding exceptions were the cinema-based behaviour change ad campaign on the prevention of teenage pregnancies in Fiji, which exemplifies how activities can be strengthened by audience research, pre-testing, piloting, and impact assessment; and the UNICEF sponsored ‘Youth of Today, Leaders for Today’ in the Solomon Islands, which conducted initial audience research as well as an evaluation. SIDT evaluated ‘Youth of Today, Leaders for Today’ to assess its reach and share in March 2007. Four hundred youth aged 15-21 were interviewed in rural and urban areas. Of these, 57% reported that they had heard the show, with 7 out of 10 reporting that they had heard it more than once; and 40% had heard the talk back show. Eighty-eight percent of respondents reported that the show was interesting or very interesting.

In Fiji, the initial ad was developed with input from some peer educators, several high school students and some out-of-school youth and tested to ensure that the message was interpreted as intended. It was evaluated after it had been playing in cinemas for three months using a short exit survey and focus group discussions (FGDs). The exit survey found that the ad was successful in making people think about teenage pregnancy, the first stage of behaviour change (conceptualisation), and in expressing their intention to be ‘more cautious,’ with some of these saying they intended to practise safer sex. The focus groups were more critical of the ad, saying that they disagreed with the negativity of the message, that it discriminated against girls and stigmatised those who became pregnant, and that the message only addressed those who might go on to tertiary education. Based on this feedback, a second ad was developed, using suggestions from youth, which focused more on the desired behaviours and less on the negative consequences of undesired behaviours. This ad has been thoroughly pre-tested and has received largely very positive comments. After it is run in cinemas, its impact will again be assessed.

To maximize the impact of other media programmes, more systematic communications processes should be applied, as was done in Fiji and the Solomon Islands, particularly to on-going, long-term media programmes, such as ‘Dance with the Devil.’

Recommendation

- That the processes used in the Fiji cinema ad campaign and the Solomon Islands radio magazine programme be used as a model for strengthening existing media work and applied, with appropriate technical assistance, particularly to on-going, long-term media programmes.

Such communications technical assistance could come from SPC if a communications technical advisor is hired or from UNPFA’s Regional Communications Officer who was involved in the work in Fiji.
Strengthened ARH Services

- Project funding $6,000 for 2 years for 3 Countries – Pohnpei, Tonga and Vanuatu.

Different terms are used for the physical spaces in which a variety of services are provided to young people in this project and in different countries. In general, youth centres refer to places which have at least one large room, sometimes more, at which, in principle, there are a variety of activities, resources and services for youth, including but not limited to those addressing reproductive health. Some have clinics attached or within them. Youth clinics refer to clinical services which are specifically for young people, which may be imbedded in clinics serving the population as a whole.

The project has worked to improve youth access to services, particularly through support for Youth Clinics, including school-based clinics; Youth Centres; and the integration of youth friendly services into existing health services. The type of services offered for youth through project youth clinics and youth centres vary widely. Some youth centres are stand alone, but most are attached to a youth clinic; some youth clinics are not linked to a youth centre. In at least one country, Fiji, there are AHD Centres and stations, which provide health-related resources and services for youth such as counseling, referrals and condoms, rather than actual clinical services. AHD stations are usually just one small room within a health centre. The review found that Youth Clinics imbedded in clinics run by NGOs and in schools were generally the most successful of the modalities tried (though not all were successful).

In 2005-2006, the project provided funding for the renovation and setting up of fourteen Youth Centres and/or Youth Clinics in Vanuatu, Solomon Islands, Marshall Islands, Fiji, Kiribati, Tonga and FSM. See Table 6 for a summary of project supported youth centres and clinics.

Table 6: Summary of Youth Centres and Youth Clinics – 2007

<table>
<thead>
<tr>
<th>Country</th>
<th>No.</th>
<th>Management Structure</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solomon Islands</td>
<td>1</td>
<td>NGO-based, Clinic and Youth Centre</td>
<td>Youth specific services (counselling, FP, STI testing &amp; treatment) Currently not operating.</td>
</tr>
<tr>
<td>Tonga</td>
<td>4</td>
<td>1 NGO with clinics 3 school clinics</td>
<td>Youth specific services (STI screening, treatment, counselling, FP)</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>2</td>
<td>NGO with clinic 1 Govt clinic with VCT facilities</td>
<td>Counselling, FP</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>1</td>
<td>NGO with clinic</td>
<td>Counselling and FP and STI services</td>
</tr>
<tr>
<td>Pohnpei, FSM</td>
<td>4</td>
<td>Government PH clinic, 3 school-based clinics</td>
<td>Youth specific services (General Health, counselling and RH)</td>
</tr>
<tr>
<td>Kiribati</td>
<td>2</td>
<td>Government with Clinic 1 school clinic</td>
<td>STI screening, treatment, counselling and FP services</td>
</tr>
<tr>
<td>Fiji</td>
<td>15</td>
<td>Government, 2 school-based clinics, 1 project supported ARH Centre, 12 Govt supported ARH stations.</td>
<td>Information and counselling, condom provision</td>
</tr>
</tbody>
</table>
Youth Centres

Youth centres have been supported as places where youth can come for information and counselling, and, for those attached to clinics, as a way for youth to discreetly access adjacent services. Most youth centres provide youth with information, education and communication (IEC) materials on health topics and condoms. In a number of cases, AHD peer educators are based at the youth centre or clinic (for example, in Kiribati, Fiji, Solomon Islands, FSM) and in at least one a Life Skills Youth Trainer is as well (Kiribati). Concerns raised about youth centres include: few youth in attendance; poor location; low attractiveness to youth, including insufficient resource materials and no computer/internet access; and lack of training in or understanding of what a youth centre should be like.

The success of the youth centres is highly varied. Although summary usage data are not easy to come by, the review found that many youth centres (and AHD information and counselling rooms in health centres) are underutilized, based on reports by those who work in them and observations. In Fiji, for example, the AHD centres or rooms, staffed by peer educators, are severely underutilized: most receive between 2-10 non-referred clients per month, with only one reporting about 25 clients per month. In addition, very few of these clients are below the age of 20. Among those visited, it was difficult to see why a young person would go there since there were no activities and in many, hardly any resources.

Suggestions for increasing usage abound. However, the exact reasons why usage is so low is not clear and this must be systematically assessed before solutions are tried out. Any remedies tested should have a clear value to youth in terms of their development and health; for example, health education and life skills courses or sessions (done in a fun and engaging, learner-centred manner); youth discussions or ‘rap’ groups on AHD topics; homework help and tutoring; exercise or dance classes; youth theatre, music, and performance; computer skills courses; youth-oriented resource libraries; CV writing assistance and job interview skills development, to name a few. Youth centres should have varied activities on a regularly scheduled basis, at least one activity a day (preferably more), and be open at hours that are suitable to youth, which usually means extending into the early evening and during some part of the weekend. In the experience of one reviewer, if the activities at the youth centre are engaging and compelling to young people, word will spread fast, particularly in places where there are not a lot of activities for youth.

Recommendation

- That the reasons for the low usage of youth centres be systematically assessed before solutions are tried out; and solutions which are applied have a clear value to youth in terms of their development and health.

Youth Clinics

Although they vary by location and country, youth clinics supported by the project generally provide a range of general and reproductive health services, including contraception, pregnancy testing, emergency contraception, and STI screening and treatment. Services are usually provided by nurses (sometimes by a nurse’s aide or doctor) usually trained in youth friendly services.
Box 1: The Tonga Family Health Association, Nuku’alofa: A Successful Youth Centre and Clinic

The Youth Centre and Clinic at the Tonga Family Health Association in Nuku’alofa is one of the best developed and most successful of the project. Activities at the Youth Centre include drama, music production and peer education and it has a high and increasing usage rate as shown in Table 7 below. Staffed by volunteer doctors, it offers general health care as well as family planning and STI screening and treatment. The clinic’s services complement those provided by the government and it provides up to 50% of STI and 10% of FP service coverage (see Tonga Country Report, Annex B).

Table 7: TFHA Youth Drop-in Centre (2004-2006)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>2,961</td>
</tr>
<tr>
<td>2005</td>
<td>6,117</td>
</tr>
<tr>
<td>2006</td>
<td>9,529</td>
</tr>
<tr>
<td>TOTAL</td>
<td>18,607</td>
</tr>
</tbody>
</table>

The review found that critical factors in the success of youth friendly services, particularly community-based and school-based youth clinics, are the commitment and values of the organization or agency, particularly of the management, and the presence of dedicated and motivated providers. When the organization is committed and appropriate staff are engaged, the clinics tend to do well (examples in addition to Tonga, can be found in FSM, see below, and Vanuatu). Some youth clinics have experienced problems with staffing. For example, in Kiribati, the nurse is often recalled to the health centre when needed, and in the Solomon Islands, when the nurse’s aide staffing the youth services left the organization and was not replaced by either the NGO or the MOH, the youth-specific services stopped. In addition, youth also complained that because a nurse’s aide, rather than a nurse, staffed the clinic, her knowledge was limited.

School-Based Clinics

- Project funding $6,000 for 2 years for 3 Countries – Pohnpei, Tonga and Vanuatu.
- Work plans: Tonga work plan reflect activity in 2005

In 2005-2006, school-based clinics were established in Pohnpei, FSM, Tonga, Vanuatu, and Kiribati (See Table 8). Two school based clinics are in the process of being established in Fiji. The establishment of school-based clinics has often been accompanied by the introduction of other AHD activities for students. See Box 2 for a short description of the school-based clinic in Pohnpei, Federated States of Micronesia, one of the most successful supported by the project.
Table 8: Overview of Project Supported School Based Clinics

<table>
<thead>
<tr>
<th>Country</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Admin Nurse</td>
<td>No</td>
<td>Admin Nurse</td>
</tr>
<tr>
<td>Pohnpei</td>
<td>1</td>
<td>Government 1 Part time</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tonga</td>
<td>-</td>
<td>1 Church 1 Full time</td>
<td>2</td>
<td>Government 1 Part time</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>-</td>
<td>0</td>
<td>2 Tertiary</td>
<td>2</td>
</tr>
<tr>
<td>Kiribati</td>
<td>-</td>
<td>-</td>
<td>1 Government 1 Part time</td>
<td></td>
</tr>
<tr>
<td>Fiji</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2 Government 2 Full time</td>
</tr>
</tbody>
</table>

Total 10: Pohnpei (FSM) - 3; Tonga – 3; Vanuatu – 2; Kiribati – 1; Fiji - 2

Box 2: Example of a Successful School Based Clinic - PICS in FSM

The AHD project in Pohnpei State piloted youth friendly services at the Pohnpei Island Central School (PICS) in 2003. This in-school clinic provides general care as well as reproductive health services, including counselling and information, family planning, pregnancy testing and STI screening, to students and staff. The clinic receives approximately 100 clients per month. It is staffed three days a week by the AHD coordinator, who also provides education in the classroom. Similar clinics are currently being established in two other schools.

There have been a few missteps in the development of school-based clinics that can be instructive for the future. For example, in Tonga, the clinic at the Queen Salote College has a nurse in attendance only one hour a week; not surprisingly, the attendance is small with an average of 5 visits a week, mostly for common ailments such as headaches and fever. The value of this for a project whose aims are heavily focused on the prevention of RH problems among youth is questionable. In Kiribati, the nurse for the school clinic is often recalled to the hospital when there are staff shortages, making the school-based services undependable.

As a strategy for providing youth with reproductive health services to prevent teen pregnancy and STIs, school-based clinics need to be strongly justified. For schools with sufficiently large student bodies and/or known serious youth health problems, such as teenage pregnancies, establishing a school clinic may be an important, strategic intervention. Generally speaking however, such clinics are a relatively expensive undertaking in part because they are usually only used by students attending the particular school. However, they do have some clear advantages as they are easy for students to access and more private than public clinics.

Based on the review findings and reviewers’ experience, the following requirements for school-based clinic support are suggested:

- Strong justification for the need for the clinic;
- Commitment, support and involvement of the school management in planning;
A written request and plan for the clinic from the school, including a clear list of the services which will be provided,

Agreement to provide a minimum standard set of services, including some RH services (such as contraception and condoms);

Commitment of adequate space for private counselling and services;

Commitment by the school or government to fund recurring clinic costs, including staff salaries;

Commitment to provide a dedicated, YFS-trained nurse;

Reasonable hours of operations, spread over several days;

**Recommendation**

- That the provision of project funds to support school-based clinics be well-justified, limited to schools which met specific requirements (listed above), and generally limited to non-recurring costs.

- That the project establish a minimum set of services as a requirement for support, which must include RH services (at least the provision of contraceptive methods appropriate for adolescents, including condoms).

**Youth Services Integrated into Existing Health Services**

In 2005, the project initiated work with health departments and health providers to introduce the concept of youth friendly sexual and reproductive health services and to encourage their integration into mainstream health service. Making existing government health services, particularly primary health care, youth friendly would in principle enable such services to be more widely available and sustainable. Integration workshops were conducted in FSM, Fiji, the Marshall Islands, Samoa, Tonga, Solomon Islands and Vanuatu.

Most health centre staff met during the review appeared open to receiving young people, whether or not they had been trained, however, no encounters were observed and no young people who had actually used the services were interviewed. Public health nurses interviewed had good knowledge of adolescent health and the special needs of youth. In some places (the Marshall Islands, Fiji, Solomon Islands and Pohnpei (FSM)) staff report that ARH services are slowly being integrated into primary health care although the review could not verify in what way or to what extent youth usage had increased. However, hospital staff themselves thought that hospitals are not very responsive to youth’s needs. Integration appears to be better in health centres where one or two health providers address all needs of the community.

In general, however, integration of YFS into existing health services has been the least successful approach to youth service provision to date. The review noted the following: lack of availability of data on the number of young people who come to government services and the reasons for their visits; anecdotal information indicating that very few youth clients access these health services unless they are already pregnant or have symptoms of STIs (or married for family planning services, although data are not available), with the possible exception of accessing condoms; few changes to adapt to youth, if any, made in most health services after training on YFS; continuing issues with privacy and confidentiality in government facilities; and difficulty establishing specific youth friendly services in government clinics and hospitals due to infrastructure and
personnel constraints. A major obstacle to developing services which youth can access is that most youth seeking reproductive health services, particularly in small communities such as those throughout the Pacific, are very reluctant to go to clinics in the same place and at the same time as adults due to the very real fear of being seen by someone in their family or known to their parents and then found out. This issue will need to be grappled with in the next programme cycle. Improvements in making condoms easily and anonymously accessible by placing open containers with condoms in them for anyone to take were noted in some health centres; in some others they can be obtained from peer educators.

While NGO-based youth clinics have been the more successful service delivery points for young people, they are located in urban centres and limited in number. They cannot address the need to provide services to youth living in rural areas and on outer islands. Thus, although less successful to date, making government health services more youth friendly and increasing the number of youth who access them remains important because it alone has the potential to achieve widespread sustainable access over the long term. Therefore, this strategy should not be abandoned but revised and new ways to make these services youth friendly and accessible will need to be devised and tested.

Although criteria for youth friendly services are generally well-known (such as youth only hours; non-judgmental and confidential services, etc.), there are no agreed upon standards for what would officially constitute a YFS globally or in the Pacific as there are for Baby Friendly Hospitals. Establishing such standards might galvanize government health services to implement them. As a part of this process, undertaking a thorough assessment of the needs and problems in developing YFS from the perspectives of the management and administrative staff of the MOH and health facilities, the direct service providers, and the youth, would help to understand the barriers and enable the project to devise specific strategies to address them. The assessment might also look at the impact of the YFS/ARH Service training to date on regular government health services, including if possible some analysis of its impact on the number of youth accessing preventive RH services and an assessment of youth’s opinions of their youth friendliness.

**Recommendations**

- That a thorough assessment be done of the needs and problems in developing YFS from the perspectives of the management and administrative staff of the MOH and health facilities, the direct service providers, and the youth.
- That a Youth Friendly Service Initiative and Package be developed and tested, which would designate services as ‘youth friendly’ if they verifiably met established criteria.

**Services for Adolescent Mothers**

- Project funding $6,000 for 2 years for 3 Countries – Pohnpei, Tonga and Vanuatu.
- Work plans reviewed: Reflected in Tonga’s work plan.

This project activity was implemented in the Marshall Islands and Tonga. The Tonga country report in Annex B describes what it has achieved for the young women who participate. In countries with high numbers of adolescent mothers, this type of service, should be given importance, particularly if its effectiveness in delaying a second adolescent pregnancy can be demonstrated.
General Issues Related to YFS

Family Planning Commodities
Family planning commodity supplies in community based youth clinics, youth centres and for education programmes are an ongoing challenge in some countries. Some have had to use multiple and often unsecured sources of commodity supplies. To ensure commodity quality and security, the AHD Coordinator and RH Coordinator should work together to ensure that both programmes benefit from supplies provided to the country. The AHD Coordinator should be involved into training related to commodities.

Management of STI
Some clinical staff in community and school-based clinics are not trained in the syndromic management of STIs. It is appreciated that country regulations on drug administration by health workers vary; however where opportunity exists, providers at project supported youth clinic should be trained in the syndromic management of STIs to ensure the delivery of quality comprehensive services at these clinics. AHD project management should network with WHO and the UNFPA STI/HIV Adviser to ensure that this occurs.

Gaps in AHD Project
While the review noted some gaps in the AHD Project, the reviewers are of the opinion that at this point it is most important for the Project to focus and strengthen its activities rather than to add new initiatives. That said, some gaps can be addressed within current activities and these are highlighted within the relevant sections above, for example, the need to address gender more thoroughly.

One area which is not highlighted above is that of efforts to address teenage pregnancy. While the AHD project does focus on reducing adolescent pregnancy to some degree, its work on this issue could be strengthened. In addition to undertaking research to deepen understanding about the circumstances of and reasons for teen pregnancy, stronger promotion of family planning, and, in particular, emergency contraception, are needed to reduce the rate of adolescent pregnancy. Emergency contraceptives are an important back-up preventive measure for young women (indeed for couples) who may, for example, make mistakes (including due to alcohol use, reportedly very common), have unexpected sex, experience condom breakage, or be forced to have sex. Emergency contraception should be promoted and be readily available through youth centres and youth clinics (and systematically made available in emergency rooms for rape cases).

Lessons Learned
This section of the report provides a list of some of the important lessons learned in the project which emerged in the review process.

- Joining projects requires planning for the transitional phase. It is essential to assess the impact on management, staffing, staff capacity, workload and existing resources and the constraints and possible problems. The transition plans should include how constraints and problems will be addressed and may include setting key milestones; and developing
standards for the partnership, for example for communication, management, administrative procedures, record-keeping, and monitoring and evaluation.

• Each UN agency has its style, manner of working in country and own administrative procedures and requirements. When agencies work together, these need to be assessed and procedures for the joint project agreed on, so that the implementing or coordinating agency has one set of requirements to meet.

• All partners should be informed about major changes in projects and consulted about concerns.

• Joint projects work best when partners want to work together and see the value in doing so; respect each others capacity and expertise; have complementary roles and expertise; and communicate openly and often with each other.

• The caliber of key project staff is a significant factor in the level of success a project will achieve.

• Programmes need strategic plans that lay out how they will build a programme (rather than just undertake activities) that result in their achieving set goals over a period of time.

• Capacity building requires more than training, particularly for complex skills such as teaching and facilitation and counselling. Such skills require follow up support and coaching or mentoring, including observation and feedback.

• Inadequate training and follow up support perpetuate low capacity and jeopardize the effectiveness of project activities.

• Standardized record-keeping and collated project data are an essential basis for reporting on project reach and part of basic assessment.

• An evidence based understanding of the problems a project is trying to address is vital for designing effective programmes.

• Gathering baseline data needs to be a part of the first phase of a project in order for its impact to be evaluated. Without operations research and evaluation, project weaknesses often remain unknown and the actual effectiveness of activities cannot be established.

• Working with Curriculum Development Units in the Ministry of Education on the development or revision of official curricula on life skills based ASRH education is complex and long-term but will reach the largest number of students, potentially with substantial education in a sustainable manner.

• Work to integrate FLE into curricula works best when it is integrated into the Ministry of Education’s regular review of their curriculum through Curriculum Development Units.
• The length of an educational programme needs to be based on the learning objectives, amount of content and the level of the learners.

• To be effective, the life skills education needs to teach the application of skills to specific behaviours and social tasks and use content relevant to young people, such as sexuality or substance use.

• Learning skills requires repeated practice, feedback and reinforcement, and application in real life situations.

• Learner participation alone does not make teaching learner-centred or effective. To be effective, the participatory methods need to be used within a process anchored in educational theory.

• Youth trainers or peer educators require substantial training, supervision, mentoring and on-going substantive support.

• Gender plays a major role in virtually all aspects of an individual’s control over his or her relationships, body, sexuality, and health and ability to use life skills. Gender awareness thus needs to be an initial element of educational programmes and the gender elements of all topics should be explored.

• Youth centres need regular (e.g. daily), compelling activities to draw young people towards them.

• Establishing school-based clinics needs to be carefully planned with school management and must include a clear definition of the kinds of services that will be provided.

• Adequate clinical staff, who are trained and competent, is essential to the success of clinical services for young people.

• Services for adolescents should be seen as an opportunity to provide proactive preventative education to all clients (i.e., If a client comes for the pill, the provider should educate her about STIs, HIV and condoms; if one comes for a headache, the provider should ensure he or she leaves with an understanding of pregnancy and STI prevention).
## Annexes


<table>
<thead>
<tr>
<th>Country</th>
<th>Principle Investigator</th>
<th>Project</th>
<th>Method of Data Collection</th>
<th>Analysis Group</th>
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<td>Rufina Tutai</td>
<td>Teen Pregnancy &amp; Contraceptive Use Among Adolescents in Cook Islands</td>
<td>* in-depth interviews * FGD * client exit interviews * YFS checklist</td>
<td>Rufina</td>
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<td>Sulueti Duvaga</td>
<td>Evaluation of Peer Educators in Fiji</td>
<td>* in-depth interviews * observations * FGD</td>
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<td>Fiji</td>
<td>Swati Mahajan</td>
<td>Outcomes of Teenage Deliveries at CWMH Fiji</td>
<td>* record reviews</td>
<td>Tim</td>
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<td>FSM</td>
<td>Pertina Albert</td>
<td>Utilisation of ASRH Services in Pohnpei State</td>
<td>* record reviews * in-depth interview * FGD</td>
<td>Annette</td>
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<td>Kiribati</td>
<td>Maoto Metai</td>
<td>P/E Programme and Its Effectiveness in STI Prevention in South Tarawa</td>
<td>* FGD * interviews * observation</td>
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<td>Contributing Causes of Teenage Pregnancy in RMI</td>
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<td>Samoa</td>
<td>Manu Samuelu</td>
<td>YFS in Samoa: Factors Affecting Utilisation of Services Among Young People</td>
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<td>Iemaima Havea</td>
<td>Utilisation of YFS in Tonga: Factors that Enhance Service Utilisation</td>
<td>* FGD * exit interviews * in-depth interviews</td>
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<td>Tuvalu</td>
<td>Filoiala Sakaio</td>
<td>Increasing Teenage Pregnancy in Tuvalu. What Are The Contributing Factors?</td>
<td>* FGD * interviews * exit interviews</td>
<td>Tim</td>
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<tr>
<td>Vanuatu</td>
<td>Joe Kalo</td>
<td>Utilisation of ARH Services by Young People in Vanuatu</td>
<td>* FGD * interviews * exit interviews</td>
<td>Tim</td>
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Annex B: Country Report - TONGA

Focus: Implementation modalities of the Adolescent Health Development (AHD) project both Adolescent Sexual Reproductive Health (ASRH) and Pacific Stars Life Skills (PSLS) activities at country levels towards an improved integrated project impact.

Key Strategy: Non Government Organisation in lead role for AHD programme implementation

Programme Implementation Structure
In Tonga, the AHD project is unique as it is located and managed by an NGO, the Tonga Family Health Association (TFHA), which was asked by the Minister of Health to coordinate the project in 2001 and to work closely with the Public Health Division of the MOH. The Life Skills Education component of the AHD project has primarily been implemented by another NGO, the Tonga National Youth Congress (TNYC), until, in 2007, UNICEF also established a partnership with TFHA to undertake CBLS workshops. This arrangement sees Government as a partner playing a key complementary role in the implementation of the project. In addition the government also plays a monitoring role. The strong support of the Ministry of Health has been instrumental in the success of the project in Tonga.

Tonga Family Health Association
The Tonga Family Health Association (TFHA) is an NGO affiliated to the International Planned Parenthood Federation (IPPF) and as such, its traditional core business has been family planning, sexual reproductive health and rights (SRHR). TFHA receives funding for its work from several sources apart from IPPF, including additional support for AHD. TFHA has received funds from the European Union (EU) and recently. Recently AusAID provided funding for its medicines and medical consumables requirements. The diversification of its funding sources has enabled TFHA to expand the project and demonstrates how the vision, leadership and skills of an AHD Coordinator are central to the success of the project in country. Tonga Family Health Association secured additional funding from EU and AusAID to further support project activities and expansion of the project in Vava’u. This illustrates how vision, leadership and project skills in the coordinator or project management become determining factors in the success of the project.

The UNFPA/UNICEF/SPC project on Adolescent Health Development has also provided funding for its work with adolescents and youth. Having been well established in Tonga, TFHA offers the following services:
- SRH Clinic
- Youth Centre
- Young Mothers Program

The SRH clinic provides services for diagnosis, treatment and counselling of STIs. There are also parallel RH services offered including Antenatal services and Women’s Health Cancer Screening Tests. Following the recent training of the clinic nurse on voluntary, confidential counselling and testing (VCCT), this service in HIV control will be soon introduced at the clinic. The STI clinic with TFHA is youth friendly been in part located at a site less exposed to the travelling public.
TFHA also runs a Youth Centre where young people socialise and obtain information and counselling on reproductive health. This centre is also the site from which TFHA conducts its own ARH peer education and life skills education programmes, including programmes in schools and in the community.

A Young Mothers Centre which receives some funding support from the AHD project, is also located in TFHA.

**Tonga National Youth Congress**

The Tonga National Youth Congress (TNYC) is an NGO established in 1991 with a range of mandate on youth developmental issues. TNYC receives an annual grant of $10,000 from Government, through the Ministry of Training, Employment, Youth and Sports, for its activities. In 2002, UNICEF signed a memorandum of understanding (MOU) with TNYC to implement the Life Skills Project. This project was later merged with the ARH project of UNFPA with Government and later TFHA.

**Pacific Star Life Skills (PSLS) Training**

An estimated total of 69 young people have been trained as trainers for LS. Most of the recorded achievements of the LS have been due to outreach activities before 2005. In 2006 only 4 of the trainers reported having conducted at least one workshop each at the community level. Workshop attendances were at least 25 youths in each session. There was no expressed concern on the use of the revise LS training manual and generally, trainers were happy with the content including the duration of the training sessions.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. Trained</th>
<th>Curriculum to be delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>25</td>
<td>50 hours</td>
</tr>
<tr>
<td>2004</td>
<td>25</td>
<td>50 hours</td>
</tr>
<tr>
<td>2006</td>
<td>19</td>
<td>15 hours</td>
</tr>
</tbody>
</table>

Tonga was cited in the 2004 Evaluation of UNICEF Pacific Stars Life Skills Project as the most successful in implementing the LS project. It was forecasted that the country would achieve the target of reaching 20% of its youth population over 2 AHD project phases.

**TFHA – Youth Clinic Nuku’alofa**

The TFHA clinic services as a youth clinic also. This clinic is a good example of a youth friendly clinic as most people that have visited the clinic are in the youth age group. Service statistics on STI and FP are tabulated below. The clinic shows a good example to Government – NGO partnership in addressing health service.

<table>
<thead>
<tr>
<th>Year</th>
<th>2002</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Outlet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>41</td>
<td>102</td>
<td>45</td>
<td>75</td>
</tr>
<tr>
<td>TFHA (NGO)</td>
<td>48</td>
<td>62</td>
<td>116</td>
<td>104</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>164</td>
<td>161</td>
<td>179</td>
</tr>
<tr>
<td>% NGO/Govt</td>
<td>53%</td>
<td>37%</td>
<td>72%</td>
<td>58%</td>
</tr>
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</table>
Table 11: TFHA Family Planning Attendance 2002 – 2006

<table>
<thead>
<tr>
<th>Service Outlet</th>
<th>2002</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
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</thead>
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<tr>
<td>Government</td>
<td>5285</td>
<td>5420</td>
<td>5122</td>
<td>5548</td>
</tr>
<tr>
<td>TFHA (NGO)</td>
<td>606</td>
<td>629</td>
<td>663</td>
<td>694</td>
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<tr>
<td><strong>Total</strong></td>
<td>5891</td>
<td>6049</td>
<td>5785</td>
<td>6242</td>
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<tr>
<td>% NGO/Govt</td>
<td>10.2</td>
<td>10.3</td>
<td>11.4</td>
<td>11%</td>
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</tbody>
</table>

TFHA Youth Centre – Nuku’alofa
The youth centre at the TFHA is well developed with some funding from the AHD project. Various youth related activities are conducted from the centre such as drama practice, music production and peer education.

Table 12: TFHA Youth Drop-in Centre Visits (2004 - 2006)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of people visiting</th>
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<tbody>
<tr>
<td>2004</td>
<td>2,961</td>
</tr>
<tr>
<td>2005</td>
<td>6,117</td>
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<tr>
<td>2006</td>
<td>9,529</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>18,607</strong></td>
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</table>

Young Mothers Centre
This club is in operation at the Tonga Family Health Association complex and was established in 2004. Two officers manage the activities at the centre and their figures for attendance at the centre is shown in Table 13. The two officers have been trained in ARH through the ARH peer education programme. One of them is also trained as a LS Trainer and the other one was trained as a Community Development Worker through SPC’s Community Education and Training Centre programme in Suva.

Table 13: Attendance at Young Mothers’ Club, Tonga

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Cum Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2005</td>
<td>28</td>
<td>38</td>
</tr>
<tr>
<td>2006</td>
<td>18</td>
<td>56</td>
</tr>
</tbody>
</table>

Activities promoted from the centre include:
- Sewing
- * Cooking
- Handicrafts
- Screenprinting
- Baking
- * Crotchet
- Baking
- Flower Art

The centre is also involved in outreach activities to young mothers where counselling sessions on ARH are also conducted. The centre managers identified the need for training and exposure to micro-enterprises or small business training to be introduced to young mothers. It was noted during the review that another government ministry is tasked with promoting small business training for youths. This avenue could be sought for the young mothers.

Table 14: Young Mother’s Community Outreach Programme, Tonga

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Outreach</th>
<th>No. Young Mothers Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>60</td>
<td>35</td>
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</table>

School-based Clinics
Tonga has had a school-based clinic in one of its Catholic School since 2004. The Mary Potter Health Clinic serves the neighbouring school of Atfo’ou College. The clinic is owned and operated by Mary’s Sisters and has a full time clinic nurse. The clinic nurse is nun of the sisters’ order and as such has pastoral responsibilities for the school also. The

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The clinic is modern with good clinic facilities including a counselling room and a separate examination room. The clinic nurse has her own plans and network to establish and progress school based clinics in 4 other Catholic high schools and 3 Tertiary Schools of the church. This clinic and network has the potential to be strengthened by future AHD projects in addressing school-based clinic including peer education in catholic administered schools.

The AHD project proposes to establish 3 school-based clinics in Tonga. The Queen Salote College clinic, one of the first in operation, was visited during the review. The school clinic is functional after renovation works funded by the AHD project. The school clinic was a former classroom and contains basic clinic equipment and IEC materials. The attendance at the clinic is small with an average of 5 visits a week. The common ailments noted include headaches and fever. School nurse visitation is limited to one hour a week with a nurse roistered from the public health nurse in the hospital.

When comparing the clinic statistics of Queen Salote College, where the nurse visit is limited to one hour a week and a full time nurse for Mary Potters Clinic, one can deduce that for a school based clinic to be successful, it is essential for the clinic nurse to be full-time or at least on site for a reasonable amount of time over several days each week. The clinic schedules need to be planned in consultation with the public health nurse of the district.

Lessons Learned

The AHD project with significant community based activities could be successful if an NGO takes a lead role. However, a good management structure with able and dedicated managers must be ensured for the success of any AHD project.

NOTE: Requested Recommendations from Dr. Lepani.
Annex C: Country Report  KIRIBATI

Focus: ARH service expansion to rural areas
Key Strategy: Networking and partnership with other development partners

General Observations
Kiribati is a country with its own unique constraints and challenges for almost all aspects of life and development. The main island of Tarawa accommodates up to 50% of the estimated 100,000 total populations. The population is very young and this is evident on the ground as one travels through the villages. The existence of a large number of schools (Primary, Junior Secondary, High School) is indicative of the very young population Kiribati has. Indeed the success of any health intervention and the initiation and adoption of any positive behavioural changes will have to be school based.

Kiribati Tentative Steps towards FLE Introduction
Although Kiribati has not received any funding for work on FLE in the 2005-2006 project allocation, as a result of ASRH workshops targeting parents, teachers and religious leaders during 2005 and 2006, the Ministry of Education has become interested in introducing FLE. The country has embarked on early work towards FLE introduction with the following plan of action.

Table 15: Tentative Steps to Family Life Education Introduction, Kiribati

<table>
<thead>
<tr>
<th>Phase</th>
<th>Activities</th>
<th>Expected Outcome</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Brainstorming session</td>
<td>General Agreement to accept and adopt FLE concept</td>
<td>2006</td>
</tr>
<tr>
<td></td>
<td>Consultation with Key Stakeholders</td>
<td>(completed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internal consultation on curriculum content</td>
<td>(current)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Study visit and exposure to functioning FLE countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Trial and Piloting of FLE in identified Schools</td>
<td>Refined / Final Version of FLE</td>
<td>2008 – 2009</td>
</tr>
<tr>
<td></td>
<td>Review of trial findings and outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Implementation of revised FLE</td>
<td>Adoption of FLE by all Schools</td>
<td>2010</td>
</tr>
</tbody>
</table>

Kiribati has identified and grouped their activities towards FLE in 4 Phases spanning a period of 4 years. This period could be shorter if appropriate resources are provided to the activity. The reviewer believes that the Kiribati phased plan could be adopted by all project countries that have yet to implement FLE in their country. The plan indeed allows for focussed assistance and resource allocation from partner agencies.

Issues raised to the reviewer included the following:
- The need for substantial technical assistance to assist in curriculum development
- Need for funding support for activities in the pending 3 phases
- The benefit of study observation tour to countries already implementing FLE by representatives of the Working Committee.
Pacific Star Life Skills Education

Table 16: Life Skills Trainees, 2006, Kiribati

<table>
<thead>
<tr>
<th>Country</th>
<th>No. Trained</th>
<th>No. Active</th>
<th>No. Workshop</th>
<th>No. Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kiribati</td>
<td>29 (2006)</td>
<td>3 (MOH)</td>
<td>2 (by MOH)</td>
<td>50 (total)</td>
</tr>
</tbody>
</table>

In 2006 a total of 29 youths from the Ministry of Education and Social Welfare (MOESW), Peace Corps and MOH were trained in Life Skills. The 5 noted as active in Table 16 are within the MOH. Activities of others trained outside of MOH are not known. In May 2007, an additional 32 youths were trained.

The LS Youth Trainer stated that his colleagues at the Ministry of Education & Social Welfare were not confident in addressing ARH issues. During the review the consultant had a lot of difficulty in tracing the trained LS youth trainer of the Ministry. However, supervisors attest to the fact that no Life Skills Workshop had been conducted by the group since 2006.

For the Ministry of Health, 3 Life Skills Trainers work from the clinic on a regular basis. One LS Youth Trainer was interviewed and stated that in the past 6 months, 2 training workshops on LS was conducted. They stated that a good portion of the LS session was redirected to ARH. Suggestion made was that all LS Youth Trainers be first trained as Peer Educators in ARH. This arrangement will give the educators the confidence to deliver LS education noting that ARH issues could crop up during the sessions.

The reviewer believes that if the core group of 29 trained Life Skills Youth Trainers trained in 2006 could be brought together for refresher training in 2007 and with appropriate incentives, the 20% target for young people trained could be achieved by this core group.

Community Based Clinic - Betio

This clinic renovation and set up was funded by UNFPA. The clinic houses a youth centre and clinic and is located within the premises of Betio Health Centre. Four peer educators (3 ARH and 1 LS) operate from the clinic. They were also interviewed during the visit. There were IEC materials and condoms available at the clinic. The clinic nurse is trained in ARH and is from the health centre establishment. The reviewer was informed that the nurse is often recalled to the health centre when the need arises. (clinic attendance)

School Based Clinic

Kiribati did not receive funding support for this activity in 2005-2006. However, Kiribati has started its school-based clinic at King George 5th School, a government school. Positive and driving factors for the Principal to welcome the clinic were unrelated to ARH but rather:

- ‘It is too far and expensive to send sick children to the hospital.’
- ‘Sending children to hospital can lead to truancy.’
- ‘The school matron has to accompany most referrals.’

The Government school nurse is scheduled to visit the school 3 times a week. Meeting this schedule is dependent on the staffing situation at the base hospital.
The concept of school-based clinic is well received by most school Principals and their management in Kiribati. This area and activity has the potential to be enhanced to be another avenue to reaching young people in the school setting.

The clinic must provide medical treatment and care for mild ailments apart from ARH to be fully appreciated.

It is without doubt that the success of both the Community Based and School Based Clinic is based, amongst others, the presence of dedicated, motivated and full time staffing. The current situation in Kiribati is most likely true for other Pacific Island Countries. The clinic nurse been from government establishment is often recalled to the hospital wards and clinic when there is shortage of staff. Such scenario and occasions can be very disruptive to the work of both clinics.

The issues regarding sustainability and the staffing structure incorporation into Government service are important and a time frame can be attached to this. In fact, Fiji was in this arrangement, where the ARH project paid for its coordinator, until government absorbed the positions into its establishment. This process took around 4 years (2 project cycles) to eventuate.

General Challenges

**Geography:** The scatteredness of the Kiribati island groups remains a challenge for expanding ASRH services outside of Tarawa, which means that AHD services will need to be integrated into government health services as opposed to establishing youth centres.

**Collaboration:** There have been some misunderstandings and competition between the Ministry AHD Team and Kiribati Family Health Association (KFHA).

**Vehicle:** The issue of transportation was raised during the review and the consultant was subjected to long waits for transportation to appointment. The vehicle used by the project is 2006 and because of the poor road condition, is in a very poor state. The island of Tarawa is quite long and travelling from one end to the other can take as long at 2 hours. The northern end of the island is unreachable by road and has 3 Junior Secondary School and 2 High Schools. Moreover, the clinic in Betio is the only one allocated a clinic nurse. The clinic nurse will ultimately service the schools that are at least 5 kilometres from the centre. A good running vehicle is really warranted to effective programme delivery.

**Services:** Youth clinic at Betio needs a lot of funding support for its work. The clinic meeting house (maneaba) need urgent maintenance and repairs. There is also a need for a resource centre for teenagers to use. The creation of a library would be welcomed.

**Focusing on Risk Groups:** While Kiribati youth can be considered to be generally at risk, community outreach programmes need to focus on early interventions for emerging high risk groups, particularly among young girls.

Opportunities for AHD Project Enhancement – Kir European Union (EU) Project
During the review, it was noted that the Kir EU Project has the potential to have a synergistic effect on the AHD project. The Kir EU project is a 4 years project of the European Union with Government of Kiribati and Fiji School of Medicine to improve health services in Outer Islands of Kiribati. The 7.7 Million Euro project has two key components:
- New clinic construction and clinic refurbishment
- Training for public health and midwives

In the project document, the following activities are noted; activity 8 – Construction of Health Centres and Dispensaries; activity 13 – Training of Outer Island Health Practitioners in Midwifery, emergency care and relevant public health discipline; and activity 17 – Strengthening PHC with integration of traditional birth attendants (TBAs) and Healers. The infrastructure component for outer islands could complement and support the expansion of ARH services and future AHD projects could benefit from joint activities especially those for outer island in Kiribati.

During the review, misunderstandings and competition especially between AHD and KFHA were discussed and ironed out. The PCC was called by the reviewer and for the very first time all interested parties came together to discuss the AHD project. This was their first PCC and they have formalized the group for schedule meetings during the year.

**NOTE:** Requested Recommendations from Dr. Lepani.
Annex D: Country Report FIJI

Management Structure and Staffing

In Fiji the project is managed by the AHD Coordinator, Sr. Sulueti Duvaga, who was appointed in 2003. It is implemented through the Ministry of Health (MOH) as a part of the Reproductive Health Programme, the Ministry of Education (MOE), Ministry of Youth and Sports (MOYS) and to a lesser degree through NGOs. NGO partners include the AIDS Task Force; Marie Stopes Fiji; the Reproductive and Family Health Association of Fiji (RFHAF); Fiji Network +; Fiji Red Cross; Live and Learn; the Foundation of the Peoples of the South Pacific International (FSPI); and the Adventist Development Relief Agency (ADRA). The project is included in the Ministry of Health’s Strategic Plan and its Reproductive Health Plan. The Ministry of Health is in the process of decentralizing its programmes and services and the AHD project’s plans for training at the divisional and subdivisional staff are already in place. It must be clear to those trained what is expected of them after the training so that it is not just an orientation, but leads to concrete action and ensures that clinic and community based activities are strengthened.

Since 2006, the project has had an AHD Coordinating Committee which includes members from the Ministry of Health, the Ministry of Education, Ministry of Youth and Sports, Ministry of Women and Social Welfare, SPC, and a number of NGOs and churches. The AHD Coordinating Committee meets quarterly and yearly stakeholder and planning meetings are convened.

The AHD Coordinator appears to be overloaded with a very heavy schedule of training, resulting in frequent absences from her office. The project would benefit from more attention to communication, support and mentoring, problem-solving, and assessment. Generally, programme implementers in the field would like more information. For example, many were unclear about the roles and responsibilities of project staff, including peer educators and their supervisors; and the annual AHD work plan and budget allocations, particularly for peer education activities in their divisions. The lack of feedback on reports; delays in or non-response to proposals; and delays dispersing funds for approved activities were also cited as problems. At times delaying activities planned with a community creates mistrust. In addition, some issues related to communication flow were identified. For example, direct communication between the AHD Coordinator and peer educator causes confusion for the peer educators’ immediate supervisors about the extent to which they are actually the supervisor. In terms of problem solving, certain issues have been raised repeatedly, particularly related to the peer educators, but have not been attended to and resolved.

Recommendations

- That consideration be given to hiring an Assistant Coordinator (depending) on funding.

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15 The NGOs which are part of the RFHAF; Fiji Red Cross Society; Marie Stopes International; AIDS Task Force of Fiji; Equal Grounds Pasifik; ADRA; and Live & Learn Environmental Education. The faith-based organisations are the Apostle Gospel Outreach Fellowship International; the Methodist Church of Fiji; the Assemblies of God of Fiji; the Seventh Day Adventists; the Gospel Church; the Assembly of Christian Churches of Fiji; the Fiji Muslim League; and Arya Pratindhi Sabha Samaj of Fiji.

16 Only the recommendations that are specific to Fiji and different from those in the main report are included here. Recommendations in the main report also apply here.
➢ That greater attention be paid to regular communication, particularly on issues listed above.
➢ That a communications flow chart be developed and all communication regarding peer educators go through their supervisors or at the very least be copied to them.
➢ That long-standing problems be addressed urgently and that issues be resolved when they arise and the resolution communicated to those who raised them.

Cross-Cutting Issues

Programme Design, Strategy and Planning

Project activities in Fiji are varied, spread out geographically and large in number. As elsewhere, the strategic thinking and planning behind them should be strengthened. Many activities seem limited in depth and scattered, which is likely to have diluted their impact. The selection of sites for project activities or the placement of a peer educator does not appear to be rooted in a specific strategy or demand driven. For example, one sub-division said that their area had the highest number of teen pregnancies in Fiji, but the project had not worked there substantially and they did not have a peer educator. There were also places which wanted a peer educator but couldn’t get one, whereas others got them, but did not know what to do with them.

There are some activities which stand out for being more thorough in their implementation which could be built upon: the mentoring of peer educators in the Western Division; the level of on-going training and support to peer educators at Nasinu Secondary School; and the cinema ad campaign.

Capacity Building

There have been many short trainings in Fiji. Although these could not all be thoroughly reviewed, it is clear that at least some are not in depth enough to meet the needs of the trainees. In addition, there is insufficient post-training technical support, mentoring and coaching for many of those trained to help them develop their understanding and skills further. It was found that the resulting capacity is not strong in some areas (the reviewer noted facilitation and teaching, in particular; however, other activities were not observed). In the cases where mentoring had occurred, for example for the peer educators in the Western Division, knowledge of certain topics, such as HIV/AIDS, at least seemed to be deeper (actual training or education was not observed), but it is likely that they could use greater support with facilitation (since the mentor is not an educator).

Level of Integration between Life Skills and ARH

Generally, the integration in Fiji is limited as elsewhere. Five of the MOH-based peer educators participated in the AHD Review meeting in 2007 which included a one week training of trainers for the AHD coordinators and two were involved in a pre-test of the new manual for a week in 2006. They appreciate and value the addition of life skills to the education they conduct and many said that they integrated it to some degree in their work, the extent of which could not be observed. Life Skills Youth Trainers report using the MOH peer educators or staff of RH NGOs to conduct reproductive health sessions during the LS workshops, indicating that the content is not integrated.

Partners who get funds for life skills from UNICEF directly have the perception that they are not seen as AHD partners of SPC and note that they are not always kept in the
communication loop. The AHD Coordinator also did not have all information about the Life Skills activities in Fiji.

**Recommendation**

- That a thorough assessment of the impact of the training and resulting current capacity be done, with particular attention to quality and depth of understanding.

**Education**

Observations of educators and trainers in general found that participatory methods are used to some extent but the experiential learning cycle on which participatory learning depends for its effectiveness is not well-executed, with the processing, generalising and application parts of the cycle being largely overlooked. Educators/trainers tend to talk or lecture quite a lot; and advise students/participants at times rather than guiding them towards their own decisions. At times the information provided is vague, unclear, semi-accurate, or contradictory.

Other issues in the main report which apply to education activities in Fiji include: education being delivered in a limited number of ways, mostly through ‘bulk training’; and few available materials and resources (curricula, lesson plans, etc., available or being used.

**MOH-based Peer Educators**

In general, there is still a lot of confusion about the position, role and responsibilities of peer educators within the MOH system. Many supervisors said that “a peer educator showed up suddenly,” that they were not aware of the programme, and did not know what the peer educator’s job was or to whom they reported. Peer educators equally reported that they did not know their jobs when they got to the posts and that the health centre staff were not prepared for them to be there and did not accept them initially. In a number of cases, there was no room or even a desk for them. Many described spending months and some a year or more developing relationships with the health centre staff and striving to prove their abilities and usefulness. After they have established themselves, most health centre staff expressed appreciation for their contribution. Indeed, at this stage of the project, the ‘peer educator’ position does seem to have taken root. In a number of places without peer educators, staff knew about them and indicated that they would like to have a peer educator. Confusion remains about how to get a peer educator and about supervision, as noted above.

The recruitment process for peer educators varies but in most places seems to be largely by word of mouth rather than through open advertisement, as evidenced by the peer educators who are relatives of hospital or health centre staff. In some cases, this has resulted in the hiring and training of peer educators who are unsuitable. Peer educators are unclear who established the policies applied to them, do not know which policies will apply to them, and lack clarity and understanding of their status in the Ministry and their future, particularly since many are older than the purported age limit. The policy that pregnant peer educators must leave the position is clearly discriminatory.

The work that they undertake varies a great deal by where they are posted. Most conduct education in the schools in conjunction with the school health team; conduct education in communities often in conjunction with the zone nurses; attend to visitors to the ARH or AHD centre or station, if they have one; provide condoms and sometimes emergency contraception; provide sessions or organize workshops on request at schools, youth camps,
churches or other places; organize events on special days; and counsel STI patients referred to them by doctors and nurses. Some provide family planning counselling; provide marital counselling; counsel pregnant young women and cases of attempted suicides; undertake contact tracing for STI cases; train and work with school or community based peer educators; and work with commercial sex workers. Many serve people of all ages.

The current two-week training for the peer educators is inadequate to prepare them for the complex tasks outlined above. On-going development of the peer educators’ capacity is inconsistent. Dr. Arvin Chaudhay in Lautoka has taken the Western Division peer educators on as mentees; he meets with them every two months as a group, and works with new peer educators, providing feedback and assistance to them. However, peer educators in other regions do not get this sort of mentoring. Consequently, peer educators tend to have varied levels of knowledge about different topics, leading some of those who had worked with peer educators to say they thought that their information was too shallow whereas others said it was too technical. Their lack of use of behaviour change theory was also criticized. During the review, the most troubling statements by peer educators were one who did not educate young people about emergency contraception because it would ‘encourage them to have sex’ and another who reported not liking to counsel STI patients because she ‘could not stand the smell.’ These sorts of statements reflect both a lack of knowledge and attitudes which would negatively affect the quality of their work.

Other issues cited by peer educators included: insufficient supervision and monitoring; the lack of evaluation; not enough work; repetitious work; lack of clients; boredom; lack of or inadequate equipment and facilities (including space, privacy for counselling, IEC materials, supplies, computer, Internet, photocopier, telephone, transportation funds, and living quarters); inadequate public relations and marketing; conflict between centre-based services and community-based activities (one person cannot be in both places); lack of materials in local languages; difficult take initiative (come up with ideas or programmes, but told no funds); difficulty communicating with the Coordinator; no imprest, required to use own funds for later reimbursement; non-resolution of long-standing problems raised repeatedly; lack of official recognition of position of peer educator; level of responsibility and work not reflected in level of pay; no MOH identification or uniform; and ‘peer educator’ being a misnomer.

Many AHD stations had a reasonably good supply of IEC materials, although some reportedly had to photocopy them. The main issue was that there was no system for requesting IEC materials and sending them out to AHD stations. Most peer educators reported that they had to go to Suva personally to pick them up. Most had a good supply of male condoms.

**Recommendations:**

- That work towards establishing an official AHD youth educator position in the Ministry of Health be continued;
- That policies regarding ‘peer educators’ be reviewed and discriminatory ones changed; and those policies clearly communicated to supervisors and youth educators.
- That youth educators be sent only to sites which have specifically requested them and which have committed the needed facilities to support their work.
That training and follow up support for youth educators be strengthened and extended including in the area of learner-centred facilitation and the use of participatory education methodologies.

That mentors be identified and brought on board for youth educators to support their further development.

That guidance be provided to MOH youth educators in identifying and using a wider variety of educational materials and ideas in developing their education programmes.

That a system be established for requesting resupply of IEC materials and that these materials be sent out.

Record-Keeping, Assessment and Evaluation

On the ground, records are generally kept, with different levels of detail and rigour depending on the person. However, the project office does not maintain collated records of all project activities by month, year or project cycle. Thus it is not possible to easily report on the number of youth using the AHD stations for what services, by station or as a whole, or to report on the number of education programmes or the number of youth reached with what type of education programme over a given time period. The Coordinator indicated, for example, that the reviewer would need to go to each Sub-Divisional Health Sister (SDHS) to get information on how many community based education programmes the MOH peer educators conducted in 2005-2006 and how many young people they reached.

As elsewhere, the project in Fiji does not have a means by which to regularly assess or evaluate its activities and their impact. Having conducted so many trainings and undertaken so many educational activities in general, their impact should now be evaluated with some urgency to prepare for the next programme cycle.

Recommendation:

That the Coordinator keep collated records of project activities.

Project Implementation

Output 1: Life Skills Based ASRH Information and Education

In-School Education

Formal School Curriculum

The Family Life Education (FLE) curriculum is 17 years old, very out of date, and hardly ever taught. Students currently learn about some SRH and AHD issues through biology, social science, religious education and home economics (mostly girls). With the hiring of a Project Officer for Family Life Education based in the Ministry of Education in June 2006 the development of a new FLE curriculum is finally getting traction. The syllabus for Forms 1-4 has been developed, the drafting of materials for forms 3-4 is starting and these will be trialled. A major achievement is that the teaching of two periods per week of FLE will be compulsory from 2009.

Issues in the development of the FLE Curriculum include: inadequate access to excellent resource and reference materials which would help avoid reinventing the FLE wheel; vacancies at the Curriculum Development Unit; lack of teacher competence in and comfort with the topic; and attitudes and mindsets about FLE. In general, however, the actual
process of the curriculum development is progressing well. FLE should eventually replace ad hoc piecemeal AHD information and education activities.

**Recommendations:**
- That published resources and references be provided to the Curriculum Development Unit (CDU) team in a user friendly format as soon as possible.
- That the FLE component be continued into the next cycle so that it can accomplish its work and do it well.
- That support be provided for the development of pre-service teacher training, beginning with an assessment of the current situation and capacity; followed by building needed capacity and the establishment of teacher qualifications and competencies.
- That principals, teachers, and parents be prepared for the curriculum prior to its introduction.
- That the expectations of the National Curriculum Framework, the funding agencies and the teachers be harmonised.

**School Based Education**
Approaches to the provision of school-based education used by the project include education provided by MOH peer educators during school health team visits; training school counsellors; and training school-based peer educators.

Most of the MOH peer educators conduct one period of education for several classes once a year at every school during school health team visits. For example, they provide Classes 7 and 8 with puberty education. Some also occasionally go to schools by invitation. Those observed mostly repeated material already in the school curriculum rather than adding to it and conducted the same lesson for classes 7 and 8. While most of the information provided was generally correct, some aspects were not, and some ‘messages’ were either confusing or unclear. As noted above, facilitation and the use of participatory methods requires strengthening.

Five teachers, four from schools in three Divisions and one from the Ministry of Education were trained in ASRH counselling in 2005. The teachers, who serve as counsellors, are reported to have organised ‘programs in their own division and strengthened FLE in their own schools.’ Two of them organize peer education at their schools. Reported outcomes are that students are informed about ASRH, referred to relevant services, and access contraception, especially ECP and condoms, however, no supporting data were provided.

At least eleven school-based peer educator trainings have been conducted in 2005-2006. Thirty-eight teachers and 625 students at 30 schools in four Divisions were trained for three days (some may have been less). The subsequent implementation appears to vary greatly. The pilot school programme at Nasinu Secondary School is quite different from later in-school peer education efforts. While Nasinu has a committed school counsellor who drives programme and provides longer initial training as well as more intensive, on-going training, support and some supervision, in other places, the students and teachers receive only the three-day training (or less). The Coordinator reports that those trained are conducting peer support, providing information and referrals, making presentations to staff and student leaders, and taking part in celebrations for International Days, such as World AIDS Day. In a few cases, they have been provided a room.
Without talking to more teachers or counsellors and/or some peer educators and observing some of their activities, it is difficult to get a concrete sense of how much they actually do or the quality of their activities. Three schools were visited: one at which the teachers and students said they had never heard of peer education and did not teach FLE; Nasinu, at which the reviewer talked only to the counsellor since it was school holidays; and the Ratu Kadavulevu School (RKS), at which the reviewer also only talked to the counsellor. The schedule included another school, however, they indicated on the phone that they had not been involved and did not teach FLE. At one health centre, a nurse we talked to said that the AHD Coordinator had done a peer educator training and that she was the one who was supposed to follow up but she did not have time to do so and did not think that anything had happened at the schools, but time did not allow for this to be verified. However, the information gathered in the review seems at odds with the some of what was reported by the Coordinator.

The quality of the work of the school-based peer educators has not yet been assessed. In the reviewer’s experience, the training provided is too short to reasonably expect to develop peer educators competent to undertake the tasks expected of them. One school reported, for example, that they planned to provide 30 students with two days of training to enable them to “impair AHD information to other students, provide peer support and referrals.” Two days is not enough for young people to master even the knowledge they need to undertake these tasks. Without extensive on-going support and education, the accuracy and quality of these peer educators’ knowledge and capacity are serious concerns. It was also found that roles and expectations of school-based peer educators are not always clear to them; for example, one peer educator gathered a sample of a boy’s discharge instead of referring him to a service. Impact evaluation has also not yet been undertaken.

Finally, an issue which came up at one school was the need for the MOH and MOE to have a policy on the distribution of condoms and other contraception in secondary schools.

**Recommendations**

- That the extent and quality of school-based peer educator capacity and what they deliver to students be critically assessed and its impact on students in the general student body (as opposed to the peer educators) be evaluated before expanding further;
- That based on the assessment adjustments be made to ensure that both teachers and peer educators have sufficient training and support to ensure quality.

**Community Based Education**

Community-based education is conducted by MOH peer educators and life skills trainers.

**Community Based Life Skills Education**

So far 76 young people from the Ministry of Youth and Sports (MOYS), Ministry of Health, and various NGO partners have been trained as Youth Trainers in Life Skills. Contracts to undertake community based life skills activities have been provided to the MOYS, the Ministry of Health, and five NGOs. UNICEF in Suva reports that a total of 2,441 young people were reached in 2005-2006 (1,116 in 2005 and 1,325 in 2006).

In 2005, UNICEF and the MOYS signed a one-year memorandum of understanding, which has been renewed annually. The MOYS initially had 8 life skills trainers in four divisions.
and following a training of trainers in February, they have an additional 5, however, at least three are no longer participating in the programme. Their Youth Trainers conduct training with the Provincial Youth Officer. In 2005, they conducted 30 3-day workshops, reaching 700 young people; in 2006, they conducted 18; and they plan to conduct 20-25 in 2007. They include ARH by having MOH peer educators or Marie Stopes undertake sessions; and substance abuse by having the police come in, for example. The main life skills activity is the three-day workshop in a community, but community-based follow up was cited as a weakness. The quality of the programme being delivered by Youth Trainers and the impact on participants has yet to be assessed.

Some interviewees indicated that the two week training of trainers was inadequate and noted that they do not have access to additional technical support after the training when implementing the programme. One suggestion was to have longer training, but spread out over time, perhaps training module by module with practice in between, rather than providing all training in a single session (this may be possible if there are in-country Trainer of Trainers). Fiji Network Plus reported that they conducted a practicum after the training to provide new trainers with some experience and enhance their skill. A couple of partners remarked that gender and patriarchal values are inadequately addressed in the curriculum.

The partners in Fiji appeared to access CBLS funds with greater ease, most likely because they can more easily access UNICEF staff for assistance. (The reviewer did not assess whether or not there were partners who had trainees but did not access funds; one interviewee reported that some trained youth were inactive after training but it was not clear that this was due to inability to access funds). The Life Skills partner agencies varied significantly in terms of follow through with implementation and the number of workshops they conducted. An analysis of those who were most and least successful in delivering the programme could provide useful information for selecting partners in the future.

The MOYS reported that it has been difficult to keep Youth Trainers in part because they are only paid per workshop day rather than by hour (so they are not paid for days spent on preparation and reporting) and are not fully employed by project. The MOYS also expressed some special concerns about merging the project more fully. They indicated that they would need clarification of roles, mandates, implementation issues and indicators they would need to report on (their own and/or those of other Ministries). For example, they wondered if they would need to work through the sub-divisional health offices as well as their own provincial offices.

Recommendations:

- Provide Youth Trainers or educators in the MOYS with an allowance by hour worked or increase work level to employ them fully.

Community-Based AHD Education

The AHD peer educators conduct education in communities often in conjunction with the zone nurses. The number of community based education programmes they have run, their length and the number of young people reached could not be readily obtained.
Centre-Based Education

Fiji has one Youth Centre in Suva. In addition, young people can receive individualized education at AHD stations, however, very few do so. There are no planned education programmes at the Centre and little which would attract youth there. In addition, at present the Youth Centre is located above the STI Clinic, which all agree is a very poor location. It is also just across the street from the Young People’s Project’s successful Youth Centre, so youth services are not geographically spread out in Suva.

Recommendations

- That peer educators are provided with the technical guidance and material support needed to improve the Centre, including the development of a regular programme of daily activities that are both educational and compelling to young people.
- That informational and other resources available at the Centre be improved.

Media

As noted in the main report, Fiji conducted an cinema-based behaviour change ad campaign on the prevention of teenage pregnancies, which exemplified how activities can be strengthened by audience research, pre-testing, piloting, and impact assessment (See main report for more details).

Recommendation

- That the process used in the cinema campaign be replicated in other areas of the project.

Output 2: Strengthened ARH Services

Youth Centre Based Services

The project’s Youth Centre and AHD “stations,” staffed by the peer educators, range from one small room to a small building with several rooms to a large floor of a building. In most, the services offered are information, counselling and the provision of condoms (in a few places emergency contraception is also offered). None offer actual clinical services though many are located within health centres. The majority of clients are STI clients referred by doctors and nurses (though some doctors do not refer their clients to the peer educators). In most places, clients are not limited to youth. Most of the centres or rooms are severely underutilized and receive very few non-referred clients; most get between 2-10 clients per month and one reported about 25 per month, very few of whom are below the age of 20. Several are located in or next to STI/HIV clinics, well-known to be stigmatized locations. No assessment has been done among young people about the reasons that they do not use the centre or stations, however, it is notable that there are no activities or services which would provide a strong draw for young people.

Integrated Services

The AHD Coordinator conducted approximately fourteen 3-day AHD trainings for nurses, other health staff, including clerks, drivers, and unestablished health staff in the Central and Western Divisions to mainstream an understanding of AHD and HIV and AIDS. In 2005-2006, approximately 230 health providers and 95 other staff were trained. Some of the nurses have reportedly done community ASRH activities but these were not observed. Some issues which were brought up included: questions about how trainees were selected; need for clarity of what is expected of services after training; and some of those trained not subsequently working in services youth are likely to use. The project needs to develop a
clear definition of what it means to integrate ASRH services into existing services and to set related targets. Expectations for the concrete actions needed to integrate ASRH services into existing ones should be clear to trainees. In addition, trainees need to be followed up within a relatively short amount of time after training to see what actions they have taken and what support they need.

Most health centre staff met seemed open to receiving young people, even when they had not been trained, however, no encounters were witnessed and no young people who had actually used the services were interviewed. None of the services visited reported having done something specific to make their services more youth friendly or to attract youth and the majority reported receiving very few adolescent clients. Based on their verbal reports, the majority of the adolescent clients they do receive are pregnant teenagers coming for ante-natal care; in addition, they receive some young people with symptoms for STIs. Since the Ministry of Health does not yet disaggregate data on adolescent use of services, data are not available to assess how many young people access the general health services for what reason or whether their number has increased. At some health services visited, condoms seem to be more freely and anonymously available; where there are peer educators, they provide condoms.

School Based Clinics
The project is just in the process of opening two school-based clinics, so it is too early to review them. A positive aspect is that the MOH is providing the nurses for these clinics.

Recommendations
- That a needs assessment be conducted among young people to determine what services they actually need, where they currently go for care, how they perceive existing services, and how they could be improved for youth.
- That MOH data be disaggregated by marital status and by age (15 and below; 19 and below, and 25 and below, for example).
- That a clear definition of what it means to integrate ASRH services into existing services be developed and related targets set so that expectations for actions are clear.
- That suggested strategies for developing the AHD centre and stations be carefully evaluated before being implemented; particular consideration should be given to how they would contribute to youth development and health; their impact on the attractiveness of the centre to young people (for example, focusing on VCCT and eventually treatment could be stigmatising).
Management Structure and Staffing

In the Solomon Islands the programme is managed by two full-time staff, a Coordinator, who took over in 2005, and an Assistant Coordinator. In addition, UNICEF Solomon Islands (SI) has an Australian Youth Ambassador who assists with the Adolescent Development Programme. The office is expanding and there will be an Adolescent Development National Officer from July 2007 and UNFPA has just hired a National Officer, who will play a supportive and coordinating role for all of their projects. UNICEF and AHD staff in-country state that their working relationships with each other are good. AHD staff also reported positive relationships with SPC and UNFPA regionally. Communication between UNICEF SI and the SPC-based Life Skills Coordinators needs improvement however.

Although there are more staff than in the other countries reviewed, the staff nonetheless still have more responsibilities than they can manage. Given that they are expected to provide technical assistance, training, follow up, and monitoring to all aspects of such a varied project spread over a very large and difficult to access geographic area in addition to coordination, reporting and financial management, the project is expecting more from them than is reasonable. Particularly, as they noted, they do not have expertise in all areas of the project. The AHD Coordinator stated that, as a nurse, it is difficult to train teachers or develop the youth centre without more technical assistance.

UNICEF SI staff indicated that when the Youth Ambassador, working nearly full time on life skills, leaves, no one in the office would be able to take on the work of facilitating NGOs access to the CBLS funds. (Note that given the increasing staff in the UNICEF office and/or a change in the process, this may be less of an issue.)

The project is implemented through both the government and NGOs, primarily the latter. In terms of project coordination, there is an AHD Committee, which meets four times a year, and an annual planning and stakeholders’ meetings.

Recommendation

➢ That consideration be given to engaging an international volunteer to assist the project with developing the Youth Centre.

Cross-Cutting Issues

Programme Design, Strategy and Planning

The project activities are wide ranging and include: school-based education through individual teachers and school-based counselling; life skills training and community based education; AHD training and community based education, including peer education and parent-child education through NGOs and churches; media and communications, including radio, community theatre, and newspaper articles; and services for youth through an NGO clinic and integrated into public health services. In addition, the project has sought to

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17 Only the recommendations that are specific to the Solomon Islands and different from those in the main report are included here. Recommendations in the main report also apply here.
involve a large number of NGOs as well as a number of churches and government health services.

In the Solomon Islands, the lack of a clear justified, strategic plan for capacity building, partner selection and program implementation is evident. A single training of teachers in ASRH and counselling was cited by staff as a poor strategy. Another example noted by a staff was the current “scatter bomb” approach of having life skills workshops here and there, which “lacks strategy and logic and has little connection to the issues in the community.” The combination of large variety of activities implemented in a dispersed and relatively shallow way reduces the likelihood of having an impact.

The project has sought to involve a large number of partners (the AHD project, for example, has about twenty partners (exclusive of CBLS partners)). This creates a number of difficulties: only one or two people from each partner can be trained, resulting in insufficient trained staff in the organisation to implement programs; effective follow up and monitoring becomes difficult to impossible; and the lack of effective follow up results in trained people not using the training and capacity not being further developed. The staff commented that with the current number of partners, they cannot keep track of them, do not know who was trained, what they did subsequently or who they reached. While having a large group of stakeholders could be positive in principle in that it could increase programme coverage, at present ensuring the quality of programme implementation is a greater concern than increasing coverage.

The 2006 life skills TOT in the Solomon Islands, which involved trainees from ten organisations, exemplifies most of these issues. For example, only one person was trained in the use of the revised manual from UNICEF’s main life skills partner to date, Save the Children, resulting in that partner feeling ill-equipped to implement the new programme, but nine additional potential partners were included, few of whom have, nine months later, accessed funds to implement life skills programmes. Partners do not seem to have been selected strategically based on the segments of the population that they can effectively reach nor was the number of partners that the current staff can effectively work with considered.

**Recommendation**

- Assess the approach taken with Save the Children to implement Life Skills (which appears to be among the more successful among the community education modalities used to date) to determine what has worked and what could be improved with a view to expanding the use of this modality.

**Communication, Coordination and Consultation**

Partners (NGOs and others) felt that there was inadequate communication and a lack of clarity about who should receive what information and from whom. NGOs, for example, said they were not informed that the projects had merged; were unclear about the job responsibilities of the AHD staff and the relationships of staff and organisations to each other; and were unaware of the yearly plans of the AHD project and project reports. Their perception is that they are not recognized as part of the programme. The UNICEF office has written a draft memo with a communications flow chart to clarify these issues for the life skills portion of the programme which could serve as an example of one way to address communication issues particularly as offices and staff expand.
Coordination among partners seems to have fallen off over the last couple of years. NGOs felt that having the AHD Coordinator seconded to an NGO (as the previous one was) would make her more accessible; consideration should be given to this idea. The NGOs who are implementers would also like greater consultation about major programme changes, such as the merging of ARH and life skills or the changes in manuals and asked to comment on the drafts, particularly as to whether they are user-friendly.

The Youth Development Officers at the Ministry of Women, Youth and Children’s Affairs (MWYCA) indicated that they have only heard about the project, but they have not been involved and would like to be more informed and to receive reports. However, according to the AHD Coordinator, they have a representative on the Project Coordinating Committee. This discrepancy, which should be sorted out, may be due to the confusion over the merging of the ARH project with the Life Skills project. In any case, they felt that there should be closer consultation with their Ministry.

**Recommendations**

- That the communications flow chart be expanded to include the whole AHD project and new staff and its effectiveness in improving communication assessed. If successful, this approach could be shared with other countries.
- That the partners meet and be consulted regularly.

**Capacity Building**

In general, those involved in the programme said that capacity building has been inadequate and some NGOs complained about the lack of quality support coming to the Solomon Islands. Issues in the area of capacity building in the main report which are relevant to the Solomon Islands include: trainings generally being too short; the cascade training model resulting in the use of trainers with limited expertise and experience; capacity building largely being equated with training; and attendance at a training being equated with mastery of the content and skill. The need for follow up, support, coaching and/or monitoring after training is evident in the teacher training on counselling, the life skills TOT and the regional media workshop. There were also questions about how trainees were selected.

**Recommendation**

- Where feasible, establish groups of “training alumni” which meet regularly to share ideas, encourage activities, learn from each other, reinforce skills, and sustain their enthusiasm.

**Materials and Commodities**

There appear to be virtually no IEC materials readily available in the Solomon Islands. The Youth Centre, for example, had almost none and nothing to take away. Some youth educators also said they did not have materials from the ARH project; that they had never seen the Training Manual or the Young Person’s Guide and did not have the Flip Chart.

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18 The situation was the same for the training on psycho-social trauma and counselling sponsored by UNICEF which people noted was quite helpful, but not followed up. The NGOs recognized that they should be using those skills now in the post-tsunami rehabilitation, but they had no way to get there and there appeared to be no plans to harness those trained.
Although there was one at the Youth Centre, they saw it as belonging to the Assistant Coordinator and not as one they could use.

Recommendation

- A needs assessment for IEC materials be done, including an assessment of the materials currently available for staff and educator use and those available for young people to take away, and plans made for addressing gaps.

Some communication glitches related to procuring commodities were found. Save the Children reported that while they could distribute 20,000-30,000 condoms per month, they are struggling to get access to them, despite having an MOU with UNFPA. They believed that they could only get 10,000 per month from UNFPA. UNFPA’s Commodity Security staff says that there is no limit to the number of condoms they can have and that they only needed to report on those that they had already received and request more and that the Director of Save the Children is aware of this. It is not clear thus exactly where the problem lies, but there is clearly a misunderstanding of some sort which needs to be sorted out. Given the importance of getting condoms out to youth, it should be addressed urgently.

Level of Integration between Life Skills and ARH

While the AHD staff in the Solomon Islands have attempted to integrate life skills into their on-going trainings and work to some degree (the extent of which could not be verified), the life skills component appears to have shifted its content to integrate ARH less. Indeed, there did not seem to be much awareness that this was expected among some. One church reported conducting a ARH-Life Skills workshop, but the topics were treated separately by different trainers rather than integrated. The NGOs see AHD and life skills as two different projects and said that SPC, UNFPA and UNICEF are “not speaking one language and do not have their act together.” Project implementers indicated that they think that ARH/AHD and Life Skills should be merged, including the funds.

Record-Keeping, Assessment and Evaluation

Record-keeping, particularly collation of records from different sources is uneven. There was no handing over to the current Coordinator and she had no records of what happened prior to her taking over. The records of youth served at the Youth Clinic are available for certain periods, though not all, but no information was readily available for those served in the public health system by those trained through the project. Information about those reached by AHD partners was also not easily obtainable despite requests. Although the numbers of those reached with life skills education were available, the numbers provided by UNICEF SI and those provided by UNICEF Pacific in Suva were not the same. Therefore, even the basic number of young people reached by the project with education or services is not readily available or certain. Beyond that and more meaningfully, in many cases, it is not very clear what the young people received, what they gained from it and what impact it has had on their lives. For example, if one says ‘reached with messages’ or simply ‘reached,’ it is not clear what this means.

19 It is not clear to the reviewer who is responsible for following up and resolving this issue – the AHD Coordinator, UNFPA staff in Suva or in Honiara. Seta has been informed.
Evaluation was not planned for, a gap raised by many, including the Permanent Secretary of the Ministry of Health. There is a lack of baseline data and at present the project has no means through which to measure its actual impact. Although there is a annual review and planning workshop for stakeholders at which concerns and future directions can be thrashed out, such a meeting does not address the need for monitoring or objective assessment and evaluation.

There is also a lack of documentation of the extent of the problems among different sub-groups of youth, and qualitative understanding of the problems crucial to developing effective programmes. One interviewee reported that in one community they went to there had been 12 teenage pregnancies the previous month. Talking to two of the girls, they found out that the girls had been going to night clubs and drinking with men who have money and having sex when drunk (reportedly three of the pregnancies were with young people and the rest were with businessmen). While this is not necessarily news and is still anecdotal, it raises the question of how common teenage pregnancies result from this circumstance compared to other situations, such as rape or sexual abuse, and whether the project is tailoring its interventions to effectively address the most common reasons for teenage pregnancy. For example, educating young people about safer sex and contraception won’t help if the person is too drunk to know what they are doing or if they are being abused.

**Project Implementation**

Generally, the NGOs impression was that project activity had slowed down drastically since 2005 and most felt that they had not been much involved. It is likely that there are multiple reasons for this perceived decrease including the change in the AHD coordinator at the same time as the projects merged, the lack of handover from the previous coordinator, different priorities of the coordinator (more on integration of services and less on community education), the revision of the life skills manual, the delay in hiring the regional Life Skills Coordinator and vacancies in UNICEF’s SI office.

**Output 1: Life Skills Based ASRH Information and Education**

**In-School Education**

*Formal School Curriculum*

The AHD project in the Solomon Islands has not worked on the curriculum. Nonetheless, on its own initiative, the Curriculum Development Unit is making significant progress in integrating sexuality, reproductive health and life skills into the primary and secondary school curriculum through health education. (Further information on this can be provided.)

*School Based Education*

School-based education has not been a major element of the AHD project in the Solomon Islands. In 2006, a workshop in ASRH and Counselling for teachers was undertaken for 18 teachers from 12 schools. When the AHD Coordinator followed up with them in April 2007, she found that only two were actively using the training. Save the Children reported having an in-school program with teams of teachers and peer educators in selected schools.
Given that not much has been done on school-based education to date, having the project focus its in-school component on supporting the Curriculum Development Unit as they need in the development of the formal school curriculum and related teacher training may be the most effective and strategic approach to increasing in-school education.

**Community Based Education**

Community-based education is conducted largely through NGOs. Some is conducted by peer educators trained under the former ARH project, a few of whom were trained in life skills in 2006. Some is conducted by those trained only in life skills.

**Community Based Life Skills Education**

UNICEF conducted Pacific Stars Life Skills TOTs in 2003 and 2004, and a refresher course in 2005. Since the initiation of the joint project, a two-week life skills training of trainers was conducted for 26 young people from all over the Solomon Islands in September 2006. So far a total of 68 young people from ten provinces, representing 14 organisations have been trained according to UNICEF SI (UNICEF Pacific Office in Suva reports that 82 young people were trained from ten organisations). The UNICEF SI office and Assistant AHD Coordinator have been developing a data base of youth trainers and at the time of the review had only been able to locate 20 of those trained. UNICEF’s main life skills partner has been Save the Children Australia (2005-2007). Other partners include the Church of Melanesia (2005); the Solomon Islands Planned Parenthood Association (SIPPA) in Guadalcanal and Malaita (2007) and the Ministry of Health and Medical Services in Makira and Isabel Provinces (2007). Most of the ten organisations with youth trained in 2006 have not yet received funds to carry out life skills activities.

A group of staff from Save the Children’s Youth Outreach Project were trained in 2002-2003 as youth trainers, following which they had a special agreement with UNICEF which paid the salaries of 7 educators. They facilitated life skills education and were responsible for follow up and support to young people in the community. According to UNICEF in Solomon Islands, between November 2005 and November 2006, the youth outreach project reached 632 volunteers, and during the six months from June to November 2006, those volunteers reached approximately 4,970 young people per month with ‘life skills messages’ (it is not clear if these are mostly the same individuals, some of the same or all different individuals). Although it was requested multiple times, information on the extent and quality of the life skills education or ‘messages’ received by those youth was not provided. At the time of the review the Youth Outreach Programme was negotiating a new agreement with UNICEF. Save is focusing on 70 communities and plans to have each staff person take responsibility for 10 volunteers per community, two of whom would be focused on life skills. A major challenge for the programme is how to provide 140 volunteers with quality training given that there is no Trainer of Trainers in the Solomon Islands.

In May 2007, 27 young people from Internally Displaced Persons (IDP) camps around Gizo Island and Simbo, Western Province received a two-week training as youth volunteers. They learnt about three life skills; practiced delivering small LS activities; considered how life skills could be applied to young people in the IDP camps; and made plans to undertake

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20 UNICEF in Suva reported that 1,000 young people were reached in 2005 and 1,000 in 2006. It was unclear how these numbers related to those provided in the Solomon Islands and requested clarification was not provided.
a survey on the types of activities young people would benefit from on their return to their communities.

**Issues regarding Life Skills**

The lack of timely follow up and the long process entailed in obtaining CBLS funds has severely affected the implementation of the life skills component in the Solomon Islands. A phrase heard repeatedly from various actors was that in the Solomon Islands the life skills programme gives young people “false hopes” – exactly the opposite of what it intends to do. One person noted that because the school push out rate is quite high, young people see training such as that on life skills, as a chance to continue their education. After training, the trainees were enthusiastic, saying, “Okay, let’s go! What do we do?” but when nothing happens eventually those trained get jobs, lose their enthusiasm, give up and/or disappear.

Many interviewees reported that the two week training was insufficient to develop the needed knowledge and skill to deliver life skills education to others and the comments of an experienced observer indicated that the quality of the education delivered by newly trained Youth Trainers needs improvement. In addition, Life Skills training has been done for many varying lengths of time and different titles bestowed, which has created general confusion about what the titles represent in terms of capacity.

The lack of competent Trainers of Trainers in the Solomon Islands severely limits the possibility of developing solid life skills education capacity there, as was experienced recently when UNICEF wanted to develop life skills activities in the Western Province after the tsunami, but they had difficulty finding someone in country to do the training. The AHD Coordinator and Assistant are reportedly being developed as Trainers of Trainers; however, it is unclear how this is actually being done. The AHD Coordinator reported that she was trained for a week on the new curriculum and then was told that she was the focal point. UNICEF SI would like to have a pool of 6-10 Trainers of Trainers at a level equivalent to the SPC-based Life Skills Coordinator.

**Recommendation**

- That if the recommended changes to the application process and number of partners do not occur, UNICEF continue to have someone employed specifically to help see the process through in the Solomon Islands office.

**Community-Based AHD Education**

The AHD staff have incorporated life skills into their training to some degree, but noted that those trained in ARH earlier are not trained in life skills. They are positive about integrating life skills but say it is “burdensome because it is separate.” Most community based AHD education also incorporates life skills to some degree. NGOs involved have included Save the Children (in Malaita and Gizo), Solomon Islands Development Trust (SIDT), and SIPPA, and churches include the South Seas Evangelical Church, the United Church and the Church of Melanesia, though not all are current partners. Numbers of those reached and with what were not readily available from most partners. In addition, the quality of the education provided could not be assessed.

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21 Note also the reservations in the main report about adding this responsibility to already overloaded staff and the need to realistically assess their likely availability to conduct training.
Peer Education
SIPPA has six “community-based educators” who are youth volunteers, working out of its Youth Centre. They received two weeks training in 2005 (possibly not by the project) and two were trained in life skills in September 2006. Issues that they highlighted included: the lack of a job description, a clear vision, and a yearly plan; inability to initiate activities or programs because they are told that there are no funds; inadequate supervision (occurs only when they provide training, i.e. two or three times a year); inadequate encouragement, recognition, training and development to keep them motivated; and inadequate compensation to survive. The peer educators were not observed providing education, so the quality could not be assessed. The distinction between a staff person and a volunteer is unclear since both are expected to work full time every day, raising concerns about ethical labour practices.

Parent-Child Education
Church of Melanesia conducted a mother-daughter workshop in 2004, followed by a father-son session in 2005. Women who came to the training were told to go back to their parishes and share their knowledge, even if for one hour. However, because they did not monitored what happened after the training, they do not know if those who were at the workshop have done anything. Their Mother’s Union has also started a Girls-Friendly Society, for which the AHD coordinator did a workshop.

Issues Regarding Community-Based Education
Generally, the community-based AHD education has focused on more on increasing awareness and providing information, with some skills education increasingly being added. Youth educators specifically mentioned their desire to learn about behaviour change. As one said, they have done “awareness, awareness, awareness for many years. People are still the same.” According to the AHD staff only the name has been changed to behaviour change communication (BCC), but they have no background on BCC theory or implementation.

In the Solomon Islands, as elsewhere, gender and rights are largely missing from the programme. Previous “girl-focused” activities reinforced gender stereotyping and roles by teaching girls cooking, sewing and fabric dying. An NGO interviewee asked, “What were they really teaching? How to be a good housewife?” Education programmes for girls should focus on promoting gender equality or developing girls’ empowerment and leadership.

Other issues in the main report which apply to education activities in the Solomon Islands include: education being delivered in a limited number of ways, mostly through ‘bulk training’; teaching, facilitation and skills in the use of participatory methods requiring improvement; and few materials and resources (curricula, lesson plans, etc.) available and/or being used.

Centre-Based Education
The SIPPA Youth Centre is a large room, painted with colourful murals, in which lots of youth activities could occur. However, it appears to be severely underutilized. The only organized activity each week is an all day “youth forum” to which youth from settlements around Honiara are invited. Seminars done at SIPPA in 2006 reached 289 out of school youth or less than 25 per month on average. The youth educators indicated that they get 5-
30 youth per day (although none were seen during the time the reviewer spent there), with more coming when the schools are on holiday. Although some people come to do research, there is no library, little information, and no working computer or Internet access. The AHD staff remarked that do not know how to develop the Youth Centre and have had no technical support to guide them.

**Recommendations**
- That the number and variety of activities at the Youth Centre be greatly increased (at least one a day) with appropriate technical and materials support.
- That informational and other resources available at the Youth Centre be improved.

**Media**
The project has used several mass media channels to reach youth with AHD information. The Solomon Star had a weekly question and answer column until 2005. Staff plan to revive it with greater youth involvement. Wantok FM directs the radio drama programme, *Dance with the Devil*, which is focused on HIV, AIDS, STIs, teen pregnancy, violence and alcohol. Formerly it was also aired on AM with sponsorship from PK Gum, but no longer is. To ensure accuracy, the AHD coordinator and assistant will review the tape before it is aired. They are now also doing drama performances with other NGOs in communities.

Since April 2006, UNICEF has sponsored a programme called “Youth of Today, Leaders for Today,” aired twice a week on SIBC, the national AM radio station. The broad aim of the half-hour pre-recorded youth magazine, is to communicate life skills to young people through issues relevant to them. To date, 44 radio magazines and six trial talk back segments have been aired, with 60 percent of those participating in the show being youth. One challenge has been that the broadcasters were not fully trained in life skills. In March 2007, SIDT evaluated the programme to assess its reach and share. Four hundred youth aged 15-21 were interviewed in rural and urban areas. Of these, 57% reported that they had heard the show; 7 out of 10 of whom had heard it more than once; and 40% had heard the talk back show. Eighty-eight percent of respondents reported that the show was interesting or very interesting.

UNICEF also sponsored a regional training for youth producers of radio magazines from Tuvalu, Fiji, and Solomon Islands on integrating life skills into youth radio programmes as a part of its communication component. The training, conducted by UNICEF Nepal radio partners, was well-received, although critical follow up support for media activities is unclear to those trained.

Solomon Islands Development Trust (SIDT), home to the Honiara Youth Theatre Group, were trained for two weeks on ARH by the former Coordinator in 2004 and in life skills by two youth trainers from SIPPA in March of 2007 for one week. The group presents a 45-minute drama on HIV and AIDS, followed by two or more hours of discussions and questions and answers with the audience, with adults, youth and children in separate groups. In 2004, they performed in crowded low-income communities around Honiara; in 2005, in the Western and Isabel Provinces. In 2006, they reached 2,785 people in 13 communities in Malaita and Central Guadalcanal; and in 2007, went to north-western Guadalcanal (numbers reached in 2005 and 2007 were requested but not provided).

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22 A second phase is being developed.
Except for the UNICEF radio magazine, no audience research or impact assessment has been done for these media programmes, so it is unclear how many youth are reached, how many tune to the radio programmes or read the newspaper column regularly, what they think of the programmes, or what messages they get from them.

**Output 2: Strengthened ARH Services**

During the review, no services for youth were observed. This, combined with a general lack of data about youth services, makes it very difficult to assess or provide comment on services.

**Youth Centre Based Services**

The initial effort to establish youth-friendly services in the Solomon Islands was through SIPPA. A clinic room adjacent to the Youth Centre staffed by a nurse’s aide was reserved for serving young people. The youth clinic hours, from 8-4, indicate that no adjustment was made to better suit youth. The volunteer community youth educators noted that the nurse’s aide could not answer their questions and thought a registered nurse should be provided.

In the 16-month period (from 7/05-10/06) for which records were available, the youth clinic had a total of 2,496 clients or an average of 150-160 per month; of which 2,146 or 86% were not in school, and 350 or 14% were in school; 1,505 or 60% were female and 991 or 40% were male. The total number of clients under the age of 20 and a break down by marital status were not available.

Of the 982 clients in the second half of 2005, 252 came for STI testing; 144 for pregnancy tests; 260 for unspecified gynaecological problems; 282 were provided condoms; 6 HIV counselling, 13 family planning counselling and 24 infertility counselling. From January to October of 2006, the clinic reported 449 clients for STI testing; 306 for pregnancy tests and 237 for unspecified gynecological problems. They undertook 9 breast exams and provided 39 referrals. They provided condoms to 552 clients; HIV counselling to 16, family planning counselling to 18 and infertility counselling to 50.

Since February 2007, when the nurse’s aide staffing the youth clinic room left, the Youth Clinic has been closed. Young people can go to the regular clinic. SIPPA does not disaggregate the records of its regular services by age, so it is not possible to ascertain if this has had an effect on the number of young people using SIPPA services. Efforts by the AHD staff to get a government nurse assigned to the clinic had not yet succeeded at the time of the review.

The organisation itself seems to be faltering, jeopardising the investments made in the Youth Centre and youth services there. Only 8 of the 13 staff positions are filled. The posts of Executive Director, Youth Coordinator, Youth Clinic Nurse’s Aide and a Clinic Nurse were among those vacant and reportedly most current staff would also like to leave.

**Integrated Services**

The AHD Coordinator has been providing training on integrating ASRH into primary health care for providers, mostly nurses, in government services. In 2006, 54 providers (32

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23 Note that the report provided is quite unclear but the reviewer believes this is the correct interpretation.
Registered Nurses, 2 midwives, 18 nurse’s aides, and 2 health promoters) in Malaita Province (15 providers); Taro Choiseul Province (18 providers); and Central Island Province and Guadalcanal Province (21 providers) were trained. The AHD Coordinator reported having followed up with the 16 trained providers from the Central Island Province. The nurses reported to her that “youth are starting to come in,” however, there is no actual data on how many youth used to come or how many come now which would confirm a change. It is also not clear what they have actually done to make their services more youth friendly after the training; none have establish hours reserved for youth. The AHD Coordinator’s Evaluation of IEC Materials reports that in focus groups young people said that “services were not reliable or youth friendly.”

**Recommendations**

- That SPC or UNFPA follow up with the regional IPPF office responsible for SIPPA to find out their plans for revitalizing SIPPA in order to secure past investments in the organisation, and particularly to ensure that a registered nurse be hired to provide services to youth.
- That operations research be done or data collection be strengthened where nurses have been trained to ascertain the extent to which services are perceived to be youth friendly and youth are in fact accessing services.
- That MOH and SIPPA regular clinic data be disaggregated by marital status and by age (15 and below; 19 and below, and 25 and below, for example).

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24 These figures come from the Annual Stakeholders Meeting report. During the evaluation, it was reported that 66 providers had been trained.
Annex F: Recommended Resources for AHD Educators

Reference Books for Trainers of Trainers or their institutions:
1. Teaching about Sexuality and HIV: Principles and Methods for Effective Education, By Evonne Hedgepeth and Joan Helmich, published by New York University Press. This is a key text – one of the only ones available that goes in depth into key elements of sexuality education, including learning domains and appropriate methods.
3. All About Sex: A Family Resource on Sex and Sexuality, Planned Parenthood, Three Rivers Press is less comprehensive than the second book but popular elsewhere as a general reference.
5. Changing Bodies, Changing Lives, also by the Boston Women’s Health Book Collective, Ruth Bell et al.
10. Sharing Responsibility: Women, Abortion and Society, Alan Guttmacher Institute, also available on line at http://www.agi-usa.org/sections/abortion.html
15. When Sex Is the Subject: Attitudes and Answers for Young Children, Pamela Wilson, Network Publications. Useful for primary school teachers and teacher training.

Books for children which show writers how to present sexuality issues to young children
16. It’s So Amazing! A Book about Eggs, Sperm, Birth, Babies, and Families, Robie Harris and Michael Emberley. For young people.
17. It’s Perfectly Normal: Changing Bodies, Growing up, Sex, and Sexual Health, Robie Harris and Michael Emberley. For young people.

For Guidelines, Lesson Plans and Curricula Examples for Curriculum Developers and Educators
In addition to references above:
http://www.siecus.org/pubs/pubs0004.html


23. The New Teaching Safer Sex, Peggy Brick et al., The Center for Family Life Education, Planned Parenthood of Greater Northern New Jersey


27. Positively Informed: Guidance and Lesson Plans for Sexuality Educators and Advocates, Andrea Irvin, International Women’s Health Coalition. Available on line at www.iwhc.org or copies can be obtained free from IWHC.


29. Filling in the Gaps: Hard to Teach Topics in Sexuality Education, SIECUS. Can be downloaded on line if you do not want to purchase a hard copy.


32. Health Skills for Life, Key Stage 3 and Key Stage 4, Jen Anderson, Christine Beels and Derek Powell, UK Health Education Authority, Thomas Nelson and Sons Ltd. Life Skills.


Note: The books from the The Center for Family Life Education, Planned Parenthood of Greater Northern New Jersey are collections of creative, easy to understand lesson plans and are particularly highly recommended.

There are also Our Whole Lives books for Grades K-1, Grades 4-6 and Grades 9-10, as well as Sexuality and Our Faith companion guides for each level.

Resources for Non-Formal Educators


For counselors, peer educators, health care providers:

Video:
38. The Miracle of Life, Nova program. This is a fantastic video which shows the process of conception on a microscopic level filmed within the human body.

Note: This is a selected list. Additional recommendations can be made for specific topics or areas.
### Annex G: List of Persons Interviewed and Sites Visited

#### AHD Project Management, Suva, Fiji

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<tr>
<th>Name</th>
<th>Position</th>
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<td>Najib Assifi</td>
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<td>Judith Léveillée</td>
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<td>Thierry Jubeau</td>
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#### Countries Desk Reviewed

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<td>Dr Airam Metai</td>
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<td>Bibiana Bureimoa</td>
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<td>Mrs Liku Turuva</td>
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<td>Mr Mosese Baseisei</td>
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<td>Mrs Emalini Naisele</td>
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<tr>
<td>Mr Savenaca Cavalevu Mr Leone Tupua</td>
<td>Project Manager Youth Coordinator/Life Skills Trainer</td>
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- Observed Peer Education: Gospel Secondary School
- Observed Life Skills Training: FJN+ Life Skills Training
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<tr>
<td>Dr. Cyril Pitakaka</td>
<td>Permanent Secretary</td>
<td>Ministry of Health</td>
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<tr>
<td>Sarah Ben</td>
<td>AHD Coordinator</td>
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<td>Crispin Siama</td>
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<tr>
<td>Isaac Muliloa</td>
<td>STI/HIV/AIDS Coordinator</td>
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<tr>
<td>Linda Puia</td>
<td>Curriculum Developer, English</td>
<td>Ministry of Education</td>
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<td>Gideon Sukumana</td>
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<td>Edward Anisitolo</td>
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<td>Samantha Cooper</td>
<td>Australian Youth Ambassador-Adolescent</td>
<td>UNICEF</td>
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<td>Ismael Toorawa</td>
<td>Programme/Operations Manager</td>
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<td>Grace Fafale</td>
<td>Acting Executive Director</td>
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<td>Abel Oska Watesao</td>
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<td>Richardson McFarlane</td>
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<td>Susan Talisi</td>
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<td>Sarah Ben &amp; Crispin Siama</td>
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<td>Jack Martin</td>
<td>HIV Programme Manager</td>
<td>Save the Children Australia</td>
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<td>Rose Maebiru</td>
<td>YOP Manager</td>
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<td>Henry Kana</td>
<td>Programme Officer</td>
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<td>Rachael Rahii</td>
<td>Youth Network</td>
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<td>Noelyn Wagapu</td>
<td>Drama Director</td>
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<td>Josephine Teakeni</td>
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<td>Voice Blong Mere</td>
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<td>Joseph Major</td>
<td>Theatre Programme</td>
<td>Solomon Islands Development Trust (SIDT)</td>
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<tr>
<td>Ethel Suri</td>
<td>President, Mothers Union</td>
<td>Church of Melanesia</td>
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<td>Joy Jino</td>
<td>SICA Federation of Women</td>
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<td>Monica Gwaite’e</td>
<td>Life Skills Trainer</td>
<td>South Seas Evangelical Church</td>
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<td>Observed workshop for out of school youth</td>
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## Annex H: List of Documents Reviewed

<table>
<thead>
<tr>
<th>Title</th>
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<tr>
<td>AHD Annual Report 2006</td>
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<td>AHD Peer Education reports</td>
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<tr>
<td>Annual Country Work Plans</td>
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<td>Annual Reports 2005 and 2006 Adolescent Development Programme</td>
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<td>Annual Work Plans</td>
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<td>ARH 2004 &amp; AHD 2005-2006 Review and Planning Workshop Reports</td>
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<td>ARH Annual Reports 2003-2005</td>
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<td>ARH clinic monitoring tools and reports</td>
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<td>ARH Review Tools 1-7</td>
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<td>ASRH Pacific Experiences Publication 2005</td>
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<tr>
<td>ASRH Research Manual 2006</td>
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<tr>
<td>Before It’s Too Late, 2005</td>
<td>UNFPA</td>
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<td>Checklist for Life Skills Programme Review</td>
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<td>Checklist on status of FLE and Peer Education Review</td>
<td>UNFPA</td>
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<td>Children and AIDS in the Pacific Island Countries, May 2006</td>
<td>UNICEF</td>
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<tr>
<td>Framework for Action for Adolescents and Youth, September 2006</td>
<td>UNFPA</td>
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<td>Improving AHD in the Pacific Region Project Document PMI3R205, March 2004</td>
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<td>Improving AHD in the Pacific Region Project Document; May 2005</td>
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<td>Improving AHD in the Pacific Region Project Document; May 2007</td>
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<td>Improving ARH in the Pacific Region – PMI/01/08</td>
<td>UNFPA</td>
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<td>Improving ARH in the Pacific Region Letter of Understanding PMI/01/08, 2001</td>
<td>UNFPA/SPC</td>
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<td>Instruments for ASRH Centre Review (including counseling)</td>
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<td>Joint AHD Programme Achievements 2006</td>
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<tr>
<td>Mid-term Review of the ARH Project, April 2003</td>
<td>UNFPA / Peter Johnson</td>
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<td>Minutes of PAC meetings 2005-2007</td>
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<td>Monitoring/field/training mission reports 2005-2007 related to all components of the project</td>
<td>UNICEF/UNFPA/SPC</td>
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<tr>
<td>Pacific Star Life Skills Manual (draft)</td>
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<td>PCC Meeting Agendas and Minutes 2005-2007 for Vanuatu</td>
<td>AHD Coordinators</td>
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<td>Project Proposal Template AHD Community-based Training Workshops</td>
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<td>Project proposals for community based life skills workshops 2005-2007</td>
<td>PSLS Partners</td>
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<td>PSLS Trainer’s Guide</td>
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<td>Quarterly Monitoring tools and reports</td>
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<td>Review of the Family Life Education Programme, October 2004</td>
<td>UNFPA/ Jeffrey Buchanan</td>
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<td>Situation Analysis Reports for Kiribati, Samoa, Solomon Islands and Vanuatu 2006</td>
<td>UNFPA</td>
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<td>State of the Pacific Youth; 2005</td>
<td>UNICEF/UNFPA/SPC</td>
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<tr>
<td>Terminal Report on Improving ARH in the Pacific Region, PMI/01/08, March 2004</td>
<td>SPC</td>
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<tr>
<td>Tuvalu Pacific Stars’ Youth Survey on Life Skills and Personal Health, June 2006</td>
<td>Seu’uala Johansson Fua</td>
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Annex I: Data Collection Instruments

Desk Review Questionnaire

A. General
1. What year were you appointed as the ARH / AHD Coordinator?
2. What are the main achievements of the joint AHD project?
3. What are the main challenges of the joint AHD project?
4. What would you recommend to improve results of AHD project in your country (programme and management changes)?
5. What are the main lessons learned in coordinating AHD project in your country?
6. How do you see the project expanding beyond its current level of implementation?

B. Output 1
1. What is the current status of work to the incorporation of Life Skills education into the schools curriculum?
2. What assistance would your country require to facilitate incorporating ARH / FLE, Life Skills into the curriculum?
3. Was there a Life Skills TOT organised in your country in the past two years? (if answer is affirmative – then ask Q4-8)
4. How were you involved in the organisation of the TOT?
5. What is the number and gender representation youth trainers in the TOT?
6. Were you satisfied with the conduct of the LS training?
7. How can the LS TOT be further improved in the country?
8. Do you feel capable of facilitating future PSLS TOT in your country?
9. Have you organised and established a Life Skills Consortium and conducted a meeting?
10. In your view, what are the main achievements of the PSLS component of the AHD project?
11. In your view, what are the main challenges of the PSLS component of the AHD project?
12. Has ASRH been integrated in LS training? Or has Life Skills been integrated into ASRH activities. If there are constraints, explain.
13. How would you improve the integration of ASRH in SL training?

Questions related to PSLS youth trainers
1. What records do you keep of workshops and activities of PSLS youth trainers?
2. Of the PSLS youth trainers, how many have conducted CBLS workshops?
3. What is the total number of young people reached in the CBLS workshops?
4. How are the CBLS educators supported and how are their activities monitored?
5. What are the main challenges in organising CBLS workshops?
6. How do you see the TOT in life skills linking with CBLS?
7. What suggestions do you have for improving conduct of CBLS workshops?

C. Output 2
1. Do you have any ARH Centre and / or Youth Clinics?
2. If you have ARH Centre and Youth Clinics, are the staffs trained in ARH services including counselling?
3. If you have ARH Centres what activities are carried out in the centre and from the centre?
4. How many youth use the ARH Centre every month? How many youth are seen at the Youth Clinic every month? Can you send us data about their age, gender, marital status and reasons for visit?
5. If you have Youth Clinics, what services are offered there?
6. How many ARH peer educators do you have?
7. How many ARH peer educators are also trained in PSLS (and vice versa)?
8. What mechanisms for supervision of PE are in place?
9. Do you keep a record book of activities carried out by peer educators?
10. Have you attended any PE activities in the past 6/12, 4/52, 1/52?
11. How do you determine the quality of the PE sessions?
12. How many community based peer education activities have been carried out by peer educators in the past two years?
13. How many youth in total would have been involved in the community outreach programme?
14. Were there any school based peer education programme carried out recently?
15. If school based peer education was carried out, what is the total number of students who were reached? For school based peer education, what were the challenges faced by the peer educators and what are possible solutions to them?
16. If your country has started school-based clinics, how many are in operation?
17. What are some of the challenges in operating a school-based clinic (if in operation)?
18. Do you know if ARH is integrated into existing health service and in what forms or ways?
19. What suggestions, if any, do you have towards further integration of ARH in the health service?
20. Do you have any special programme for adolescent mothers and if this is in existence, what are some of the activities and coverage?
21. How can we maximise the utilisation of youth clinics by young people?

D. Output 3
1. Do you have a functional Project Coordinating Committee (PCC)?
2. What difficulties do you have in organising PCC meetings and how would you address these to keep the PCC alive?
3. What are some of your observations and comments on the preparation of country work plans?
4. What are some of your observations regarding the integration of project activities and their implementation at country levels?
5. What are some of your observations with regards to general management, monitoring and supervision of the project by the executing agency?
6. For future project success, are you capable in managing the AHD joint project?
7. Do you think the current structure within the project, including staffing, is adequate and able to deliver the activities needed to be undertaken?
8. With regards to capacity building, what suggestions would like to make with regards to in country project management capability / enhancement?
9. What kind of support do you need to help drive the implementation of the AHD project forward?
10. Do you have difficulties in meeting the reporting requirements (program and financial) of SPC – if so how we address these?
Annex J: Evaluation Terms of Reference

The purpose of the consultancy is to:

- Review the achievements of the joint project, analyse lessons learnt, examine strengths and weaknesses and propose changes to the original project agreement.
- Evaluate the level of integration achieved between all elements of the ARH project, particularly the integration of the PSLS component and propose strategies for maximising harmonisation of the implementation of an integrated approach to delivering all components of the AHD project at the regional and country levels.

Scope of Services:

Under the overall supervision of the Review Task Force, the consultants will:

- Review the AHD Project’s programmatic priorities, management structure, programmatic performance and outputs with special emphasis on: Identification of potential areas for programmatic adjustment at the strategic level and operational level
- Identification of any current gaps that provide opportunities for further SPC-UNFPA-UNICEF initiatives
- Review the current status of integration of all components of the AHD project, namely: (1) Strengthening adolescent health information and education through formal AHD educational programme and non formal educational approach (2) Strengthening the Life skills approach (3) Expanding youth-friendly services. This would include the identification of operational and programmatic strengths, weaknesses and constraining factors in the integration of all components of the AHD Project.
- Document lessons learned from the integration of all components the AHD Project ensuring maximal impact for future implementation at the country level.
- Identify modalities for maximising harmonisation of the implementation of all elements of the AHD project, with particular emphasis on the Life Skills component, at regional and country levels.
- Note: This consultancy is not a financial audit.

Specific to the AHD Project Review:

AHD Performance and Service Delivery

1- Review the AHD Project performance since May 2005 against the project objectives and key performance indicators, particularly as outlined in the project document. This review is to be based on an analysis of project documents, reports, stakeholders’ feedback, and other relevant resources.
2- Solicit feedback from stakeholders on the quality, quantity, and timeliness of services provided by the AHD project and how these could be enhanced.
3- Analyse the extent to which the AHD project has met the identified needs of youth and modalities that have been successful that can potentially be upscaled.

Strategic Directions of the AHD Project
1. Review programmatic design and operational modalities and identify opportunities for integration of all components in this joint project.

2. Referring to the project document, including the logframe, review current programmatic priorities and activities against the review findings, and suggest any appropriate adjustments at the strategic or operational levels.

3. Highlight any current gaps in the AHD activities that could provide opportunities for new SPC-UNFPA-UNICEF (even UN-) initiatives.

4. Review the relationship between the different parties and other relevant organisations/agencies in the region, noting constraints and opportunities and recommend appropriate future interaction between these entities.

AHD Project Management and Capacity

1. Review the AHD project management capacity as outlined in the project document. This includes AHD project management, the appropriateness and timing of training courses, budget monitoring, report, activity design and implementation, as well as programmatic quality assurance.

2. Identify potential management opportunities for increased collaboration of the joint AHD project with other SPC/UN programmes e.g. modalities for release of funding and financial reporting in line with the Paris Declaration and new UN processes (HACT).

3. Review current management structure and identify potential changes in the management structure that would facilitate the accomplishment of outcomes and outputs of the project.

Specific to the Integration of all components of the AHD project particularly Pacific Stars Life Skills activities

1. Review the implementation modalities of all components of the AHD project, particularly Pacific Stars Life Skills activities, at both regional and country levels and propose recommendations that would contribute to improved integrated project impact.

2. Solicit feedback from key partners, including project countries, on their experiences with the implementation of all components of the AHD project, particularly Pacific Stars Life Skills activities, and how these can be strengthened.

3. Review the mechanisms for and coordination of delivering Pacific Stars Life Skills training (Training of Trainers, Refresher Training & Community-Based Training) and propose ways for strengthening delivery at both strategic and operation levels.

4. Identify key issues and gaps in the integration of all components of the AHD project, particularly Pacific Stars Life Skills activities, and propose recommendations as to how these could be strengthened.

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