The Status of HIV Prevention, Sexuality and Reproductive Health Education

Fiji, Kiribati, Solomon Islands and Vanuatu
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Credits:
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Acronyms

ABC  Abstinence, Be Faithful, Condoms (HIV prevention options)
AHD  Adolescent Health and Development (usually refers to the regional project initially implemented by UNFPA and later co-implemented with UNICEF, which ended in 2001)
AIDS  Acquired Immuno-Deficiency Syndrome
AUD  Australian Dollar
CDU  Curriculum Development Unit (or department), part of MOE
FLE  Family Life Education (often this is a ‘cover’ for SRH education)
GDP  Gross Domestic Product
HIV  Human Immuno-deficiency Virus
MOE  Ministry of Education
MOH  Ministry of Health
MSM  Men who have Sex with Men or Male to Male Sex
PPP  Purchasing Power Parity
SIDT  Solomon Islands Development Trust
STI  Sexually Transmitted Infection(s)
SPC  Secretariat of the Pacific Community
SRH  Sexual and Reproductive Health
SW  Sex work or Sex worker
UNESCO  United Nations Educational, Scientific and Cultural Organization
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
WHO  World Health Organization

Glossary

(Adjusted) net enrollment rate: The number of pupils of the school-age group for primary education, enrolled either in primary or secondary education, expressed as a percentage of the total population in that age group.

Net intake rate: New entrants in the first grade of primary education who are of the official primary school-entrance age, expressed as a percentage of the population of the same age.

SRH/HIV education: an age-appropriate, culturally relevant approach to teaching and learning about sex, relationships, reproductive health and HIV by providing scientifically accurate, realistic, non-judgmental information.

Under-5 mortality rate: The probability per 1,000 that a newborn baby will die before reaching age five, if subject to current age-specific mortality rates.
Introduction

The United Nations Children's Fund (UNICEF) regional office for the Pacific in Fiji commissioned this review of education sector responses to Human Immunodeficiency Virus (HIV) in four Pacific countries: Fiji, Kiribati, the Solomon Islands and Vanuatu. In line with UNICEF’s mandate, the focus of the review was on the learners: young people aged 10-24. This review considered ‘education sector’ broadly, and took non-formal and out-of-school educational efforts into consideration, especially since in many countries covered by this review the education system has been unable, for economical and geographical reasons, to reach all in need of a formal education, especially beyond the primary level. However, the main focus of the report was on the formal education system, as it is here that most progress can be made, with least overall investment, towards providing universal and comprehensive sexuality, reproductive health and HIV prevention education (hereafter: SRH/HIV education) to all children and adolescents who need it.

HIV cannot be seen in isolation from sex, sexual behavior, sexuality, reproductive health, gender, abuse/violence and the issue of needle/drug use, including alcohol. HIV prevention is best integrated in a wider range of subjects and topics. Therefore, the review looked at the wider context of HIV prevention and also considered reproductive and sexual health, as well as gender equality and alcohol/drug abuse prevention education, all covered by the acronym SRH/HIV education.

Since the prevalence of sexually transmitted infections (STI) in the Pacific is relatively high, education about the treatment and care of STIs, as well as referral to STI treatment services were also a focus of this study. Since the issue of HIV, and in particular some of the behaviors it is associated with (sex work, injecting drug use and male to male sex) are generally considered sensitive and clouded in silence and secrecy, the review also included a focus on stigma and discrimination.

The review included the issue of linkages to prevention services not usually provided in a school setting, in particular as voluntary counseling, including support services in case of unwanted pregnancy, HIV testing services and private businesses or government services that provide condoms.

Since the HIV epidemics in these countries are relatively small, the focus of the review was on prevention of HIV infection, and has left out issues related to care, treatment and support.
Methodology

The review started with a review of the literature, either peer-reviewed or produced by UN agencies, other intergovernmental organizations and NGOs. This led to the formulation of questions and topics for key informant interviews and a small number of group interviews with teachers, students and parents in the four countries involved. A process of peer reviewing was used to further fine-tune reported findings and ensure accuracy of the recommendations, although just two people responded to the request to provide comments.

Background: A very brief summary of best practice in sexuality and HIV prevention education

In order to help frame the focus of this review, in this section best practices in sexuality, reproductive health and HIV prevention (SRH/HIV) education will be briefly presented. UNESCO, in collaboration with UNICEF, UNFPA and WHO, brought together a group of top-experts in the field of sexuality education to develop what has become known as the ‘International Guidance on Sexuality Education’1. It proposed the following definition:

Sexuality education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one’s own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality (p.2).

Why is SRH/HIV education important for children and adolescents? First of all, the word ‘adolescence’ is defined by the process of physical and psychological changes that occur in a young person, often described as growing up. This includes a strengthening or awakening of sexual feelings and interests and a desire to be more independent and start building a social life apart from parents and siblings. SRH/HIV education can help young people understand the physiological and psychological changes they are going through, reduce anxieties and fears, deal with conflicting messages and ideas about sexuality and gender that they may be exposed to, as well as prepare them for life as sexual beings. It can also prevent possible harmful effects of sex, such as STIs, HIV and unwanted pregnancy.

Some common misconceptions about sexuality education, which often form obstacles to its successful introduction and implementation, include:

1. The fear that teaching young people about sexuality may lead them to have sex earlier. There is, however, overwhelming scientific evidence that this is untrue2, just as telling young people about murder and bank robberies does not lead them to become criminals.

2. The fear that it robs children of their presumed innocence. However, this view underestimates what children and adolescents learn about sex and sexuality among themselves—this often involves ‘learning by doing’. They obtain many correct and incorrect ideas about sex and sexuality from the Internet, mass media and movies. Sexuality education can balance and correct the conflicting and sometimes damaging images children and adolescents receive via these channels. There is strong evidence that providing comprehensive sexuality education to children and young people delays the onset of their sexual debut, and leads to other positive health outcomes2.
3. It is also sometimes claimed that sexuality education is ‘against the culture’ or ‘against tradition’. This is a difficult argument to counter, as often the person using it defines for him/herself what is considered part of the culture or tradition and what is not. One argument to counter this view is to point to the many changes globalization has brought to every society and culture, the new risks and vulnerabilities these processes bring for youth and the opportunities schools provide for building their resilience in the face of these risks. The UNESCO guidelines suggest that religious and other stakeholders are closely involved in the process of improving and expanding SRH/HIV education in school settings (p.8). It should be remembered that SRH/HIV education and ‘tradition’ are not necessarily in opposition to each other. Whatever our understanding is of culture and tradition, the proven fact remains that health- and social outcomes of children and adolescents are generally much better when they receive comprehensive SRH/HIV education than when they do not, and at the same time they can still learn about and respect their culture and traditions.

Comprehensive SRH/HIV education should focus not only on facts and knowledge, but also explain and clarify attitudes, norms and values, develop and promote skills (for example, to negotiate and to communicate about sex, or to use condoms) and to promote and sustain a series of risk-reducing behaviors. UNESCO’s global panel of experts, after reviewing all possible evidence, has outlined the following components that should be covered in order to achieve successful and effective sexuality education programs (Vol. II, p.7):

1. **Relationships**, including the topics ‘families’, ‘friendship, love and romantic relationships’, ‘tolerance and respect’ and ‘long-term commitment, marriage and parenting’.
2. **Values, attitudes and skills**, including the topics ‘values, attitudes and sources of sexual learning’, ‘Norms and peer influence on sexual behavior’, ‘decision making’, ‘communication, refusal and negotiation skills’ and ‘finding help and support’.
5. **Sexual behavior**, including the topics ‘sex, sexuality and the sexual life cycle’ and ‘shared sexual behavior and sexual response’
6. **Sexual and reproductive health**, including the topics ‘pregnancy prevention’, ‘understanding, recognizing and reducing the risk of STIs including HIV’ and ‘HIV and AIDS stigma, care, treatment and support’.

It should be noted that most traditional approaches to SRH/HIV education focus only, or mainly on the topics described under point (4) as well as the first topic of point (1). The UNESCO expert panel calls for sexuality education efforts to be defined in a much broader way.

UNESCO’s guidelines are age-appropriate. This means that for each of the components outlined above, there is a series of learning objectives for different age groups: 5-8 years and 9-12 years (primary schools) and 12-15 and 15-18 years (secondary/vocational training schools). In countries where many children do not have access to secondary education, it is important to consider how sexuality education needs can be met via other channels.

Where SRH/HIV education cannot be taught as a stand-alone subject, it should be carefully integrated in multiple existing subjects.
Short Overview of Socio-Economic and Population Indicators

Fiji is a predominantly (54%) Melanesian country. About a third of the population is of Indian heritage. The country consists of around 332 islands of which 110 are inhabited. The total population as estimated by the UN was around 857,000 in 2011³; the IMF estimated a population of 899,000 in 2012⁴. The gross domestic product (GDP) per capita standardized for purchasing power parity (PPP) was 4,728 US$ per annum in 2012 [ibid]. Nearly a quarter of Fijians (22.9%) survived on less than 2 US$ per day in 2009 and 10.1% lived under the Fijian Government’s set poverty line⁵ but the economy has been growing steadily and prospects are good. Life expectancy at birth is 69. The under-five mortality rate was 16 per 1000 in 2011, down from 18 in 2008⁶. Access to clean water and sanitation facilities was 83% as of 2010⁷. Fiji is 96th on the UNDP’s Human Development Index.
Short Overview of Educational Indicators

The Government of Fiji spent 4.1% of GDP on education in 2011, down from 5.8% in 2007. Spending as a percentage of total Government expenditure also dropped, from 20.4% in 2007 to 14.4% in 2011. No literacy data could be found for Fiji.

The net intake rate in grade 1 was 77% in 2011, up from 74% in 2008; a small gender gap has been overcome since 2008, with a slightly higher rate for girls than for boys in 2011. The enrollment ratio in primary schools was 96.5% in 2011, stable over the past 5 years. The net enrollment ratio in secondary schools was 84.4% in 2011, with a slight upward trend since 2007 (88% for girls and 80% for boys). There were 103-104 girls per 100 boys enrolled in primary and secondary education combined; there were 108 girls per 100 boys in secondary education.

Repeating dropped from 2.2% of students enrolled in primary education per year in 2007 to 0.61% in 2011, despite the teacher-pupil ratio worsening (i.e. bigger classes). For secondary students, repeating dropped from nearly 2% in 2009 to 1% in 2011.

Around 91% of the cohort of Grade 1 students had persisted to complete the last grade of primary school (2008); 88% of girls and 93% of boys. Around 96% of boys and girls who complete the last grade of primary school continue into secondary education (2008), down from 99% in 2007.

Short Overview of the HIV, STI and Teenage Pregnancy Situation in Fiji

According to Fiji’s Progress Report submitted to UNAIDS in March 2012, at the end of 2011 a cumulative total of 420 confirmed HIV cases had been reported in the country since the first case was diagnosed in January 1989. It was, however, not clear how many of the confirmed HIV cases were still alive. At the time of reporting, fewer than 100 people living with HIV were in contact with Fiji’s formal health care services. There were slightly more men than women among Fiji’s known HIV cases. The number of new HIV infections in 2010 and 2011 were 33 and 54, respectively. The number of reported cases seems to have gradually increased in recent years.

Fiji is classified as a low HIV prevalence country. The number of people living with HIV in 2011 was estimated to be between 200 and 500 on a population of around 850,000. The prevalence of HIV for 15-49 year olds is estimated to be less than 0.1%. Although no HIV prevalence surveys have ever been conducted in Fiji, the very small number of HIV infections detected among the many thousands of HIV tests undertaken each year supports this low estimate.
The Progress Report states that heterosexual intercourse is the primary reported mode of transmission, and adds that there is no link with sex work. A recent study on men who have sex with men found high levels of stigma and low levels of condom use among men who have sex with men, as well as a high prevalence of payments or giving ‘gifts’ to facilitate male-to-male sex. The stigma of homosexuality is likely to contribute to a severe under-reporting of male-to-male sex as a mode of transmission in official reports. A few studies on sex work have been conducted in Fiji, indicating that the context of sex work is a likely avenue for an expanded HIV epidemic. According to Fiji’s 2010 UNGASS Progress report, 11% of uniformed services personnel and 9% of male tertiary students reported commercial sex in the past year (2008). Injecting drug use is not a major factor in Fiji’s HIV epidemic.

According to statistics of the Ministry of Health, the number of unwanted teenage pregnancies dropped from 5.11 per 1000 in 2009 to 3.8 per 1000 in 2010. According to World Bank data, adolescent fertility (births per 1000 women aged 15-19) was 43 in 2011, down from 45 in 2008.

The Education Sector Response
Policy and Curriculum Framework

Fiji’s Ministry of Education, National Heritage, Culture and Arts, Youth and Sports (hereafter MOE or ‘Ministry of Education’) adopted a National Curriculum Framework in 2009, which paved the way for expanded adolescent reproductive and sexual health education, which in Fiji is called ‘Family Life Education’ (FLE). Fiji’s Education Sector Strategy 2009-2011 defined FLE as follows:

> Family Life Education (FLE) under the MoE is designed to assist young people to develop and cope with the many transitions they will face on their journey from childhood to adulthood. The focus is on life skills learning that will that will assist them understand changes and the need to change in order to build their character. […]

Also in 2009, Fiji developed a reproductive health policy. It contained a ‘policy statement’ which included the following strategic areas for action were defined in the policy:

1. Development of a formal youth-friendly ASRH educational program that offers school-based and teacher-facilitated information for different age groups, including younger adolescents and ‘most at risk young people (MARYP)’. The delivery of educational packages should be gender-sensitive and apply a life skills based approach.

2. Development of a non-formal youth-friendly Peer Education program that offer gender-sensitive and life skills based ASRH information in a non-formal setting, that target most-at-risk young people, both in-school and out-of-school.
3. Development of youth-friendly services that address the needs of young people.

A national FLE education policy was also drafted in 2009. The Minister of Education, however, never ratified it, because he deemed the National Curriculum Statement sufficient to implement and rollout FLE.

A 2010 review report of the regional Adolescent Health and Development Project\textsuperscript{20} identified the following additional gaps in Fiji’s FLE program:

1. Insufficient allocation of time for FLE;

2. Teachers remained unconfident to effectively teach and assess knowledge, practices, behaviors and attitudes of students;

3. There was a lack of support from mission/religious schools on selected topics of the FLE program;

4. There were misunderstandings among both students and teachers about certain delivery approaches and resources used for teaching;

5. There was absence of a national mandate for school-based peer education programs.

Fiji’s HIV/AIDS decree\textsuperscript{21}, issued in 2011, while widely commended for being progressive, inclusive and mindful of the rights of people living with HIV and people at risk for HIV, makes no mention of the need for (or young people’s right to) SRH/HIV education; nevertheless, the document seems to have sparked the MOE to develop an HIV policy (discussed below).

Fiji’s National Youth Policy (2011)\textsuperscript{22}, issued by the Ministry of Education, clearly defines the need for SRH/HIV education, responding to the need for a ‘national mandate’ that the AHD review report called for. One of the eight policies in the document has as its aim ‘to encourage youths to appreciate and practice high standards of personal health, hygiene and health lifestyles’ (p.2). It also calls for programs to ‘discourage young people from anti-social behavior such as drug and substance abuse, sexually transmitted infections and HIV-AIDS, juvenile delinquency any other issues identified by young people and youth stakeholders (p. 6). Under the same policy, it supports ‘adolescent and reproductive health education in schools and out of schools, preventative and community health programs to deal with infectious and non-communicable diseases, and mental health awareness and advocacy programs’ (p.7).
In the new Education Sector Strategic Development Plan 2012-2014\textsuperscript{23}, FLE was listed as one of 13 priorities under Outcome 2: ‘All children especially […] disadvantaged students and those with special needs will acquire knowledge, develop lifelong skills, religious values and good citizenship through a relevant, responsive, and innovative curriculum’. The plan aimed to implement a revised FLE curriculum in all schools by the end of the year 2014. Under Outcome 3: ‘The welfare of students [is] promoted and protected through school improvement programmes that build character and bring about social cohesion in an environment that is clean and secure’ (p.26), one of six priorities is ‘Implement programmes that address social issues such as reproductive health, HIV & AIDS [sic], substance abuse and child protection’, and another is to improve counseling and guidance services provided via schools. A budget was reserved for ‘strengthening awareness and programmes on social issues’ in 2012-2014, and indicators included increased awareness of ‘HIV & AIDS and social issues’ and reduced incidence of drug-related cases. Outcome 6 called for improved collaboration with and involvement of stakeholders from outside the education sector, including at the school-level (p.32).

On 6 May 2013, the Ministry of Education approved an HIV policy\textsuperscript{24} that also incorporates FLE. According to this comprehensive document, Fiji schools shall:

- Ensure that students and school personnel living with HIV & AIDS are treated in a just, humane and life affirming way;
- Ensure the prohibition of the testing of any individual (Student/School personnel) as a prerequisite for admission to, or to continue attendance or for appointment to a post or continuation of service;
- Ensure that students living with HIV & AIDS have the right as any other to attend schools;
- Ensure that school personnel living with HIV & AIDS have the right to continuation of service;
- Promote respect and understanding on the disclosure of confidential information on students and school personnel living with HIV & AIDS.
- Support the teaching of HIV & AIDS through the relevant subjects in the curriculum and other educational programmes at all schools for all students and school personnel;
- Ensure that provisions are in place for all schools to implement universal precautions to eliminate the risk of transmission of all blood-borne pathogens, including HIV;
- Develop and promote prevention measures on the spread of HIV during sports and other school activities (p.2).

Related to this, the policy calls for ‘a holistic and age appropriate and child friendly Family Life and HIV & AIDS education programme’ to be ‘encouraged’ at all schools, including providing accurate and adequate information and skills for the prevention of HIV transmission, providing information on the effects of drugs, sexual abuse, violence, mental health and STIs and how
these relate to the spread of HIV (p.7). The document also aims to promote referral to health and counseling services, as well as to cultivate ‘an enabling environment by encouraging respect for and eliminating prejudice and stereotypes relating to persons living with or affected by HIV & AIDS (p.8). The document also states that ‘unauthorized disclosure’ of someone’s HIV status is ‘illegal’ (p.9).

The policy makes plea for more learner-centered pedagogical approaches when it states:

Participatory methods of learning are more effective including games, role plays and drama. Children should be encouraged to ask questions and to expect reasonable, comprehensible and appropriate answers (p.10).

Recent History of FLE in Fiji

Efforts to resurrect FLE re-started in 2007-2008 and have had remarkable results. As of 2013, FLE is embedded in primary education curricula for elementary science and health science (grade 1-6) and in basic science (grade 7-8). However, it is not a stand-alone subject and is not examinable in grades 1-8. Time allocated to the FLE subject varied from 40-90 minutes per week. FLE is now a stand-alone subject in schools from Grade 9 and 10 (Form 3 and 4), and also as part of the subjects of basic science (grade 9-10), biology (grade 11-13) and home economics (grade 9-13). At least 90% of Fiji’s 170 secondary schools were now teaching it at these grade-levels, according to key informants. It is assessed as part of national internal assessment framework meaning that teachers are mandated to teach FLE and to report on the results. The FLE program for grade 10-13 (form 5, 6 and 7) was still being scaled-up, and is estimated to have a 40-50% coverage at present.

An important factor in explaining the success of FLE in Fiji is that it has become an examinable and stand-alone subject, whereas in the past FLE was very loosely integrated in many subjects, without any real emphasis, since the 1980s; this program died a ‘natural death’ due teacher discomfort, and also because it was too academic and factual, and issues like gender and lifeskills were entirely left out of it (Source: Mr Penisoni, UNFPA).

Recent efforts have been supported first by a coalition of UNFPA, SPC and UNICEF, but since the regional AHD program closed in 2011, it has been technically driven mainly by UNFPA. In particular, Mr Penisoni Nauputo has played a pivotal role in this regard, partly as a paid UNFPA consultant, partly as an unpaid volunteer. His insights provide much of the backbone of the Fiji section of this report.

There were three basic factors behind the success of Fiji’s FLE program: first, the shift from academic ‘prescription’ and a focus on content to an outcome-based curriculum (in general); second, a change in pedagogy from teacher-centered to student-centered teaching and learning, and third, the inclusiveness of the consultation process in developing the FLE curriculum, involving a much wider range of stakeholders than during the preparations for the failed FLE program of the 1980s.
I reviewed the syllabi for Form 3-6 (Grade 9-12). In Form 3, students ‘examine the consequences of sexual activities and the health risks associated with adolescent/teenage pregnancy’ under the Human Growth and Development learning area, including contraceptive methods for girls; related ‘life skills and values’ focus on ‘self-esteem, communication, negotiation, abstinence and truthfulness’. HIV and STI transmission and prevention are also introduced, with ‘refusal skills’ as one of the life skills. Other learning areas focus on healthy relationships ‘within the family’, analyse advertising for alcohol and tobacco, and discuss the control of violent impulses and referral to out-of-school health services. In Form 4, students discuss and describe ‘the physical and social effects associated with teenage pregnancies’, including on how to offer help and empathy and ‘offer peer support’. The HIV sub-strand focuses on ‘the relationship between planned and unplanned pregnancy and HIV/AIDS and STIs, focusing strongly on ‘responsibility, honesty, truthfulness and refusal skills’. Under the ‘Building healthy relationships’ strand, the Form 4 students learn to understand the relation of gender to sex and sexuality, and in another sub-strand learn how relationships based on trust and sharing decisions are ‘effective’. Under the ‘Personal Safety’ sub-strand, students learn about legal and illegal drugs, sexual relationships including ‘risky sexual behaviors’. In Form 6, under the ‘Human Growth and Development’ strand, students learn to discuss and analyze ‘young people’s sexual orientation within the human life cycle’. Suggested content is on ‘lifestyle choices: traditional vs modern’, and ‘gays, lesbians, bisexual, homosexual and heterosexual’. Life-skills and values include love, tolerance, and respect. Under the ‘Sexual and reproductive health’ sub-strand a more epidemiological view of HIV and STIs is offered, and young people are invited to collect and analyse data on HIV and STIs in different Pacific countries, and commonly-used intervention strategies. In Form 6, ‘vulnerabilities and risk factors associated with late adolescence and adulthood’ are introduced, including ‘the advantages of delayed sexual activity and disadvantages of early sexual engagement’. There is a focus on peer pressure, vulnerable settings and ‘personal risk behaviors’. The effects of different contraceptive methods are also discussed. Under the ‘Building Healthy Relationships’ strand, students learn to investigate the influence of diversity of cultures, beliefs and gender roles on relationships, including the issues of ‘heroes, mentors, customs, taboo’. Under the ‘Resilience’ sub-strands, students ‘observe and practice skills to alleviate gender bias, [and] cultural and religious stereotypes towards relationships among adolescents and young people’.

Overall, the curriculum of Fiji is diverse and detailed, and does, at least on paper, include more sensitive issues than the curricula of the other Pacific countries, perhaps with the exception of the Solomon Islands, where some of these issues are introduced at an earlier age.

Since 2009 there has been a pilot-project in which FLE was fully integrated and implemented for grades 9-13. This project will be evaluated by the University of Fiji later in 2013, with the
ToR for the evaluation now completed and negotiations ongoing. The outcomes of this evaluation are expected to further guide the ongoing implementation of the FLE program.

**Collaboration with MOH**

Another reason for the success of FLE has been the strong collaboration between MOE and MOH. MOH has provided inputs to the newly revised curriculum and it has also been involved in providing some training to teachers who were going to teach the new curriculum. Collaboration is continuing on a WHO initiative, ‘Health Promoting Schools’, for which there is a joint task force on which MoH and MoE personnel sit. Part of this is dealing with reproductive and sexual health, coined ‘adolescent health’. There is also a peer education program initiated by the MoH, which works in and via schools (see under *Non-formal education*, below).

**Perceptions of Learners**

Focus group discussions were held with male and female students as well as teachers with experience teaching FLE. These discussions were organized and led by Ms Sharana Ali of UNICEF. According to her report, most male students found FLE education useful. A key message from the education that the boys received was related to bodily changes; they found this knowledge useful as they undergo these changes. They also liked sessions on good decision making and learning about sexuality and how to behave around the opposite sex. They especially liked sessions where they were taught on how to respond to problems in life and work on solutions. They mentioned that they like the topics covered in FLE as sometimes parents do not talk to them openly and that through FLE, they were able to understand and know about issues which they may not have gotten from their parents.

The group of girls mentioned key messages like ‘not to get pregnant at early age’ and ‘keeping a distance from boys’. Other messages the girls mentioned were about sex and HIV/AIDS, how to control emotions, about teen pregnancies and how to remain motivated to study.

Both boys and girls felt that learning should begin as early as when a child turns 10 years old, i.e. before the onset of puberty and before their body starts to change so that they are aware of what to expect and prepared. Despite girls usually developing earlier than boys, most felt that both girls and boys should start learning about SRH at the same age. Students were in favor of mixed classes rather than single-sex groups, as this would bring different perspectives on the issues discussed. They felt that mixed forum allowed them to better understand each other. Both boys and girls mentioned that some female teachers were uncomfortable talking about FLE-related issues. The girls said they usually do not ask teachers for more information because topics are well covered and they also check on the internet or in textbooks if they do not understand anything.
Despite their exposure to FLE in schools, when asked if they felt they needed to learn more about SRH/HIV, there was a unanimous yes from all boys and girls. Girls preferred teachers as the main source of improved information and learning, but also mentioned parents and the Church; boys also mentioned teachers but they also highlighted that they would prefer information from their own friends and peers. This, they said, is because peers understand them better, do not question them, they are not shy and they do not feel awkward. Peers also ‘keep their secrets and are trustworthy’. Regarding the school-based FLE program itself, the boys mentioned that they would like to see more interesting ways of delivering the FLE programme using creative posters, charts, PowerPoint presentations, drama and quizzes.

**Perceptions of Teachers**

According to the teachers, students always look forward to the FLE sessions but students also get information from the media. Students are talking about sexual abuse taking place in communities. At the same time, teachers expressed their frustration that some students are not taking the programme seriously. They felt that if the subject is tested and students sit for an exam, it would motivate them to take topics seriously—apparently the school where the group discussion was held was one of the schools where this had not yet happened. Teachers also felt that they were ‘thrown in the deep end’ without any training and skills on talking to students on such sensitive subjects. They also do not have any pacific specific materials and manuals to guide discussions. They suggested that materials need to be within the pacific specific context and that topics taught should be sensitive to ethnic and cultural differences and needs.

‘To be honest, when I was told to do FLE, I didn’t want to do it. I had no training. I had to go online. Teachers should be trained and skills should be given to them. It was a burden for me to teach it as it is hard to talk about those things.’ – FLE teacher, Fiji

Teachers agreed that the FLE programme was very important. However, they found children very complex and not easy to understand. The teachers suggested that they should be trained better to understand children better, so that they could read the signs and are aware when something is going wrong with students. Their view was that students prefer to ask their peers about sex and reproductive issues and they learn from their experiences. They strongly believed that peer-to-peer teaching is a better opportunity to reach students with information on SRH and HIV. ‘They listen more to students who are from their same age group’. When asked whom they thought had ‘responsibility’ for teaching SRH/HIV, teachers believed that it was ‘everyone’s responsibility’. They then added that parents could play a greater role than they currently do.

The teachers’ opinion was that SRH and HIV materials and messaging need to be age-appropriate and interesting to students. Students prefer visual messaging and videos and documentaries were mentioned. According to the teachers, students are aware of the
opposite sex from as young as 7-9 years old. Therefore, age appropriate information should begin from Grade 2 at least (currently, the issue of puberty and bodily changes in girls and boys is not taught until Grade 7 – when many children will already have been in puberty for several years). Parents need to be educated because ‘in both Fijian and Indian cultures culture dictates all aspects of life for children’. Teachers proposed that parents need to be more involved in the curriculum design and guidelines and head teachers should inform parents of the importance of sexuality education.

When asked about teenage pregnancies in their school, teachers said that the schools lack proper guidance on such issues and there is a need for a school counselor.

**Non-Formal Education Sector Responses**

The MoH’s Health Promotion Unit (now called ‘Wellness Unit’) runs a peer education program in all 16 subdistricts of Fiji, with 1 peer educator per each sub-district. These peer-education positions are paid positions; the peer educators were aged 18-25 years old at the time of their recruitment (now several years ago) and were trained at that time. Key informants admitted more training was needed and that the topics discussed are rather general in nature. Training in counseling skills was planned for later in the year. One of the 16 peer educators of the MoH who works in Suva district, out of the Our Place drop-in center, mentioned that he mainly provides health education lectures to groups of 30 primary school children, visiting every school in his sub-district once per year. He also mentioned trainings of peer educators in each school: 23 students and 2 teachers/counselors are trained each year in all schools, in a two-day training. The selection of the students happens according to set criteria, which include that the student has to be ‘active’, ‘vocal’ and also academic criteria. The teachers decide the final selection. Usually they select students from Form 3-4-5 (aged 15-17 years old) so that they can be retained in the program for several years after their training. He mentioned that many teachers were ‘grateful’ to him after he did his sessions in schools, as they are at a loss how to teach the new FLE curriculum that has been introduced. These teachers felt more confident and motivated to teach FLE due to the activities and ice-breakers. The PE program covers mainly primary school students, aged 8-12, with MoE covering secondary schools.

The National Substance Abuse Advisory Committee runs the ‘Stars Program’. This is an NGO but under the umbrella of the MoE. Mr Joeli Colati of the Fiji Network of People living with HIV (FJN+), who works with NSAAC on this program, said ‘many changes’ can be seen in the attitudes of teachers and students who have been exposed to the trainings and advocacy conducted by the peer educators. However, despite these positive changes, stigma still occurs. FLE curriculum in schools is rather basic and homo- and bisexuality are not mentioned; there is no mention of anal sex either. The problem of bullying in schools of people who are ‘different’ gender- or sexuality-wise, should also be addressed in a next version of the FLE curriculum, perhaps around the topic of sexual/gender diversity. Unlike the
peer educators from the MoH these are unpaid positions, and operate via the school system rather than via health centers. According to key informants, the Peer Educators of NSAAC seem to be better trained and of the same age-group as their beneficiaries, whereas the MoH peer educators are paid and not as well trained.

‘Our Place’ is a youth-friendly clinic and drop-in centers in Fiji; it oversees three Hubs: one in Suva, one in the West and one in the North. STI and HIV tests are conducted and the MOH peer educators from these districts also work from here.

**Discussion**

Fiji is the most advanced country when it comes to implementing FLE education. It has a favorable policy environment for FLE, even though a specific formal policy on FLE education does not exist. Its curriculum and syllabi have gone through a broad consultative process and are balanced and comprehensive, although certain topics have been omitted and others are introduced at too late an age. Fiji is also the country with most youth in secondary schools, i.e. the education system has the deepest reach of the four countries studied. However, the problems Fiji retains are related to teacher training and further pertain to questions around quality. Assuring quality, starting off by a better monitoring system for learning outcomes, would be Fiji’s logical next step.

**Obstacles**

According to the key informants consulted, there are still obstacles to further implementation of the school-based FLE program in Fiji. These include:

1. Resistance at the senior level in the MOE against some elements of FLE and against the idea of intensifying/expanding it. As an example of this, a national-level FLE policy has existed in draft form since 2009 but has still not been signed. However, FLE has now been integrated into a new school-based policy on HIV.

2. Time allocation: in the years where FLE is not (yet) an examinable subject (i.e. all years except Grade 9-10, and soon 11-12), teachers often sacrifice the time needed to teach it to focus on examinable subjects. This is because schools are judged and evaluated by their overall ‘pass rates’. This is also now being addressed, with a new way of assessing schools in development.

3. There remains anxiety among teachers and parents about teaching FLE to children and young people. A lack of support and awareness in communities remains, and strong advocacy efforts are needed to create the proper environment for delivering the FLE program, also with Churches. Some religious schools appear unwilling to expand efforts to provide SRH/HIV education to children.
4. Some elements of FLE appear to be taught at too late an age. For example, bodily changes and puberty are introduced in Grade 7, when students are 12-14 years of age. In contrast, in the Solomon Islands this topic is already introduced in Grade 4 (age 9-11).

5. There remains a lack of both in-service and pre-service teacher training on how to teach FLE using learner-centered approaches. In particular, teacher-training institutions are not yet prepared to teach the FLE program in pre-service training. Teachers remain largely incapable of providing counseling to students on SRH/HIV issues; the question is whether they should, or whether counseling could be made available to students via external channels.

6. The role of the peer education program ('Stars') and the health education program of the MOH versus the school-based FLE program remains unspecified and a bit unclear. Likewise, the WHO-supported health-promoting school initiative and related advocacy and policy efforts could be better coordinated with those related to FLE.

7. The donor/technical support situation is unstable and unreliable. This makes it difficult to take a long-term programmatic approach to implementing FLE (this may be more the case for the poorer countries in the review than for Fiji).

Country-Specific Recommendations

1. Fiji is delivering FLE on an ever-increasing scale across its archipelago. The focus of improving FLE should now shift from coverage/quantity to the issue of quality. This means evaluating how FLE is delivered in classrooms; evaluating what teachers actually teach and what students actually learn and ‘take away’ from FLE, also in comparison to other sources of information they access. The upcoming evaluation of the 10 pilot schools who have been implementing FLE for the past 5 years across grades 9-13 will likely provide strong evidence for the acceptability and effectiveness of comprehensive SRH/HIV education in the Fijian context, especially if the evaluation compares learning outcomes and other outcomes (i.e. teenage pregnancies in the school, self-reported SRH problems among students) with schools where no FLE program was provided. At a later stage, the question of what the longer-term impact of FLE is on HIV risk behaviors and other health outcomes could also be studied.

2. A stronger focus on teacher training in FLE, both in-service and pre-service, as well as the further development of more attractive and effective teaching-learning materials is warranted, based on the proposed evaluation under (1). Teacher training institutions, especially Fiji National University and the University of the South Pacific,
should be assisted in integrating the newly reviewed curriculum, including the FLE parts, in their pre-service training program. They could help to scale up in-service teacher training efforts as well.

3. Advocacy with local-level decision-makers and stakeholders remains pivotal to ensure the smooth scale-up of Fiji’s FLE program. A fact sheet or toolkit could be developed with basic facts about SRH/HIV education and what it aims to achieve, making the link between expanding and intensifying FLE with decreasing teenage pregnancy and STI/HIV infections. There are many unused avenues for advocacy, via the networks of Chiefs as well as Churches. Provincial administrators could also be possible allies; so far they have not yet been involved in any FLE related efforts.

4. Fiji has the highest coverage of secondary schooling in the Pacific region. Despite this, close to 15% of high-school aged youth are not in school. If lessons from other countries are anything to go by, out-of-school youth are typically at higher risk for HIV, STI and teenage pregnancy than those attending schools (because school attendance is often a proxy for having a more or less stable family life). In order to achieve the highest possible coverage of SRH/HIV education and reaching those who might need it most, a strategy to reach out-of-school youth should be developed, and collaboration between MOE, the Ministry of Youth and Sports and NGOs should be established to reach the 15% of youth who are not in schools.

5. Some FLE topics, including the issue of bodily changes/puberty, should be introduced at an earlier age than at present, due to students maturing earlier than in the past. There are also topics missing in the FLE curriculum at present, for example alternative sexualities/homosexuality and the issue of respect for gender/sexual diversity and how to respond to bullying. The current curriculum review process could be an opportunity to achieve this.

6. The role of the Stars peer education program and the MoH’s peer education/health education activities versus the FLE program needs to be clarified and delineated. Some teachers may wrongfully assume that they can skip the delivery of FLE education if their school is visited by a health educator or has a peer educator in the classroom. In fact and in line with Recommendation (4) above, NGOs and peer education efforts should attempt to reach the 15% of Fiji’s youth who are not in secondary schools. Second, the role of FLE in the context of WHO-efforts to support ‘Health Promoting Schools’ should be spelt out more clearly. Both issues should have been clarified in the new HIV policy of the MOE24, but they are not.
Short Overview of Socio-Economic and Population Indicators

Kiribati is a predominantly Micronesian country consisting of 32 atolls and one raised island, disbursed over an area of 3.5 million square kilometers (roughly half the size of the United States mainland). According to Wikipedia, the population of Kiribati was around 102,500 in 2010. The gross domestic product (GDP) per capita standardized for purchasing power parity (PPP) was 5,721 US$ per annum in 2012. No data was available about the proportion of the population living on less than 2 US$ per day. Male life expectancy is 59 and female life expectancy is 63. The under-five mortality rate was 47 per 1000 in 2011, down from 52 in 2008. No data on access to clean water or sanitation facilities was found, although this is widely known to be a problem. Kiribati is 121th on the UNDP’s 2013 Human Development Index ranking.
Short Overview of Educational Indicators

As of 2007 and 2008, the latest year for which information was found, the Kiribati Government spent approximately a quarter of its annual budget on education, for an education budget of a bit over 20 million AUD per year\(^2\). No literacy data could be found for Kiribati. The intake rate or net enrollment data are also not available for Kiribati (at least not after 2005), nor are data on the % of students who complete primary and secondary education, respectively, or the % of students who enter tertiary education. The figure from the population-survey (2005) (below) shows that barely half of 15-19 year old youth in Kiribati were in school in 2005. However, school enrolment rates have dropped sharply since then.

![Education status of youth by age-group](2005)

Figure 1: Education status of youth by age-group (2005).

Gross enrolment ratios in 2010 had fallen in the junior secondary schools, from 41 and 35 for males and females respectively, and in senior secondary schools to 17 and 12 respectively. There were 107 girls enrolled in primary and secondary education for each 100 boys as of 2008; later data was not available\(^8\). Despite a growing population, absolute enrollment in lower secondary school dropped from 7,851 in 2003 to 6,653 in 2010; gross enrollment ratios also dropped from 121 to 95 in this period; paradoxically, overall enrollment was stable at around 11,400. Enrollment in Grade 12 rose from 848 to 1421 between 2003 and 2008. Meanwhile, total absolute enrollment in primary schools was stable at around 15,900 for all these years\(^8\). Overall, it can be concluded that the coverage and reach of the Kiribati secondary education system is very low, especially on the outer/smaller islands, and seems to be dropping even further. The sharp decline in secondary school enrolment since 2005-6 is alarming and requires further investigation.
Short Overview of the HIV, STI and Teenage Pregnancy Situation

According to the Global AIDS Progress Report submitted by Kiribati’s National AIDS Programme on 31 March 2012, Kiribati is experiencing a ‘low level general HIV epidemic’. On a population of just over 100,000, Kiribati has an estimated 55 cumulative cases of HIV dating from 1991 to the end of December 2011. Of this cumulative number, most were male, but a more even gender balance emerged among new cases over the last decade. There have been 23 confirmed AIDS related deaths but this number was suspected to be higher. Of the current 28 people living with HIV in Kiribati, 6 are on antiretroviral treatment (ART). The whereabouts of the remaining 22 is unknown. This represents an HIV prevalence of 0.053 per 100,000. Of these cases, the main mode of transmission is understood to have been heterosexual sex, followed by perinatal transmission. Groups identified to be most at risk include seafarers, their spouses (and children), and those involved in commercial or transactional sex. Over 2010-2011, 2 new cases of HIV were confirmed.

According to the Ministry’s Health Information Unit, quoted in the same report, the number of teenage pregnancies reported in Kiribati for 2010 was 155 and rose to 218 in 2011. The 2009 Demographic Health Survey found that about 10% of women aged between 15–19 years reported that they were either pregnant or had a child at the time of the survey, and 28% of 19 year old women had begun childbearing. Socio-economic factors seem to have some influence on early childbearing, with 19% of teenage women in the lowest wealth quintile having begun childbearing, compared to just 5% of teenage women in the highest wealth quintile. Around 19% of young women and 56% of young men had sexual intercourse before they turned 18.

UNICEF conducted a Knowledge, Attitudes and Practices (KAP) survey among 367 Kiribati youth aged 15-24, of whom 236 were sexually active. A mixed sampling strategy was used, making the results not representative for all Kiribati youth, instead artificially dividing them into ‘risk/vulnerability groups’ beforehand. 13.2% of all 15-19 year olds sampled had had sex before the age of 15. It was found that 35% of sexually active males reported same-sex behavior, 83.4% unprotected, with a number of partners ranging from 1-31. Forced male-to-male sex was reported by 47.2% of young males in Kiribati; it reached 67% on Kiribati’s Abemama island. Thirty-six of the respondents in the sample engaged in commercial and/or transactional sex. Only 49% reported using a condom at last sex. Overall, 43% of sexually active youth reported forced sex; first sex was forced for 21.1% of sexually active youth overall. Sexually active youth reported 42.9% condom use at last sex with a non-regular partner.

The Kiribati Government does not collect data on adolescent fertility—or at least this data could not be found on the World Bank database.
The Education Sector Response
Policy and Curriculum Framework

Kiribati has adopted a ‘National Curriculum and Assessment Tool (NCAF)’, paving the way for the potential expansion of adolescent sexuality education\textsuperscript{20}. According to Kiribati’s Global HIV/AIDS Report\textsuperscript{28} (p.18), sexual and reproductive health (SRH) and life-skills based HIV & AIDS education are not taught in formal education as part of the curriculum. There were plans for the MOH’s Adolescent Health Division Coordinator to work with the Ministry of Education Curriculum Development Division on plans to include SRH in the school curriculum.

According to the same report, in 2010-2011 the Kiribati Family Health Association, Kiribati Red Cross, and AHD have delivered both SRH and HIV & AIDS education to schools and colleges as special, extracurricular activities.

The AHD report\textsuperscript{20} referred to above notes that as of 2010, health education in Kiribati addresses some elements of SRH/HIV education as well as the issue of violence and substance abuse. Some teacher training and awareness on FLE was conducted with involvement of the Secretariat of the Pacific Community (SPC). SRH/HIV were ‘integrated in the primary health program’ (p. 10). However, it mentioned a need to ‘create more awareness’ on the need to provide SRH/HIV education in Kiribati schools within the MOE itself.

Recent History of FLE in Kiribati

In 2010 a consultation about introducing FLE was held with Churches, supported by UNFPA, in which Mormons, Catholics and Protestants all participated.

Recently, overall syllabi for Grade 3 and 4 have been completed which are completed and awaiting approval. This project was funded by AUSAID under the Kiribati Education Improvement Project. A wide range of consultations was held in the process of its development, including with Churches and NGOs and the Kiribati Family Health Association. Technical assistance was received from AUSAID for this process. SRH and HIV was integrated into three learning components of the syllabi and curriculum: Health, Physical Education and Moral Education. It was for the first time that the topic was formally integrated into the primary school curriculum. Work on teacher guides for Grade 3 and 4 was planned together with the Teacher Training college, to be followed by a new syllabus for Grade 5 and 6 and teacher guides for 5 and 6 before the end of this year.

According to Mr Karawa of the Curriculum Department, next year the new curriculum will be extended and new syllabi and teacher guides will be developed for Grade 7-9, followed by 10-13. The FLE subject will be integrated in Grade 7-13 under the subject of Personal Development, also with the same thee components. It will be integrated in Basic Science
during Junior, and under Science for those choosing the Science (rather than the Arts) stream. A Syllabus of Family Life Education had previously been developed for grade 7-13, but it was never used. Now, components of it will be integrated into the new Syllabi to be developed for junior and senior high school. FLE as a separate subject was not considered realistic as there was not enough time in the curriculum to teach it as a stand-alone subject.

In general, the UNFPA AHD programme, as well as AHD advisor, has been the main provider of technical support for FLE education in Kiribati. AUSAID indicated that they were not interested in funding educational reform nor curriculum development beyond Grade 6, hence it is unlikely that AUSAID will play a role in furthering FLE in Kiribati in the near future.

Contents of the FLE Curriculum/syllabi

Not applicable, since no FLE curriculum/syllabus is currently in use.

Collaboration with MOH

Several key informants mentioned that a lack of collaboration between the MOE and the MOH is a key obstacle to the introduction and expansion of FLE in Kiribati.

Perceptions of Learners

A group of six young volunteers of the Kiribati Family Health Association was consulted. When talking about their experience receiving SRH education in schools, they all said they received it, around the age of 13-14. The young people who chose Science as their senior ‘stream’ said they learned 60% of what they know about SRH in schools; those who chose Arts, and had only Basic Science during junior high school said they learned only 10% of what they know in high school. None of them had learned anything from their parents; they said there was a strong taboo to speak about these issues between parents and children. They said they learned 5% from friends; the rest came from the training at KFHA and a bit from the Internet. They liked the idea of a website in Kiribati language where all SRH info would be compiled and which they could refer young people to as well.

Talking at what age they thought children should learn about sexuality, some said 16 and others (the majority) said 10. In general they thought girls (and boys too) should learn about SRH before they started menstruating.

Five male students were interviewed who were studying in Form 2, i.e. around 13-14 years of age. They had not yet received formal SRH education, which was bound to start in Form 3. The boys had been exposed to some SRH information in year 6 of primary school: they learned about bodily changes, body parts, menstruation. They said they learned most of what they know about SRH from movies (‘romantic movies’). Also they learned things from friends.
They had never talked to parents about it. Some had searched and found information on the internet, in English, as there is no Kiribati language website. When I asked about their preferred channel of learning about this, two boys mentioned parents and three mentioned the school. When asked at what age children/young people should receive this kind of information, a wide range of answers was given between 12 and 18. The consensus was around 14-15. Interestingly, they thought the age that girls should receive this information should be a bit higher.

Six female students were interviewed who were also studying in Form 2, i.e. around 13-14 years old. They said they learned most of what they knew about SRH from school, as well as from friends, and movies. They did not learn anything from parents. But when I asked how they had learned about menstruation, they said their mothers had told them about this, and this had happened before they actually started menstruating. They had not had SRH education in secondary school. Asked about preferred channels for learning this, they mentioned school; they did not want to learn from parents. The preferred age to receive SRH education ranged between 12 and 18. They had heard about pregnant girls in schools but they did not personally know anybody. These girls had ‘left because they were ashamed’, they said.

**Perceptions of Teachers**

Three very young teachers were interviewed who had just been employed to teach Science to Form 2-3. None of them had ever taught SRH education but this was planned to happen for the first time after the holiday break. The two women, one of whom was pregnant and married, the other was single, were extremely shy to talk about this and it was obvious they were not prepared to teach this topic. Later the male teacher said he agreed that unmarried people might not be suitable to talk or teach about this issue. The teachers saw a big responsibility and role for the school, though, and thought parents would appreciate their efforts in educating youth and they did not expect resistance. They thought the appropriate age at which youth should start learning about SRH was 11-12, i.e. at the time girls started menstruating. None of the three teachers had had any formal training on how to teach this subject; they had been educated a bit in high school. They would welcome an outside person to come and teach it on their behalf, especially the first time: ‘Teachers sometimes do not dare to speak directly about these issues, hence it might be difficult.’ They thought boys and girls might speak out more freely in single-sex groups.
Non-Formal Education Sector Responses

Government

The Health Promotion Unit of the MOH focuses on communication about health issues, including the development of IEC materials and outreach to the community. The top priorities for youth health were teenage pregnancy and STI. There were 8 people working in the unit who were all involved in community outreach activities. They work together with other organizations, including the Kiribati Family health Association, the Red Cross and Church groups. They provide IEC during these activities. Some of the outreach activities cover schools as well, at the junior and senior secondary level. However the Health Promotion Unit has never been involved in the training of teachers, although the staff would be capable to do so.

NGO

The Kiribati Family Health Association has one clinic on Tarawa and six groups of volunteers in outer islands, each consisting of 10 male and 10 female Youth Volunteers in order to conduct peer-to-peer education to young people in communities. The volunteer positions are unpaid, but small allowances are provided based on activities conducted. The focus is on raising awareness of HIV, STI and teenage pregnancy. Condoms are also distributed. Referral to the clinics is made for STI testing or treatment as necessary. The volunteers also reach out to schools; usually it is peer-to-peer education, but sometimes there are health activities during which the volunteers do work in larger groups via the schools in half-day events. In 2011, the volunteers, reaching 7,000 clients, reported 12,000 ‘activities’. In 2012, the numbers were even higher. If these figures are correct, KFHA reaches up to 7% of Kiribati’s population each year, which is quite significant. The program was started under the umbrella of the regional AHD project.

The volunteers recently visited the Catholic high school, which had in the past resisted involvement. Condoms could be talked about and presented in illustrations, but they are not distributed there or demonstrated. ‘Protestants and others don't encourage us to speak about condoms to young people, as they worry it might encourage them to have sex. They want us to talk about leading a Christian life’, the Director of KFHA said. Last year, 40 teachers from high schools were trained by KFHA on SRH/HIV education and how to provide it. They also held advocacy meetings with school principals from around Tarawa, trying to gain support for SRH. The KFHA was indirectly involved in the development of the new Grade 3-4 curriculum and syllabus; they provided the IPPF Manual called ‘One in All’ to the CDU and followed up with discussions. However they are not part of the committee that was working on the development of the syllabi and the text books themselves. They said they had asked to be part of it, but the MOE had not responded to the request nor invited them.
The Kiribati Red Cross runs drama shows as part of a road show, using 21 newly-trained peer educators/outreach workers of different ages. The focus of their awareness raising is HIV and on the recruitment of blood donors; they also work via schools, occasionally. They covered just one school this year, where a drama and video film performance were held and about 300 students came to watch it. There were no question and answer sessions after or before it. Red Cross reached an estimated 2,000 15-35 year old ‘youth’ in 2012. Condoms are also freely available at the Red Cross center, and youth can get them without asking anyone for them; the peer educators also have condoms and pamphlets for distribution.

**Churches**

A minister at the Kiribati Protestant Community Center admitted that the Church could do more in providing SRH/HIV education, although there was discomfort with the idea of promoting condoms. Premarital sex, teenage pregnancies and STIs were seen as big and growing problems. The Church could play a role in advocating with parents, making them more comfortable about the provision of SRH/HIV education to youth. There could also be activities organized for parents, helping them educate and raise awareness among their children.

**Discussion**

In terms of the scope and quality of their SRH education programme, Kiribati seems furthest behind of the four countries studied. First of all, although data is lacking, it seems less than half of Kiribati adolescents are in school. This means non-formal education efforts need to be scaled up in order to fulfill young people’s SRH/HIV education needs as a short-to-medium measure. For those in the formal system, apart from an overall Curriculum Assessment Tool that was developed, no policy statements or documents were found that indicate that the Kiribati MOE is seriously planning to initiate and expand FLE. There is neither a curriculum nor syllabi to teach FLE in schools and there is no push for making FLE a stand-alone subject. Donor support, on which the country largely depends, is on and off. There is a strong need for advocacy at the local level; too often ‘resistance of the Church’ is used as an excuse for doing nothing.
Obstacles

1. There is no solid partnership between the health sector and the education sector in advocating for adolescent health issues through formal education. This was already mentioned in the 2009 AHD review report. This is partly caused by a lack of urgency and awareness at the MoE/CDU level.

2. A second obstacle is the cultural and religious taboos on talking about sexuality openly, although this is sometimes used as an excuse for doing nothing. In advocacy efforts, a clear link should be laid between the proven effect of SRH/HIV education in increasing awareness and improving healthy behaviors to prevent teenage pregnancy and STI. If the MOE accepts SRH and incorporates topics into the compulsory curriculum, problems remain, as teachers may refuse to teach it due to cultural and religious inhibitions.

3. There is a lack of resources: money is needed for the development of textbooks and for in-service teacher training, and the provision of technical support has been inconsistent.

Country-Specific Recommendations

1. Because of the large proportion of youth out of the formal education system, Kiribati needs a comprehensive SRH/HIV education strategy that is clearly coordinated between the formal education system and NGOs, based on a commonly agreed curriculum with clear learning outcomes. The strategy should set a division of labor between MOE and different NGOs on how to achieve the highest possible coverage of youth, starting with the most populated areas and those at highest risk. If funding limits what can be achieved, reaching out-of-school youth via KFHA, Red Cross and interested church organizations should be prioritized, as the 2009 UNICEF/MOH study has indicated high levels of risk among Kiribati’s out of school youth.

2. Advocacy is needed at the central and the local level, both to expand and improve formal SRH/HIV education via schools as well as informal strategies, i.e. via health- and peer educators and mass media. Advocacy should be guided by the data, showing high levels of unwanted teenage pregnancy and high prevalence of STI; this should convince stakeholders and gatekeepers that something has to happen.

3. For the formal education system, the overall curriculum for Grade 5-6 is set to be developed in 2013, with AUSAID support. The MOE would like to review the curriculum for Grade 7-13 in 2014-2015. If this indeed happens, it provides an opportunity to ensure a comprehensive, learner-centered, culturally and age-appropriate, examinable FLE component is integrated in the curriculum/syllabus and textbooks. KFHA, Red Cross and Church representatives should be involved in a consultative process, technically supported by UNFPA.
4. Teacher training remains a major gap. Health workers/volunteers and other people could play a bigger role in teacher training; closer collaboration between MOH and MOE is needed in order to help facilitate this; this could be a ‘by-product’ of the proposed overall SRH/HIV strategy (see (1)).

5. Although Internet coverage and smart phone use is still low, it is rising rapidly among Kiribati youth. A website with comprehensive SRH/HIV information in the Kiribati language should be developed which can underpin peer outreach work and also inform teachers and parents, as well as young people themselves. No such website currently exists.

6. Church leaders expressed interest in greater involvement; Catholic Bishop has started a working group within the Church to discuss this; Protestant minister was interested to introduce the topic in sermons and in Women’s and Youth Groups, but felt he needed more training and information in order to do so. Churches could play a role in advocating with parents for the need to provide SRH/HIV education.

7. Parents could play a greater role in providing SRH to their children, but they need tools and knowledge to do so, both factual knowledge and suggestions on how to communicate with children about this. Youth expressed a desire to learn from parents or family members, as well as at schools. A pamphlet/booklet for parents should be developed to assist those who would like to take more responsibilities educating their children about SRH/HIV.
Short Overview of Socio-Economic and Population Indicators

The Solomon Islands is a predominantly Melanesian country. It covers a large sea area with almost 1,000 islands, and it has a population of 523,000 (2009). The gross domestic product (GDP) per capita standardized for purchasing power parity (PPP) was 3,192 US$ per annum in 2012. No data was available about the proportion of the population living on less than 2 US$ per day. Life expectancy at birth is 68. The under-five mortality rate was 22 per 1000 in 2011, down from 24 in 2008. No data on access to clean water or sanitation facilities was found, but this is believed to be an important problem for public health. The Solomon Islands is 143rd on the UNDP’s Human Development Index.

Short Overview of Educational Indicators

The Solomon Islands spent about 7% of its GDP on education in 2010, a figure that has gradually risen in recent years. 34% of all Government expenditure was spent on education in 2010, up from 22% in 2008. This may be more an indication of the small size of Government expenditure than an indicator of educational achievement: the country has a low net intake rate of just 21% of the primary-school-aged population for Grade 1 (gross intake ratio is 66.4% for Grade 1) and the net enrolment ratio for primary school children is 86.8% with a small disadvantage of girls versus boys. Net enrolment in secondary schools is 42.7%, with again slightly more boys enrolled than girls (43.8 versus 41.5); there were 96 girls enrolled for each 100 boys in primary and secondary education as of 2010; later data was not available. No data was available on progression and completion rates in either primary or secondary schools in the Solomon Islands. No literacy data could be found for the Solomon Islands. In total there are 1000 schools (30 in Honiara) and between 5-6,000 teachers.
Short Overview of the HIV, STI and Teenage Pregnancy Situation

The Solomon Islands ‘Global AIDS Response Progress Report 2012’, reporting on the period 2010-2011, mentions that the Solomon Islands was classified as a low HIV prevalent country with an estimated HIV prevalence of just 0.002% of the total population. Since the first reported case in 1994, a cumulative total of 17 HIV positive cases had been confirmed as of December 2011 on a total population of around 523,000. From the beginning of the epidemic, seven Solomon islanders have died of AIDS related causes.

The report notes that there were four newly diagnosed HIV infections during the reporting period, two each in 2010 and 2011. Three of the four people diagnosed were symptomatic with AIDS, one of whom died of AIDS related causes in 2010. The report states that the Solomon Islands have just ten people known to be currently living with HIV, of whom nine are women. Eight of these people are on antiretroviral treatment; two others are not, which the report says is for ‘reasons attributed to fear of stigma and discrimination’. There are no known cases of pediatric HIV. However, three children have been born (prior to 2010) to women living with HIV but none have been tested and the children’s HIV status is not known.

In 2010, UNICEF and the Ministry of Health and Medical Services undertook a KAP survey on HIV and AIDS risk and vulnerability among 604 Solomon Islands youth in three provinces and Honiara, of whom over three quarters were sexually active. A mixed sampling strategy was used, making the results not representative for all Solomon Islands youth, instead artificially dividing them into ‘risk/vulnerability groups’ beforehand. The study found that nearly 15% of all 15-19 year olds sampled had first sex before age 15. 38 percent of sexually active youth reported forced sex. First sex was forced for 20.4% of sexually active youth overall. Five (2.1%) sexually active males reported having had male-to-male sex, four of whom without using condoms, with the number of partners ranging from 1-6. Forced sex was reported by three out of five MSM. 56 respondents in the sample, including 15 males, engaged in commercial and/or transactional sex. Only 34% reported using a condom at last sex. Sexually active youth reported 32.8% condom use at last sex with a non-regular partner. The youth surveyed had a relatively low level (32%) of comprehensive knowledge of HIV and AIDS and only 5% of the sexually active youth had been tested for HIV and received their results.

According to World Bank data, adolescent fertility (births per 1000 women aged 15-19) was 66 in 2011, down from 69 in 2008.
The Education Sector Response

Policy and Curriculum Framework

The Ministry of Education and Human Resources Development (MOE) published its Education Strategic Framework 2007-2015 in the year 2006. On page 30, under the heading ‘curriculum’, the following statement is found:

Development in general encompasses the interaction of cultures. It is the responsibility of each nation to ensure that its values and customs are protected and maintained. The [MOE] will therefore work towards establishing values education in the curriculum. This will involve the development of syllabi on cultural, social, moral and spiritual/religious values, as well as values that promote peace, democracy and national unity. In general these holistic values will include an appreciation of the interconnectedness of people and their environment, as well as topics such as population education, reproductive health education and HIV/AIDS.

The plan calls for increased investment in health curricula and teaching and learning materials, without specifying much further. The Solomon Islands have adopted a National Curriculum Framework/Statement, which stipulates that Family Life Education is partly integrated, partly a stand-alone program in the schools, as part of the Health Education and Family Life Education curricula.

The Global AIDS Progress report of the Solomon Islands states that HIV education is part of the primary and secondary school syllabus in the Solomon Islands and that it is included in the Solomon Islands Institute of Higher Education’s teacher training curriculum. It mentions the international NGO, ADRA, which has implemented an HIV curriculum development program for primary school teachers in 17 primary schools in Honiara. The Ministry of Education has indicated that it will integrate the resources developed for teaching health in primary schools nationally during 2012 (p.27).

The National HIV Policy and Multi-sectoral Strategic Plan 2005-2010 called for ‘health education and promotion’ to be ‘included among awareness and advocacy activities for prevention’, with the following objectives:

- To ensure people make informed decisions in regards to risk behaviour and safe sex practices by providing appropriate information [about abstinence, faithfulness and condoms], and increase availability of condoms. Strategies include to: “support HIV prevention initiatives in youths and adolescent reproductive health (ARH)/sexual education and Family Life [Education]… with a key focus being to ‘implement sex education (formal & informal) [in] schools’ (p. 28);
- To reduce risk and vulnerability among women and girls, the plan indicates that “adolescents need sexual education and appropriate services as many young people especially girls have poor awareness.” To address this, the plan calls to “expand adolescence and sexual health for young women to all provinces” (p.42);
- Develop appropriate [information, education and communication materials] for BCI [?] in ARH education in schools; curriculum review and development, ARH training for teachers/educators (p.58).

No successive National Strategy on HIV could be found for the Solomon Islands for this review. However, a National Health Strategic Plan 2010-2015 was developed, focusing mainly on health sector responses. The education sector is mentioned once:

The health sector and some health-related sectors, especially education, will reduce the most important individual and family behavior-related risk factors through health promotion and some prevention services (p.26).
As part of an ADRA peer education project in primary schools (see below), a school policy was developed to avoid discrimination and create a good learning environment for children living with or affected by HIV. The MOE was involved in it as well and the idea was to make it into a national policy, but funding was cut and the project was not further pursued. However, apparently the policy was still on the table, and being finalized.

**Recent History of FLE in the Solomon Islands**

Since 2004, a partly stand-alone FLE curriculum was developed from scratch, complete with syllabi, teacher guides and text books which were designed in Australia and very colorful, with involvement of a wide range of stakeholders, including UNFPA and UNESCO. Subject Advisory Committees were set up to ensure the information was age-appropriate and appropriate to the Solomon culture. The curriculum was furthermore approved by the National Curriculum Committee, which has legal binding status. There is no policy in addition to the curriculum statements, however, a Health Promoting Schools Policy is being developed and currently in draft-form. A school-based policy on HIV, modeled on the ADRA policy mentioned above, is also in development.

New teachers are trained at the University of the South Pacific on how to use the new curriculum. In-service training has also occurred to a certain extent. The Government has used its own funds complemented by funds from AUSAID. The big gap is the lack of in-service training for the new curriculum. Many teachers have started to use the new books and the teacher guides without having received training. Some teachers feel uncomfortable teaching SRH/HIV related topics. Such teachers are advised not to skip the topics but to ask a health worker or nurse from outside to come in and teach it. Because local communities are involved since the beginning, there has been little resistance to the introduction of SRH/HIV education so far.

**Contents of the Curriculum/Syllabi**

SRH/HIV education is comprehensively integrated into all five strands under Health Education from grade 1-9 under different subjects. There are five strands in primary health education, as follows:

1. Personal health, growth and development. This includes changes during puberty and early adolescence and reproductive and sexual health, starting from 1st term in Grade 4 – which is much timelier than in the other countries.

2. Food and nutrition for health

3. Personal body care and safety, including hygiene of the reproductive organs in Grade 5 and 6 and prevention of sexual abuse in Grade 4.

4. Healthy communities and environments

5. Diseases and drug education, including tobacco and betelnut in Grade 4 and alcohol and marijuana in Grade 5, and how to resist peer pressure and media influences in Grade 6.
For the junior secondary level, the same strands are used, and most of the SRH/HIV related education is under the 1st strand (personal health, growth and development). Grade 7 includes the topics of ‘healthy relationships’, ‘STIs’, ‘HIV’, ‘illicit drug use’ and ‘human sexuality’; Grade 8 has ‘reproductive and sexual health issues’, ‘birth control and family planning’, ‘pregnancy and health’ and ‘caring for babies’, and continues the topics of STI and HIV in more detail. Grade 9 includes the topics of ‘gender and sexuality’, ‘social and cultural influences on personal health’ and ‘suicide and its prevention’, and repeats the topics of STI and HIV and ‘lifestyle related diseases’. Currently there is discussion whether the same strands should be continued for grades 10-12 or whether there should be different strands there.

Overall the Solomon Islands curriculum is impressively comprehensive, age-appropriate and complete. The achievement of starting ‘puberty education’ at in Grade 4 – when learners are 10 years old, on average – is particularly impressive, as in other countries this topic is usually breached only in Grade 6 or 7.

Perceptions of Parents

A group discussion was held with 3 parents who were working at UNICEF office. The parents suggested most information young people in the Solomon Islands get about sexuality and reproductive health is via peers, followed by movies/the media. They agree young people should have access to more and better education, noting the problem of teenage pregnancies, leading to expulsion from school (for both boy and girl). There is a big difference in knowledge between outer-island youth and youth in Honiara. Schools can correct inconsistencies and falsehoods in the knowledge young people pick up from TV or Internet or from each other.

The parents noted that 50% of Solomon's primary school students drop out after Grade 6. The Government has made it a priority to enable 100% of primary school students to have access to schooling up and until grade 9. Hence, sexuality education should be conducted mostly in Grade 6. When asked if the parents felt comfortable if their kids were educated on issues like condoms, abortion, homosexuality, masturbation, they said 'yes'. When asked if they felt comfortable talking to their children, they said they did, but one of them had not spoken to her 13-year-old son yet and would welcome guidance on how to best approach this. A father said it was embarrassing to explain to a girl about physiology, and suggested fathers should educate sons and mothers should educate daughters. One mother said that her children asked her questions after doing an assignment for school related to reproductive health. This might be a good way to get parents and children to talk about it. The parents saw a role for peer educators trained by MoH.
Non-Formal Education Sector Responses

Government

The MoH’s Adolescent Health and Development unit has led the development of a national Peer Education manual. It should be studied to what extent the topics in the curriculum in schools and those in the PE manual match so that in-school and out-of-school youth are exposed to similar knowledge, attitudes and skills; this was beyond the scope of this consultancy.

NGOs

The Solomon Islands Planned Parenthood Association (SIPPA) focuses on family planning and promotion of sexual and reproductive health, focusing mainly on young people. Nationwide, there are about 60 active health volunteers in communities, of whom 12 around Honiara. The volunteers go to schools and teach entire classes. Usually in schools this happens in mixed groups; in some outer communities they separate the groups into boys and girls, depending on what the elders and facilitators want. Volunteers are recruited from different Churches. Mainly the International Planned Parenthood Federation and some other donors provide funding for smaller amounts, including UNICEF and UNFPA. Four SIPPA volunteers were interviewed; they said the most common problems among young people whom they came across were STIs and teenage pregnancies. SIPPA volunteers and staff both said that generally the guardians of tradition and customs are the Chiefs and elders in villages, as well as the Church. These were the biggest obstacles to improving the sexual and reproductive health of young people. Young people mostly want to learn more, but were restrained by the climate imposed by Church and Chiefs. Parents are also sometimes an obstacle. A lack of teacher training was also mentioned, as well as a severe lack of services. It was frustrating that the volunteers increased awareness about STI and reproductive health and created a demand for testing- and treatment services, which were not available in many places. Currently many people go for ‘custom treatments’ for STI, which are herbal, and may treat the symptoms but not necessarily the bacteria or virus causing the STI.

The Adventist Development and Relief Agency (ADRA) ran a project between 2008 and 2012; it has since been discontinued due to a lack of funding. It focused on grade 4-6 in 17 primary schools in Honiara. Ten male and ten female students in Grade 4 were recruited as peer educators. The project picked ‘naughty’ children with poor grades rather than the usual practice of selecting the model-children with good academic grades. The Trainers were selected ‘mentor teachers’, one male and female, in each school. The training consisted of 1-2 hours daily or 1 day weekly training following 20 junior and 7 senior lessons. By the time the students finished Grade 6 they received a certificate and a PE ID card. The parents, students and teachers were all impressed by the progress, and several of the academically struggling ‘peer educators’ moved up the ranks and became among the best students in their classes. The Curriculum Development Unit of the MOE endorsed the training materials and the MOH’s IEC Unit was also involved and vetted the materials, and took over the ToT Training materials for use with teachers. There were plans to reproduce these and use them as supplementary teaching/learning materials across the Solomon Islands for all teachers. A second component of the project worked via the Churches, using both the Solomon Islands Christian Association and the Solomon Islands Full Gospel Association, developing a joint resource for teaching pastors to educate peer educators among Church youth who did not go to schools. A third component focused on livelihood training for youth that were not in touch with either the school or the church.
Churches

A representative of the Anglican Church said there were plans to work on teacher training in three Anglican schools around Honiara, i.e. 2 schools that have grade 1-7 and one school that has grade 1-9. It is very difficult for teachers to discuss SRH/HIV issues with students; even the teaching of reproductive health organs is too hard for some of them. The MOE should make SRH education compulsory in the curriculum, as this would solve the problem of some Churches about condoms, as Churches are bound to teach the national curriculum. In this sense, the MOE should consult the Churches about the SRH curriculum and get them on board for a policy (not sure if this exists yet) so that the Church will have to comply with the content, including condoms.

Discussion

The Solomon Islands may have the best and most progressive curriculum, syllabi and textbooks on FLE. Despite this, the Education Ministry is unable to reach a significant proportion of secondary-school-aged youth, hence, there is a need for a common approach to deliver SRH/HIV education to youth, encompassing the formal education sector as well as non-formal approaches delivered via NGOs and Churches. The internal cultural and linguistic differences in the Solomon Islands make it difficult to develop and implement a standardized package of SRH/HIV education and services. Advocacy remains necessary in certain places, and research to evaluate the introduction of FLE in the past 9 years is called for.

Obstacles

- The fact that many Solomon youth are unable to continue into secondary education reduces the potential effectiveness of a school-based SRH education strategy; there is a need to ensure a singular package of knowledge, attitudes and skills that is delivered to young people both in- and out of schools.
- There are huge cultural differences and differences in customs across the Solomon Islands archipelago, including 80-90 languages and dialects. Pidgin English is much less widely understood than Bislama in Vanuatu, for example. This makes the development of teaching-learning materials a challenge.
- The fact that the country is so scattered makes it difficult to standardize and scale-up efforts from the central level. There is also a lack of basic health services, let alone STI testing and treatment services in large parts of the country.
- The Solomon Islands Catholic Church was mentioned as particularly resistant to better sexuality education, much more so than in other Pacific countries. Despite our best efforts, I was unable to meet a representative of the Catholic Church in the Solomon Islands.
- The perception of people in the community about sexuality education was also seen as an obstacle; there was a lot of ignorance about what it was and what it was not.
- A big obstacle is the lack of funding for in-service teacher training. This is currently done only in the main islands. Books are already delivered to all schools but the training on how to use them is lacking.
Country-Specific Recommendations

1. Because of the large proportion of youth out of the formal education system, especially at the secondary level (i.e. more than a third of 15-19 year old youth are not in school), the Solomon Islands needs a comprehensive SRH/HIV education strategy that is clearly coordinated between the formal education system and NGOs, based on a commonly agreed curriculum with clear learning outcomes. The MOE should take the lead in developing this, starting with a commonly agreed division of labor between MOE and different NGOs on how to achieve the highest possible coverage of youth, starting with the most populated areas and those at highest risk. If funding limits what can be achieved, reaching out-of-school youth via SIPPA, ADRA and interested church organizations should be prioritized, as the 2009 UNICEF/MOH study has indicated high levels of risk among the Solomon Island’s out of school youth.

2. Advocacy remains essential to ensure the smooth implementation of SRH/HIV for young people in the Solomon Islands. The idea of developing a local-level advocacy toolkit to help convince Chiefs, religious leaders and elders, as well as (where necessary) school principals and teachers on the need for SRH education should be considered, similar to other Pacific countries; this could be developed as a regional initiative for country-level adaptation.

3. Similar to Fiji, the Solomon Islands made impressive progress in setting up the policy/curriculum framework and producing the syllabi and textbooks for implementation of SRH/HIV education in schools. Similar to the situation in Fiji, the focus should shift to quality now: many teachers remain untrained and not confident to teach SRH/HIV education and some rely on outsiders to teach these topics, who may do so without knowing the curriculum well.

4. Also similar to Fiji, in order to conduct advocacy, better data is needed to prove the effectiveness and usefulness of the Solomon Island’s SRH/HIV education efforts. After nearly 10 years of gradually expanding implementation, an evaluation of schools that have been implementing FLE for at least 5 years should be considered. This will likely provide strong evidence for the acceptability and effectiveness of comprehensive SRH/HIV education in the Solomon Islands context, especially if the evaluation compares learning outcomes and other outcomes (i.e. teenage pregnancies in the school, self-reported SRH problems among students) with schools where no such program was provided.

5. Current training for peer educators, as well as for teachers, should include the issue of traditional and local healing practices and how local beliefs diseases in general, and about STIs in particular, may co-exist with Western-based biomedical knowledge imparted upon teachers and peer educators. This will likely make the teaching of healthy behaviors both more appropriate for local contexts, as well as more effective.

6. The Solomon Islands should document its successes in initiating and expanding FLE education to the extent that it has in a relatively short period of time; the lessons it learned during the process will be interesting for other countries to study.

7. The Primary School peer education program implemented by ADRA in 17 primary schools in Honiara, which functioned as a program to retain children vulnerable of dropping out of the system, should be described and used as a best practice for other countries. Especially the decision to focus on ‘bad’ children as peer educators, rather than the children most liked by teachers due to their diligence and high academic scores, m
Short Overview of Socio-Economic and Population Indicators

Vanuatu is a Melanesian country of 82 islands, of which 65 are inhabited. The estimated population was 240,000 as of 2009. The gross domestic product (GDP) per capita standardized for purchasing power parity (PPP) was 5,065 US$ per annum in 2012. No data was available about the proportion of the population living on less than 2 US$ per day. Life expectancy at birth was 71 in 2010. The under-five mortality rate was 13 per 1000 in 2011, down from 15 in 2008. Around 57% of the population had access to clean water and sanitation facilities in 2010, up from 54% in 2008. Vanuatu is 124th on the UNDP's Human Development Index.

Vanuatu spent just 5.2% of its GDP on education in 2009, down from 6.6% the year before. This amounts to 23.7% of total government expenditure, also in 2009, down from 28.1% the year before. Vanuatu has an adult literacy rate of 82.5% (84.3% for males, 80.9% for females), however, literacy rates for the 15-24 age group are around 94.3%. The net intake rate in grade 1 was 40.3% of the corresponding population, up from previous years. Females had a higher intake-rate than males. Net enrollment in primary schools was unknown, but in secondary schools it was 47.4%.

Vanuatu has very high repeating rates, with 13.4% of enrolled students in primary schools repeating; in secondary schools the repeating rate is 2.3% (2009). The persistence to the last grade of primary school was 71.5% of the cohort (2008); the primary completion rate was 83.4% in 2010. 78% of those completing primary school progressed to secondary schools.
There were 97 girls enrolled in primary and secondary education for each 100 boys as of 2010; later data was not available.8

Short Overview of the HIV, STI and Teenage Pregnancy Situation

According to the Global AIDS Progress report 201239, submitted by the Ministry of Health, the country has low prevalence of HIV infection with six people (four females and two males; five adults and one child) having been diagnosed with HIV since 2002. The last diagnosis was in 2011. The key mode of transmission is through unprotected sexual intercourse. There has been one reported case of mother to child transmission of HIV.

UNICEF conducted a Knowledge, Attitudes and Practices survey among youth aged 15-2440, similar to the one conducted in the Solomon Islands and Kiribati. Again, unfortunately, a mixed sampling strategy was used, making the results not representative for all Vanuatu youth, instead artificially dividing them into ‘risk/vulnerability groups’ beforehand. 11.4% of all 15-19 year olds sampled had had their first sex before the age of 15. 45% of sexually active youth reported forced sex. First sex was forced for 36% of sexually active youth overall. It found that 12.9% of young people (9% of males and 16.5% of females) had experience in commercial sex. Fourteen (8%) sexually active males reported having had sex with other men, of who 11 unprotected. Forced sex of MSM was reported by nearly two thirds of them. Sixty-six respondents in the sample, including 22 males, engaged in commercial sex and 101 in transactional sex. Only 39% of them reported using a condom at last sex. Sexually active youth reported 42% condom use at last sex with a non-regular partner.

A ‘secondary analysis’ of 2008 surveillance data41, published in 2013, found that 16% of all youth in the study had experienced sex by the age of 15. Four fifths of youth aged 15-25 had been sexually active in the past 12 months, with ‘young participants (15-20 years) more likely to have sex when compared to older participants (21-24 years)’. Interestingly, ‘youths who stayed with immediate family were involved in more sexual intercourse compared to those who stayed with peers and relatives’ (p.2); no explanation was offered for this finding.

According to data from the World Bank, the adolescent birth rate in Vanuatu dropped from 53 to 51 per 1000 women aged 15-19 between 2008 and 201116.
The Education Sector Response

Policy and Curriculum Framework

The Vanuatu Education Sector Strategy 2007-2016\textsuperscript{42}, produced in December 2006, lists ‘Life Skills’ as one of the three learning objectives, besides numeracy and literacy, for students finalizing grade 8 (basic education).

Throughout the document there is no mention of reproductive or sexual health, let alone Family Life Education; the only mention made to it is in the annex at the end of the document, where a list of ‘Pacific definitions’ is presented, which include ‘Contextual issues eg health, AIDS/HIV, gender awareness, civic education and governance, environmental, enterprise skills, physical education’ (p.40). Apart from the new Curriculum Statement (described below), no other policy documents related to FLE were found.

The 2010 AHD review report\textsuperscript{20} identified the following gaps in Vanuatu:

1. The FLE curriculum was only available in English and not in Bislama;
2. The composition of the Curriculum Working Group was ‘very exclusive’ and ‘not reflective of the wider spectrum of Vanuatu society’. In particular, there was an absence of religious and traditional leaders in meetings and consultations. There also was a lack of awareness and consultations with principals and head teachers;
3. The current scope and sequence were ‘too content-based’ and ‘very heavy’;
4. A lack of continuity from primary to secondary schools was identified.

Recent History of FLE in Vanuatu

The curriculum department deputy-director said it is important to start sexual and reproductive health education at an earlier age than senior high school because of the growing number of teenage pregnancies and also because a lot of people go to school only till grade 10. HIV had been integrated in the curriculum in the 1990s but had since been removed. In the current process of curriculum reform it is being brought back in, under the heading of Family Life Education (FLE). The process of consultation for the new curriculum was very broad and included MOH, NGOs and the Chiefs and Churches. The consultations took place in 2011 and seem to have taken into account the 2010 recommendation of the AHD project review, which had suggested that the process should be more inclusive.

Teacher training was to be the next phase. Teaching and learning materials need to be developed, as well as teacher training guides. This was planned to be done with the Teacher Training Institute, and could be completed by December 2013 for roll-out in mid-2014. There are 3,000 teachers in Vanuatu, hence a lot of teacher training work has to be completed first. It was noted that the quality of teacher trainers is another important issue to keep in mind. The MOE has placed two Teacher Trainers in every province recently, tasked with providing teacher trainings in their provinces. Another key informant related to the MOE noted that these trainers are quite old, and many are conservative when it comes to providing FLE / SRH education to youngsters.
Mainly AUSAID, NZAID, UNFPA and UNICEF provided donor and technical support; for FLE and SRH/HIV education, it has been UNFPA's AHD country programs working with MOE's that have been most significant in this regard.

The Catholic Mission in Vanuatu runs 66 schools with a total of 9,735 students, making it the second-biggest education provider after the Vanuatu Government. The Mission representatives I spoke to said they had not been involved in the development of the new FLE curriculum, but they were happy to comply with it, as the curriculum taught in the Catholic schools follows the national curriculum. The Mission was already preparing for better sexuality education in the Catholic schools, especially for grade 11-13. There is a certain freedom to interpret the Church's teachings, and the teachings should start with morality and education, focusing on abstinence and faithfulness in marriage, but that for situations where these cannot be attained condoms could be permitted. The welfare and wellbeing of the individual overrules Church dogma. Nowadays there is more openness about SRH/HIV issues in the Catholic Church, and the Bishop of Vanuatu was also very open to the idea of improving SRH education in schools. Speaking from experience the spokespersons mentioned that the issue of stigma and discrimination and the impact sex can have on friendships and popularity in the school might be issues to include in SRH/HIV education.

The Catholic Mission would welcome additional training of its FLE teachers; perhaps the new FLE curriculum could be a good opportunity to do so. The issue of sexual abuse in families, especially in broken families where stepfathers sometimes cross the line, should also be addressed. In line with what the Curriculum Department said, the Mission representatives noted a need for teacher training as well as a need to develop additional teaching and learning materials for use in the classroom.

The Seven Day Adventist Church is the third-largest education provider in Vanuatu, after the State and the Catholic Church. They run 32 schools; 3 senior high schools, 5 junior high schools and 25 primary schools. The schools followed the official Government curriculum; hence, health and FLE education were part of it. Each school and each Church had a Family Life Education coordinator, as well as a Health coordinator. The FLE person was also in charge of premarital counseling. While the Church valued abstinence until marriage and faithfulness, but was not against teaching young people about condoms. Teaching about condoms was okay, as people may use them as a birth control measure after marriage. Condom demonstrations are fine too, but the Church objects to the idea of distributing condoms to students at school; condoms could only be introduced as a last resort, not by handing them out but by telling students where they can get them if they really need them. This is a compromise the Church could live with. People could be made to understand the importance of it, also in the light of high STI and teen pregnancy rates, although teenage pregnancies were rare in the Adventist schools.
The Vanuatu National Curriculum Statement was completed in 2010. Under the chapter on ‘Essential cross-curriculum components’ and the heading of ‘Healthy living’, it states:

Students need to acquire skills in decision-making, and in managing and handling situations of stress in relation to health. They need to be aware of their responsibilities regarding safe sex and the prevention of […] STIs. They should understand the risks of substance abuse and the harm it can cause to their health, and of the impact their behavior has on the health of others.’ (p. 46)

Under the heading ‘Safety’, risks associated with unsafe sex and substance abuse is also mentioned (p.48). The curriculum from Kindergarten until senior high school is organized along five Key Learning Areas: Personal Development, Culture and Community, Language and Communication, Mathematics, and Spiritual and Character Development. The ‘Personal Development’ area is most important in terms of FLE: it includes promoting lifelong health-related fitness, preventing illness, injury and disease, and promoting healthy relationships (p.57). The issue of puberty and physical growth is introduced in years 7-8; this should be the first two years of high school, but in some instances (where no high school is available) these two years are added to the primary school curriculum. ‘Family life’ is introduced in years 9 and 10, as ‘young adults need to acquire significant knowledge, skills and attitudes about their personal development and behavior. […] Family Life [education] will ensure students are prepared to be responsible young adults and be aware of their responsibilities to themselves, their families and others’ (p.65). For year 11-13, the curriculum notes that the learning areas of Personal Development and Spiritual and Character Development are ‘important preparations’, but these will ‘not be externally examined’ (p.66). It adds: ‘The curriculum at this level will be subject to policy to be approved and promulgated by the Minister of Education’.

The Health and Physical Education Syllabus for year 7-10 was also reviewed. In Year 7, students learn about physiology under Physical Education and about puberty under Health. It also introduces ‘healthy relationships’. In Year 8, the ‘changing roles of adolescents during transition from early to mid-adolescents’ [sic] is introduced under the same Health subject. It also introduces depression among adolescents, and causes and effects and ways to overcome depression. Under the sub-strand of Building Healthy Relationships, gender issues are introduced, including ‘expectations of males and females.’ In Year 9, also under Health, ‘discuss the sexuality cycle and develop positive self esteem’ is mentioned. Furthermore, under Safety and Prevention, ‘Identify and analyze key prevention skills and behaviors to keep adolescents and youth away from risk (condoms, contraceptives, violence, teen pregnancies and STIs); under ‘Mental Health/Resilience’ the focus is to develop ‘resilience among adolescents towards bullying, violence and discrimination’. There is also discussion of health services in the community that serve adolescents, if they need them. In Year 10, under the Health subject, students are expected to ‘analyze, discuss and express positive elements of their sexuality’. Under ‘Safety and prevention’, students are to discuss different STIs and
HIV, and ways of transmission and prevention. Under ‘Healthy relationships’ students are to ‘demonstrate appropriate behaviors in a variety of relationships.’ Interestingly, one of the indicators for this is that students ‘refuse inappropriate sexual advances by strangers, family members and foreigners.’

Whereas the curriculum is very comprehensive, it does not mention differences in anal, oral and vaginal sex in terms of risk for transmission of HIV or STIs, or about condoms.

**Perceptions of Learners**

Separate focus group discussions were held with male and female students. Almost half of the students mentioned that they had received information and education from their parents, both fathers and mothers. Others overheard older youth talk about sex. They learned about HIV from TV. One girl and one boy mentioned they had been taught via the NGO Wan Smol Bag. Friends were also an important source of information for both boys and girls. ‘I began asking questions to my mom after watching a movie, I was curious. So I asked my mother. But she did not really answer [laughs].’ One girl had been taught about hormones, and she was encouraged not to get involved in sex, and to control herself.

Both boys and girls knew about girls having to leave school due to pregnancy. In fact only a day before the FGD a girl had been expelled from school after becoming pregnant. The girls thought this was a good thing, so she could take care of the baby, but also not to set a bad example for the other girls in the school. The boys found it unfair that a girl would be expelled whereas the boy could remain in school. The girls thought the boy would also be expelled if it was found out he had made a girl pregnant. The girls mentioned that they thought that teenage pregnancy is more likely to occur in families where the parents are strictest and talk least about sexuality with their children. ‘It is not good if parents just forbid and ban everything without explaining. This is why we are having teenage pregnancies. Parents should be more open with their children.’

All students had had SRH/HIV education at school; they didn’t learn many things they didn’t already know before. There was no information provided about wet dreams, masturbation, homosexuality and ‘not really’ about HIV transmission either. When I probed the girls, they were unaware about different sexual modes of transmission of HIV (anal, oral, vaginal) but knew about needles and mother to child transmission. The only thing that was really new knowledge to them was about pregnancy stages, stages of puberty and (for the boys) menstruation.

When asked when children and youth should start learning about SRH/HIV, one girl said ‘the younger the better’ because hormones would start at an early age and children are exposed to movies and other sources that will awaken their curiosity. The girls settled on age 13-15, but one girl said it should start at the age of 10. There was no difference between the desired age of boys and girls for sexuality education.
All boys and girls said they wanted to learn more about SRH/HIV, but they were not clear on how. Many girls said they wanted to learn more from parents or family members, but the boys mentioned the Internet and books as well as friends. Some girls mentioned they wanted to learn from teachers only if the teachers were mature and married, i.e. if they have experience. The boys also mentioned similar-age peer educators as a preferred way of learning more about SRH/HIV, as well as the Internet and TV programs. Several had seen the Love Patrol series, but thought there should be ‘more action’.

Some girls suggested SRH/HIV education should be, at least partly, done in single-sex groups. They had felt uncomfortable during SRH education sessions in classes, saying the boys had been ‘staring’ at them. On the other hand, it is important that boys and girls do learn the same things, so they can understand each other. The boys said it could be done in mixed-groups. Others said it would be better separate, but they agreed the content should be the same.

Perceptions of Teachers
A group discussion with teachers was held. The teachers said that SRH/HIV education should start at home, by the parents. Parents are firstly responsible for it to respond to questions from their children. But they admitted that most parents do not talk to their children about sexuality or reproductive health. They said pastors/church people play a role here as well, as well as aunties/older family members, more so than the parents. A majority of the teachers thought SRH/HIV education should start earlier than is the case currently. Another teacher said it should start ‘as soon as they are able to read’. One teacher was concerned to do it too early, saying she worried it might ‘contaminate their minds’. Another one thought one should wait until the student begins asking questions about it. Later in the discussion, the teachers agreed it is needed earlier than in the old days. ‘When I was that age, I didn’t know anything, but young people know a lot already these days’.

All teachers said they felt comfortable teaching the topic, but they admitted that in Grade 10, the issue of STI is discussed quite late in the year when people are rushing to get the curriculum done before the end. She put pictures of STIs in the classroom, and left them there for a week, seemingly in an attempt to scare the students: ‘It is good, they can see the reality of it.’ The same teacher also mentioned that they are teaching students so that they can pass their exams, ‘not for life’. This indicates that there was more of a theoretical approach rather than a practical approach in the current SRH/HIV education. They thought some teachers touch on it very briefly or not at all. Two teachers had experience teaching in rural schools, they said it was more uncomfortable and difficult to teach SRH/HIV education than in the city. One teacher said she had two cousins in her class and this made her feel very uncomfortable. They talked about conception to birth, stages of pregnancy, menstrual cycle. One teacher remarked that some boys didn’t feel the need to learn about this, but since it is now in the syllabus and compulsory, they have to. The teachers did not show or demonstrate condoms in the class; one said she did not want to ‘encourage’ students by
doing so, and she thought it was OK just to show pictures of condoms. The teachers also mentioned that some young and single teachers were unwilling or unable to teach SRH/HIV education, because of a lack of experience.

Non-Formal Education Sector Responses

**Government**

The Vanuatu Rural Development and Training Centers Association (VRDTCA) is an umbrella organization for rural training centers in all islands. Most of the clients are young people aged 15-25, with a majority being 15-20 years of age. An estimated 60-70% of the students are men. Many have been unable to continue formal schooling or have dropped out and are 'quite disadvantaged'. Since most of the FLE education is provided via the formal education system after they leave it, they are in the dark about issues related to SRH/HIV. There is a series of modules for workshops that are provided, and one of these is about HIV and reproductive health. VRDTCA was interested to share the curricula with UNICEF for review, and was willing to collaborate to improve the curricula, train trainers in each of the rural training centers, and develop some teaching-learning materials. The timing is good for an improvement of the institution’s SRH/HIV education, since the modules (referred to as ‘Units of Competencies Standards’) were in the process of being reviewed and updated and SRH/HIV education could be integrated.

**NGOs**

The NGO Wan Smol Bag (WSB) runs a well-established clinic/drop-in center for youth. They used to run a program in which they would invite Grade 6-7 schoolchildren to the WSB drop-in center and teach them about puberty, STI and other issues. It was a good way to reach them before they left school, as most of them would not continue into secondary education. However, when the UNICEF/UNFPA funds stopped, the program did not continue. Even now, more than half of the clients of the drop-in center were not in school, it was estimated. There are still theater programs being organized for which school children are invited. The clinic gets 5000 clients per year, sometimes up to 45 clients per day. Most boys and girls appear with STI symptoms and get tested as a result of these; gonorrhea and chlamydia are common. The prevalence is quite high, and most clients are aged 15-25, as young people get sexually active at a very young age. Parental consent is not needed for tests of people under age 18. The eight peer educators refer young people to the clinic; nowadays, more and more youth come to the clinic by themselves. There is also a program focusing on providing safer sex workshops for MSM and sex workers, funded by AUSAID; WSB have recruited 1 MSM and 1 SW peer educator. Apart from STI issues, most questions are related to family planning and menstruation, and physical/bodily changes. Most school-based clients come for ‘emergency pregnancy prevention’. They have not had many questions related to sexuality/homosexuality, although they have started to reach out to MSM and SW since the AUSAID funding for this began, and the counselors have been trained to provide counseling.
to MSM and SW and to be non-judgmental. WSB also conducts outreach workshops on reproductive health to communities around Vanuatu. These were 3-day workshops to which everybody could join but the focus was on young people.

Vanuatu Family Health Association (VFHA) run two clinics, one in Port Vila and one in Santo. Apart from that they provide community outreach via its four trained nurses, and also provide outreach to junior and senior high schools and via Church groups (Pentecostals, Seven-day Adventists). The reach and coverage depended on the budget they have; in 2013 they had reached out to four schools and three Churches, all around Port Vila. The school-based outreach focused on reproductive health, STI, HIV, unwanted pregnancy. ‘Preventive counseling’ related to teenage pregnancy is provided; many girls come to ask for an abortion, which is not legal in Vanuatu. Counselors tried to discourage girls from abortions but many ended up doing it via traditional methods, which could be quite dangerous. The VFHA also has the morning-after pill, but they do not publicize this fact in schools as it may encourage ‘bad behavior’. Often girls who came in fearing that they had become pregnant were too late anyway, coming in 3-7 days after having sexual contact. For STI checks and tests, no parental consent was demanded for those under 18 years of age. VFHA receives its main funding from the IPPF, and contributed data from its clinics to the Health Info System run by the MOH. VFHA works together with Wan Smol Bag in capacity building and also sharing of IEC materials. VFHA staff said that parents are a key obstacle to improving SRH education for young people; they left this task to teachers, who were often shy or not able to provide it. VFHA worked with UNICEF on a Hotline project for which funding had now stopped. Despite this, VFHA has continued it, using some of its own staff.

I met with five peer educators of VFHA. They explained to me that 2 of them had been recruited from each island, and they were trained in 2010 using the National Peer Education Manual. There was a two-week training after which they were supposed to receive refresher training and a certificate, and they would become ‘national outreach workers’ – however the second training never materialized. Since then the young men have continued working as volunteers but they felt unhappy that the MoH had seemingly forgotten them. Main topics discussed with school classes were STI, pregnancy prevention, HIV. Teenage pregnancy was a big problem. One of their tasks was to bring clients to the Clinic; some were too shy to do so, those were referred to the hotline, which the peer educators described as very important to support the work of VFHA. The educators worked every day, they said, but they did not keep track or count the number of people they saw or the topics they discussed. They mentioned religious/traditional festivals in the outer islands where many people come together and a lot of sexual activity happens, could be good opportunities for outreach.

The US Peace Corps has 28 health volunteers and 36 education volunteers working in communities in Vanuatu. In 2012, 36 organizations and 48 communities were involved in SRH/HIV prevention activities led by volunteers, including health education in (mainly primary) schools. Gender issues, especially Vanuatu forms of masculinity and related values
and behaviors, should be part and parcel of SRH/HIV education efforts. Peace Corps volunteers use a teaching/learning material that was developed for Vanuatu specifically, consisting of drawings, which can be used for community training events. They also have the Gender And Development (GAD) program, where young people are taught in youth camps: Girls Leading our World (GLOW) and Boys in Leadership Development (BUILD) camps were held in Vanuatu to develop self-esteem and leadership qualities. In 2009 PC trained Village Health Workers about HIV, focusing on debunking local myths about HIV and AIDS and to reduce stigma and discrimination; this was funded through PEPFAR. PC would be interested to play a role in in-service Teacher Training, using some of its volunteers as facilitators.

Save the Children Australia (SC-A) is implementing the Strengthening Adolescent Reproductive and Sexual Health Program (STARS). It had a number of components, including youth-friendly spaces, livelihood projects with SC-youth clubs, HIV/AIDS with ISZA foundation on educating ‘drop-outs’ and reducing STI and HIV transmission as well as stigma and discrimination. They also were involved in social marketing of condoms and educating on correct and consistent condom use. An in-school SRH/HIV education program was piloted in 2 high schools in Port Vila: Malapa college and Onesua high school. It involved pre- and post testing; data are available but had not been entered or analyzed nor shared, but pre-test scores were low at around 40% accuracy. There were 5 SRH/HIV sessions outside school hours, of about 90 minutes-2 hours length, focusing on 13-17 year-olds, grade 9-10. For the SRH sessions they have separate groups for boys and girls. It was suggested that SC-A conduct the same program in 3 additional schools, as a pilot, over the coming years. SC-A also runs a peer education program for ‘drop-outs’. They use a manual for this, which is also used for the in-school program. Just in the past weeks, 69 peer educators had been trained divided over three two-week long trainings in three provinces. They were selected by the Youth Clubs and with help of the health practitioners in the health centers where the Youth Clubs were based (in two out of the three provinces).

Churches

One key informant from outside the Church, in contrast to most other people I spoke to, said the Church(es) and the Chiefs were not the key obstacle to improved SRH/HIV education in Vanuatu. Ten years ago they were, but with the increase in teenage pregnancies and the high level of sexually transmitted infections among teenagers, plus the linkages between land disputes on remote islands being claimed by young men with no father, or who claim they are the son of a particular man from that island, they are more and more accepting and agreeing that young people and children are taught about sexual and reproductive health. NGOs and also the Church must be credited for many improvements in gender inequality in the past 10 years.

The Vanuatu Council of Churches (VCC) said all Church members are concerned about the health of their flock. Some Churches have their own policies about HIV. NGOs and Governments should consult the VCC to ensure there are no problems in the implementation
of their programs in the field. The VCC representative said that where Government has taken over schools, sometimes ‘the right teachings are not given to the children’; they are not taught ‘to stay away from immoral things’. VCC said Government schools have started coming to them for support in religious education, noting that students are increasingly disobedient. The Church wants children to be brought up ‘holistically’ in terms of their spiritual, physical and moral life, and it guards traditions and traditional values typical to the Pacific. Young people should be treated with love and respect; modern trends may lead to more neglect of youth, which would make them indulge in immoral things. The VCC representative claimed that large festivals and national events cause teenage pregnancies as young people are encouraged by their peers during times of less adult supervision.

The VCC agrees that ‘Aabstinence, Be Faithful and Condoms’ is taught to young people, not only Abstinence and ‘Be faithful’. However condoms should not be the first, or even an equal option. Preventive education should focus on ‘knowing your values’. VCC would be interested to be involved in advocacy efforts for better SRH/ HIV education in the field. An event bringing all Church leaders together to develop a policy statement is one of the options; this could then be used for local-level advocacy in areas where the implementation of SRH/HIV education efforts is problematic.

VCC is already working with UNICEF in the area of Child Protection and they are developing an area of work; VCC is interested in the areas of prevention of bullying in schools as well as the sensitive issue of incest and child sexual abuse by stepfathers.
Discussion

Vanuatu is another Pacific nation where a large share of secondary-school-aged youth is not in school any longer. There is a need to develop a joint strategy to reach Vanuatu youth with comprehensive SRH/HIV education, focusing both on the in-school and out-of-school youth population. While Vanuatu is on the verge of implementing a comprehensive FLE curriculum and syllabi for grades 9-13, a lack of funds for teacher training and for the development of teacher-guides and student-books means that much more needs to be done in order to ensure students gain access to the SRH/HIV education they need. There remains a lack of commitment from important stakeholders such as the Church and conservative Chiefs, also at the provincial level, for SRH/HIV education, both for in- and out-of-school, although sometimes this argument may be used as an excuse to do nothing. In discussions with Church stakeholders, who control a large number of Vanuatu’s primary and secondary schools, I encountered no objections against improving comprehensive SRH/HIV education in Vanuatu schools.

Obstacles

1. There remain cultural obstacles to talking about SRH/HIV openly, including among teachers.
2. There is a lack of commitment from stakeholders, especially the Government and NGOs, also at the provincial level. There is a need for advocacy at the local level, with Principals, Chiefs and PTAs. Perhaps a local-level Advocacy Toolkit could be developed in Bislama, where evidence from around the world about the positive impact of SRH education on children and youth is translated and explained in an appropriate manner.
3. There is a need for teaching/learning materials and for Teacher Guides and student textbooks on FLE, these are planned but may not yet be funded properly. There are language issues too; some teachers teach in French, some in English and some in Bislama. There is a lack of materials in French, in particular. The curricula and syllabi should be made available in three languages.
4. The time available for FLE is only 1 hour per week, with a lot of issues needing to be covered. Extra-curricular add-ons could be considered, but there need to be some incentives for this for teachers.
5. The examination of the FLE module is still an issue. Examination is avoided, as it is difficult to measure and test on attitudes, which is the main part of the program. The MOE is looking at other forms to measure progress, like participation in activities.
6.
Country-Specific Recommendations

1. Because of the large proportion of youth out of the formal education system, especially at the secondary level, Vanuatu needs a comprehensive SRH/HIV education strategy that is clearly coordinated between the formal education system, the Churches and NGOs, based on the newly agreed curriculum and its learning outcomes. The MOE should take the lead in developing this, starting with a commonly agreed division of labor between MOE and different NGOs and Churches on how to achieve the highest possible coverage of youth, starting with the most populated areas and those at highest risk. If funding limits what can be achieved, reaching out-of-school youth via Wan Smol Bag, VFHA, Save the Children and interested church organizations should be prioritized, as the 2009 UNICEF/MOH study has indicated high risk among the Vanuatu’s out of school youth.

2. Advocacy remains essential to ensure the smooth implementation of SRH/HIV for young people in Vanuatu. The idea of developing a local-level advocacy toolkit to help convince Chiefs, religious leaders and elders, as well as (where necessary) school principals and teachers on the need for SRH education should be considered, similar to other Pacific countries; this could be developed as a regional initiative for country-level adaptation.

3. There is a lack of knowledge about the impact of the FLE curriculum, even before the reformed/refurbished curriculum and syllabi. Similar to what SC-A has done in their pilot program, a pre- and post-intervention study should be conducted so that more light can be shed on the effect and impact of the implementation, as well as implementation bottle necks (such as teacher reluctance, parents resistance etc).

4. The question needs to be answered whether it would be better to train specific teachers for FLE who might then cover a number of schools to provide FLE fulltime, rather than as part of other subjects. Such teachers could also be school counselors. There should be regular in-service teacher training in FLE for at least 1 week or longer.

5. The Youth Friendly Health Services manual, which was developed in Vanuatu in 2009 and finalized in 2010, should be urgently printed and distributed by UNICEF.

6. Peer educators should receive refresher trainings at least every two years, and they should receive a certificate or ‘pass’ acknowledging their service and work for their communities. MoH should organize training for a new generation of peer educators to reach people out-of-school, based on the new FLE curriculum. Both the Adolescent Reproductive Health manual and Peer Education Manuals need to be reprinted urgently, something UNICEF might be interested to do. Before doing so, they should
be thoroughly revised and updated with the newest information. Refresher- and new peer educator trainings should have more focus on the specific reproductive and sexual health needs of men and boys, many of whom are reluctant to seek medical attention for STIs.

7. UNICEF Vanuatu could work with the Vanuatu Rural Development and Training Centers Association to review their existing curriculum for FLE/health education, to train their rural training centers trainers in FLE and SRH education, in developing teaching/learning materials for use in the classroom.

8. The Seven Day Adventists asked for support to provide training to their FLE coordinators who meet once per year in Port Vila. The Catholic Mission would also welcome training for their teachers in the new FLE curriculum.

9. Even though a recent survey showed that only 5% of Vanuatu’s school students are computer literate, a website that contains SRH information is Bislama language would be helpful for those who can access it, as well as perhaps for trainers/teachers and peer educators who would like to consolidate or check the accuracy of their knowledge. VFHA and the National Youth Council would welcome such a website.
Concluding Section:

The Rationale for Reviving a Common Regional Approach

This concluding section focuses on the need for a revived regional approach to improving and expanding SRH/HIV education in the four Pacific countries. It starts with an overview of commonalities between the countries, followed by the rationale for a regional approach, recommended regional activities and a proposed division of labor for UN support.

Overview of Commonalities of the countries visited

1. All countries visited presented small and largely contained HIV epidemics combined with significant STI epidemics and high teenage pregnancy rates.

2. Apart from this, common problems for young people include unemployment and school dropout, as well as a growing problem of alcohol-, drugs- and tobacco use, and non-communicable diseases/lifestyle related diseases.

3. All four countries have large numbers of out-of-school youth in the 15-19 years-of-age categories, ranging from about 15% in Fiji to around 50% or higher in Kiribati. This warrants the development of SRH/HIV education strategies for both in-school and out-of-school settings.

4. All countries reported significant cultural taboos as well as some religious and Chief’s resistance to (some aspects of) SRH/HIV education, at least in particular geographical areas. This warrants a common cross-country advocacy push, focusing on the local/field level.

5. In all countries, improvements have been made in recent years in the policy environment for SRH/HIV education. All countries have basically agreed on a number of similar curricular learning outcomes and topics, which do not differ much between them. There were important processes of curricular reform ongoing at the time of the review, presenting further opportunities for improvement in SRH/HIV education.

6. All countries reported a lack of teacher training, at the pre-service level (Fiji, Kiribati and Vanuatu) as well as at the in-service level (all countries). There are possibilities to set up joint teacher training activities at the regional level, or to better utilize in-country capacity to provide in-service teacher training using health care workers or peer educators/peer educator trainers; for pre-service training, more work is needed
with Universities and teacher training institutions, with the possible exception of the Solomon Islands.

7. All countries, with the exception of Fiji, reported problems in terms of accessing regular and long-term technical and financial support for initiating or improving SRH/HIV education. There was a common history of unsustainable, short-term support and sometimes ‘donor-driven’ priorities. A regional approach, developed jointly and based on common findings and agreed priorities and directions for action, should take a long-term perspective and guarantee ongoing support to the country level for at least 6-10 years.

The need for a regional approach to support SRH/HIV education efforts

In this section I will argue for Ministries of Education in the four countries (or perhaps more than four), as well as their UN and NGO partners and donor agencies, to work together to revive the regional approach so successfully taken under the previous regional UNFPA/UNICEF Adolescent Health and Development project.

The achievements of the AHD project are considerable. Achievements in improving SRH/HIV education in the past years, which can be fully or partly attributed to the AHD project and its follow up by UNFPA have been as follows:

1. The social climate in favor of SRH/HIV education has shifted remarkably in the past decade: some countries that were very conservative (including Kiribati) have become more favorable to it, as a result of data on STI and teenage pregnancy among youth, as well as due to continued advocacy efforts.

2. All four countries have incorporated ‘Family Life Education’ into newly developed Curriculum Standards/Statements.

3. Fiji, Solomon Islands and Kiribati have developed FLE in schools as partly integrated, partly stand-alone subjects; Vanuatu is implementing FLE as a full stand-alone subject.

4. All countries have conducted important curricular reform processes in recent years.

As was pointed out in a recent evaluation report of the AHD project, many of the achievements are difficult to attribute to the project, and M&E could have, in general, been done in a better manner. During the country visits many stakeholders praised the support they received from the AHD program while it was up and running, and they lamented the demise of the regional project and, since then, the lack of consistency in donor-support for the efforts to expand SRH/HIV education in the education system.
A regional approach is warranted for three main reasons: First, because the countries in the Pacific have many commonalities and similar obstacles and opportunities for implementing SRH/HIV education, enabling them to easily share and take advantage of each other’s success-stories and lessons learned. Second, the Pacific countries have small populations and relatively underfunded education systems, perhaps with the exception of Fiji; by taking a regional approach with joint development processes, considerable economies of scale could be achieved. Third, the development partner agencies key to improving SRH/HIV education (UNFPA, UNESCO, UNICEF, AUSAID and SPC) will be able to work together in a more coherent and coordinated manner at the country level if agreement on a common approach is reached at the regional level.

**Recommended Regional Joint Activities**

1. In all countries there are large numbers of secondary-school aged youth who are not attending schools. However, none of the countries has a common strategy for SRH/HIV education that includes both in-school and out-of-school youth. The MoE in each country should lead a process in which all major organizations working on reaching out-of-school youth with SRH/HIV education should participate. Regionally, a blueprint for such a strategy could be developed for further adaptation at the national level.

2. In all countries, teacher training remains a big gap. Now that curricula have been developed in all four countries, with strong similarities in terms of content, a regional push for in-service teacher training could be initiated, and regional workshops for teacher training institutions focusing on how to integrate SRH/HIV education into pre-service teacher training programs in the four countries.

3. ‘National Peer Educator/Outreach Worker Manuals’ should be developed as a part of the above-mentioned strategy, aiming to standardize how peer educators are trained and what they should know. In Vanuatu a start has been made with this process, however it has never been finalized, and teaching/training activities for peer educators/outreach workers have not yet been designed.

4. Apart from a National Peer Educator/Outreach Worker manual, there could be the regionally-coordinated joint development of other teaching/learning tools in local languages, including websites in local languages that can strengthen both in-school and out-of-school SRH/HIV education efforts, a booklet sharing good practices for learner-centered activities in teaching SRH/HIV in schools, and a pamphlet for parents on how to breach the topic of SRH/HIV with their children. Such tools should incorporate the findings of research done locally, including the UNESCO regional
study on teacher/learner attitudes and the UNICEF study on most-at-risk adolescents (for Kiribati, Solomon Islands and Vanuatu).

5. A joint generic SRH/HIV Advocacy Toolkit should be developed on why it is needed to provide SRH/HIV education to children and adolescents. Such a document should provide tips and strategies for convincing Church representatives, Chiefs, other local politicians/administrators, school directors and parents, utilizing the latest national data on STI, risk behaviors and teenage pregnancy among youth, results of the UNESCO study on teacher/learner attitudes in the Pacific, as well as international evidence for the effect SRH/HIV education can have in reducing STI and teenage pregnancy rates. The blueprint for the toolkit should be developed at the regional level, for translation and adaptation at the national level. Involvement of all stakeholders in the adaptation process at both the regional level and the national level will be essential to ensure it is inclusive, acceptable and effective.

6. All countries reported the need to better measure the progress of implementation of FLE in-country, as well as the effect it was having on students participating in it. A regional initiative to develop a common M&E framework, including output and outcome indicators and agreed means of verification, can shed better light on progress made and remaining gaps and improve reporting on FLE and its implementation.

7. Many achievements in the four countries visited have gone undocumented. Lessons learned should be described in a document that can be used as a resource for other countries. This can include the primary school peer education program with vulnerable students (Solomon Islands), the ‘school policy and HIV’ (Solomon Islands), the ‘hotline’ project for youth (Kiribati and Vanuatu), peer education with young MSM and sex workers (Kiribati), the consultation/advocacy process for FLE with churches and chiefs (Fiji), the SRH/HIV drama shows for school children (Vanuatu) and the regional capacity building for curricular reform process (regional).

8. Further research is needed to better understand cultural and religious sensitivities to SRH/HIV education, in order to improve the design of advocacy strategies.
Suggested United Nations division of labor for providing technical and financial support

There has been a plan for a joint program for SRH/HIV education between UNICEF, UNESCO and UNFPA. This has proven difficult, partly because of the fact that the UNESCO regional office is based in Samoa and UNFPA and UNICEF are both in Fiji. By agreeing on a broad set of activities to be jointly planned and implemented it is hoped that the partnership can be strengthened. The table below is proposed for initial discussion.

**Table: Key regional areas of action and proposed UN lead agency**

<table>
<thead>
<tr>
<th>Activity (see previous section for details)</th>
<th>Lead UN agency</th>
<th>Partner agency</th>
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<tbody>
<tr>
<td>1 Common strategy for SRH/HIV incorporating in-school and out-of-school youth</td>
<td>UNFPA</td>
<td>UNESCO, UNICEF</td>
</tr>
<tr>
<td>2 Teacher training initiative / integration into pre-service teacher training</td>
<td>UNESCO</td>
<td>UNFPA, UNICEF</td>
</tr>
<tr>
<td>3 National Peer Educator Manual</td>
<td>UNFPA</td>
<td>UNICEF</td>
</tr>
<tr>
<td>4 Local SRH/HIV website - Pamphlet for parents on teaching SRH/HIV to children - Booklet on learner-centered SRH/HIV activities in classrooms</td>
<td>UNFPA</td>
<td>UNICEF, WHO</td>
</tr>
<tr>
<td>5 SRH/HIV Advocacy Toolkit</td>
<td>UNICEF</td>
<td>UNFPA, UNESCO</td>
</tr>
<tr>
<td>6 SRH/HIV education M&amp;E framework</td>
<td>UNESCO</td>
<td>UNFPA, UNESCO</td>
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<tr>
<td>7 Documenting achievements, best practices</td>
<td>UNAIDS</td>
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<tr>
<td>8 Design/conduct research on cultural obstacles to SRH/HIV education</td>
<td>UNESCO</td>
<td>UNICEF</td>
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References


8 Data obtained from the UNESCO Institute for Statistics, available at: http://www.uis.unesco.org/Pages/default.aspx


Taken from an Excel file reviewing policies and strategies on sexuality education, obtained from UNICEF EAPRO, 2012.


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