
Final Report

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The views expressed in this Report are those of my own and do not reflect the official positions of UNFPA, UNICEF or SPC.

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List of Abbreviations and Acronyms

Acquired Immune Deficiency Syndrome  AIDS
Adolescent Birth Rate  ABR
Adolescent Health and Development  AHD
Adolescent Reproductive Health  ARH
Annual Report  AR
Annual Work-Plan  AWP
Australian Agency for International Development  AusAID
Australian Volunteers International  AVI
Behaviour Change Communication  BCC
Evaluation Consultant  EC
Faith Based organization  FBO
Family Life Education  FLE
Federated States of Micronesia  FSM
Human Immunodeficiency Virus  HIV
International Planned Parenthood Federation  IPPF
Kiribati Family Health Association  KFHA
Knowledge, Attitudes, Practices and Behaviour  KAPB
Life Skills  LS
Maternal Mortality Rate  MMR
Memorandum of Understanding  MOU
Ministry of Education  MOE
Ministry of Health  MOH
Most at Risk Population  MARYP
New Zealand’s International Aid and Development Agency  NZAID
Non-Governmental Organization  NGO
Out-patients Department  OPD
Pacific Island Country  PIC
Pacific Island Countries & Territories  PICTs
Peer Educators  PE
Physical Health Education  PHE
Reproductive Health  RH
Republic of Marshall Islands  RMI
Second Generation Surveillance Survey  SGS
Secretariat of the Pacific Community  SPC
Sexual and Reproductive Health  SRH
Sexually Transmitted Infection  STI
Strategy Plan  SP
Terms of Reference  TOR
Tonga Family Health Association  TFHA
United Nations Children’s Fund  UNICEF
United Nations Population Fund  UNFPA
Volunteers Service Oversea  VSO
World Health Organization  WHO
Youth Friendly Services  YFS
A EXECUTIVE SUMMARY

This is an end of project (EOP) evaluation of the UNFPA, UNICEF, SPC joint ADH Project 2008 – 2012 in 10 Pacific island countries (PICs) in the context of the “Adolescent Health and Development (AHD) in the Pacific: Strategic Plan 2009-2012”. The EOP evaluation is intended to assess the relevance, validity of design, effectiveness, efficiency, impact, sustainability and leadership, management and institutional arrangements of interventions to guide decisions on development, management, coordination, monitoring and evaluation of similar projects in the future.

The objective of the AHD Project could be summed up by paraphrasing the Outcome statement of the Strategic Plan which is to improve the knowledge, attitudes and behaviours (KAPB) regarding sexual health among young people.

The evaluation was conducted by an independent external Evaluation Consultant (EC) over a period of 25 working days in January and February, 2012. The EC conducted extensive desk review of documents as well as visited four countries, viz., Kiribati, Fiji, Solomon Islands and Tonga to meet with implementers, stakeholders and beneficiaries to gain in-depth insights into project implementation. A Questionnaire was sent by e-mail to AHD Coordinators of the six project countries not visited (Cook Island, Federated States of Micronesia, Marshall Island, Samoa, Tuvalu and Vanuatu). Views from donors (AusAID and NZAID) were also gathered through a meeting at the Australian Embassy, Suva and telephone conference with New Zealand.

In terms of relevance, the project activities were consistent with UNFPA’s global and UNFPA PSRO’s priorities and the national RH policies, strategies and priorities set out in most of the Pacific island countries. The combined PICs have a high youth population (15 – 24 yrs) ranging from 16.4% to 22.4% in some countries1. Many adolescents are engaged in unprotected sexual practices and a large proportion of young people become sexually active during middle and late adolescence which put them at risk of SRH problems, particularly early pregnancy and STIs. Also, among PICs, access to health, information, education services is generally lacking. Women and girls are generally more disadvantaged in Melanesian countries because of the social status they inherit2. Project activities were to contribute towards reducing some of these problems.

In terms of validity of design, while the Strategic Plan (SP) read like a project document it stopped short of indicating specific project sites where the project activities were to be implemented or the size of populations to be reached. It only set out “to provide guidance and direction in the next phase of the AHD programme for the period 2009 to 2012”. Without the mention of specific project sites and the population size to be targeted, one could easily assume that the project was nation-wide. However, in reality, small-scale activities were carried out in mostly urban areas. Activities were decided through annual workplans (AWPs) with each of the 10 PICs implementing its own mini project. There were also no baseline indicators for any of the countries in the SP nor mention of specific results to be achieved in each country or the sub-region by the end of the project. As an example, one of the Objectively Verifiable Indicators (OVI) for Outcome 2 states, “Percentage of females & males 15-24 yrs who can identify risk taking behaviour (ie. who both correctly identify main modes of HIV transmission and reject major misconceptions about transmissions)” without indicating from what baseline percentage and the degree of increase that the project is to achieve by the end of the project cycle. The design of the project was missing a critical action plan giving clear geographic coverage and population size to be covered in each of the implement countries. This has made it very difficult to measure any specific outputs/results. (See Annex 2: AHD in the Pacific Strategic Plan 2009 – 2012 and its accompanying logframe).

In terms of the effectiveness, the project was able to achieve its advocacy goal by getting most PICs’ health policies and strategies to include ASRH issues. However, it is one thing to have written

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1 SPC-SDP Population Data Sheet, 2011
2 Information extracted from the situation analysis section of the document: AHD in the Pacific – Strategic Plan 2009 – 2012.
policies but another to translate them into actions matched by national budget commitments and services to young people. The latter includes extending clinic hours and expanding staffing and/or equipping facilities to accommodate the needs of young people. These have been found wanting.

**Efficiency:** The ARs indicated that Youth-Friendly Services clinics increase from 55 to 63 across all the countries by the end of 2010. In an example of the efficient use and sharing of resources, the AHD Coordinator in Tonga, reported that both the AHD funded and AusAID “Response Fund” sponsored school clinics shared the same TFHA resources (nurse and volunteer peer educators) to reach out to students with information on SRH, STIs and HIV prevention. This meant that the same resource persons serviced both the AHD sponsored schools and the AusAID sponsored schools without the need for each project to duplicate its human resources.

However, with regard to the project’s delivery on the visions and promises of the SP, over 42% of total financial resources went towards programme management, with the bulk going to the Programme Management Unit (PMU) located within SPC and a number of staff positions at regional level. This was an excessive use of resources at the management level whereas more financial and human resources were needed in the field to reach intended target populations. Besides, actual funding available for implementation of the SP fell short of planned.

Though requested in the TOR (see para 18, pg. 13 & 14), it was not possible to measure impact directly attributable to project activities due to a number of factors including the absence of project sites’ baseline and end-line data. One of the questions posed in the Evaluation Methodology Framework of the TOR was, “Has teenage pregnancies declined as a result of AHD activities?” The EC could not find any documented evidence that teenage pregnancies have declined as a direct result of the AHD activities either from the Annual Reports reviewed or from interviews with implementers and stakeholders in the four countries visited. This is an operational research question that will need to be built into a future project in order to evaluate such impact. The theory of change here is that with increased knowledge and awareness of their own sexual and reproductive health, teenagers will delay engaging in sexual intercourse and/or use protection to prevent pregnancy and STIs/HIV. Never-the-less, information from some country reports do point to the project as having some perceived impact on young people as illustrated by the mini survey conducted in a school in Fiji (see Box story in the main report). The EC was also told repeatedly in interviews with AHD Coordinators, youth volunteers and peer educators that peer education has an impact on the youth populations they served even though they could not produce any documentary proof.

**Sustainability** of the AHD project in most of the PICs is a big concern. AHD Coordinators in the countries visited informed the EC that most of their MOHs viewed the AHD project as “SPC/UNFPA’s project” with activities to be funded wholly from project funds. Most MOHs followed the principle of “No funds, no activities”. In 2011, the above stance of some governments significantly affected the implementation of approved annual planned activities at the country levels with governments not advancing funds from their regular MOH resources to carry out the AHD activities, including paying staff salaries when the release of project funds were delayed for six months by UNFPA due to an SPC qualified audit. Funds were normally channeled through SPC as the lead joint implementing agency.

With the exception of Fiji and the Solomon Islands appointing regular government staff as AHD Coordinators, all other implementing countries depended solely on AHD Project funds to pay salaries of the staffs involved in the activities as well as for the activities themselves. In cases where regular MOH funds were provided for AHD activities, they were minimal and such activities were isolated from mainstream MOH programmes. There is a strong concern that most of the AHD project activities will cease at the end of the project cycle without continued external financial support as there were no firm commitments to continue the project when funds dry up.

**Management and Institutional Arrangements** of the AHD project also had a number of issues. The SP envisaged a programme management unit (PMU) to undertake regional implementation functions
based in the SPC headquarters in Suva, Fiji. The regional team was initially funded by UNFPA and from 2011 SPC funded the salaries of the PMU staff as part of its contribution to the joint AHD Project. The EC was informed by the Director-General of SPC that due to financial constraints within SPC, the PMU services would no longer be available from end February, 2012 and that the team would be disbanded. This has implications for the overall project management as UNFPA will have to take up this responsibility. As per the SPC report, a total of 50 – 60 personnel are involved in the AHD Project across the 10 PICs. These include staff of the Project Management Unit based in the SPC headquarters office, the national AHD Coordinators, Project Assistants, nurses and peer educators based at the country level. This total number is a little deceptive as they include peer educators who are not working full time on AHD activities. In reality, activities are driven by the national AHD Coordinators. Further, due to a qualified audit of SPC that reflected on the management and leadership of SPC, UNFPA had to change institutional arrangements for funds disbursements to the implementing countries from 2011. Solomon Islands MOH also received a qualified audit from UNFPA for 2010 financial disbursements.

There was high turn-over of AHD project staffs in some countries due to staff retirement, lack of funding for human resources and/or staff leaving for “better jobs” due to insecurity of job permanence. Capacity of staff to provide YFS was also severely strained. Most were not sufficiently trained to identify needs of young people or how to provide counseling;

Some of the lessons learned from the EOP include but not limited to the following:

- A planning document such as the SP should be complemented by a project document with clearly defined geographic and population coverage as well as clearly stated baseline indicators and desired level of results to be achieved at the end of the project cycle. It is difficult to evaluate and measure a project’s impact without purposive pre-project and end of project surveys as with this End of Project Evaluation;
- Communications and agreements with all partners, both government and NGOs, at the inception phase of a project is very important to avoid any misunderstanding as to the intent and purpose of the project including eventual absorption of any project staff and equipment into the regular GO/NGO programme;
- A risk assessment and an exit plan or strategy should be part of the project formulation for eventual ending of the project;
- Communities are more open to receiving sensitive SRH messages when presented in an edutainment format such as through drama form and story-telling;
- Information received from the technical staff in the field are that young people are generally shy and reluctant to go to regular out-patients departments (OPDs) of a hospital or general clinic to consult doctors and nurses about their sexual problems. Though there are no published data to confirm this, the EC was informed by many of the YFS staff that clinics that have extended hours beyond the normal working hours attracted more young people to access counseling and treatment;

Recommendations:

Sustainability

1. To ensure sustainability and ownership, there is an urgent need to revisit the MOUs with a number of governments concerning the AHD project (or similar projects) as they (governments) see such projects as not part and parcel of their regular health programmes but as extra-budgetary, donor-funded stand-alone activities. It should be made clear to governments from the very beginning that such project activities are of a limited duration to complement their regular national programmes and/or that they are experimental to test out theories and strategies without risks to government budgets;
2. Governments should build in a strategy to absorb and sustain the project staff and activities and even to scale them up nationally when it is proven that the project activities are beneficial to the target populations;
3. The EC strongly recommends that immediate negotiations be initiated with governments to take over the projects at the end of the project cycle;

**Management**

4. A risk analysis should be done before launching a project;
5. An exit strategy should also be designed into similar projects;
6. In small countries that have limited resources, it is better to work with all stakeholders and agencies together so as to complement each other’s activities rather than duplicate them – targeting the same group with similar/same activities at different times during the year;
7. Instead of increasing the number of YFS clinics, it is recommended that existing clinics be made truly youth friendly by extending their operating hours to attract young people, improving their existing infrastructures and equipping them suitably. Youths of the community should be involved to help make spaces designated for youth centers and YFS clinics truly youth;
8. Based on the experience in the implementation of the AHD Project, it is recommended that UNFPA should think carefully before using the joint programming approach for similar projects in the future. Parallel programming may be a better option;

**M&E**

9. In order to be able to measure impact at the end of a project, it is essential to have obtain baseline data and set target mile-stones during inception of the project. End of project surveys should be done to collect end-line data for comparison and measurement of achievements;
10. Quality reviews and M&E should be built in to ensure that projects do not go off-track;
11. The Annual Report format should be the same for the duration of the project to ease tracking of progress and comparison of data from one year to the next on;
12. Before finalizing a multi-country AR, it is recommended that the draft AR be shared with project countries for information quality checks related to their country implementation;
13. There is a need to review and evaluate the concept and application of “Peer Educators” placed in the health clinics and NGOs as most PEs currently work out of their peer environments. UNFPA could consider recommending to the MOHs to retrain and upgrade some of these PEs to Community Health Educators;
14. Similarly, schools and universities should evaluate their peer education programmes to measure their impacts against measurable indicators where such PE programmes have been taking place for some time;

**Opportunities for UNFPA**

15. As an entry point to providing SRH/FLE information and education to unemployed young people in the PICs as well as meeting the economic and social development issue of the region, UNFPA should consider introducing livelihood-skills training and micro-financing to attract them to youth centres; and
16. UNFPA does not have the full complement of human resources to implement and monitor country level projects as well as to help build capacity in countries where there is no UNFPA presence. To overcome this, it is recommended that UNFPA explore with bilateral agencies that sponsor placing of volunteers at their own costs with future similar projects. Such agencies include the Australian Volunteers International (AVI), Volunteer Service New Zealand (VSA) and Volunteer Service Overseas (VSO) of UK who pay for their own volunteers.
B Introduction

1. The population of Pacific Island Countries and Territories (PICTs) was estimated to be 10 million as of June 2011\(^3\) (PNG alone has a population of 6.8 million) with those under the age of 24 years accounting for 56% of the total population\(^4\). Youths\(^5\) between the ages of 15-24 years comprise 20% of the PICTs population. Youth unemployment is a major concern and challenge for the Pacific region. A recent report indicated that in Kiribati, Marshall Islands and Samoa, half or more of young men age 20 – 24 years are not in productive activity (58 per cent of males 20 – 24 years in Kiribati, 44 per cent in Marshall Islands and 46 per cent in Samoa)\(^6\).

2. The 2011 Pacific Regional MDG Tracking Report\(^7\) noted that there is a high correlation between maternal mortality ratio (MMR) to high adolescent\(^8\) birth rate (ABR) in the PICTs due to high teenage pregnancies and increased complications. MMR was close to 300 per 100,000 live births with an ABR of approximately 150 in the Republic of the Marshall Islands, whilst in Kiribati MMR was about 200 per 100,000 live births with an ABR of more than 60 and in Tonga the MMR was 80 per 100,000 live births with an estimated ABR of 20.

3. There is also significant pressure on natural resources, land, food security, government goods and services (health, education, housing, water supply, electricity, and telecommunications) and its fragile pristine environment due to the increasing populations of PICTS and the high percentage of youths in each of the PICTs. This underlines the greater need to addressing youth issues and their needs. However, they are also a major resource in terms of promoting and advocating for sustained and sustainable national development and increased productivity if their potentials are harnessed. Young people’s skills can be harnessed to contribute meaningfully to nations building, sustained economic growth and increased productivity. Without harnessing their skills and addressing their holistic development issues and needs, problems such as early marriage, teen-age pregnancies, STIs, and youth unemployment are bound to increase with the specter of an increased HIV pandemic. Young people have special needs in terms of sexual and reproductive health information and education that affect their health behaviours.

4. While HIV prevalence is low in the Pacific Island Countries (PICs) covered by the AHD Project, prevalence of sexually transmitted infections (STIs) is alarmingly high, particularly among young people. Teenage pregnancy in the sub-region is among the highest in the world especially in the Marshall Islands, Nauru, Solomon Islands, Vanuatu and Kiribati\(^5\). Majority of teenage mothers indicated that their pregnancies were not wanted. UNICEF’s “The State of Pacific Youth 2011” reported that sexual abuse, sexual violence and rape are major problems in the Cook Islands, Fiji and Marshall Islands. It further highlighted that a quarter of female high school students in Marshall Islands experienced “dating violence” with a third having been physically forced to have sexual intercourse against their will. Unmet needs for contraceptives and family planning remains high among the poor, disadvantaged women and female adolescents. Contraceptive prevalence rate in the

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\(^3\) Pacific Island population projections data sheet, June 2011. Secretariat of the Pacific Communities.

\(^4\) “Regional Youth Initiatives with a focus on youth unemployment”, A Joint Paper by SPC and the Pacific Islands Forum Secretariat tabled at the Pacific Plan Action Committee meeting, 16-17 August, 2011.

\(^5\) Youth: the UN General Assembly defines “youth” as those persons between 15 and 24 years. The definition was adopted during the International Year of the Youth in 1985 and is the one generally used by UN agencies and other partners. However, it is important to note that respective national governments would have its own definitions and age threshold for adolescents, young people and youth.

\(^6\) The State of Pacific Youth 2011: Opportunities and Obstacles. UNICEF Pacific

\(^7\) 2011 Pacific Regional MDG Tracking Report, Pacific Islands Forum Secretariat, Page 53, Figure 11.

\(^8\) Adolescents are defined as between the age group 10-19 years. These overlapping age groups young people (10-24 years and adolescents 10-19 years) are combined in the age group of young people 15-24 years.

PICs has stagnated between 35 – 40 per cent with Kiribati and Solomon Islands below the 30 per cent figure.\(^{10}\)

### B1 Background to the AHD Project

5. In 2001, UNFPA supported the Secretariat of the Pacific Community (SPC) to establish an adolescent reproductive health (ARH) project to address the reproductive health needs of young people in nine (9) of the 22 PICTs. The project resulted in increased support for the implementation of ARH activities, expanded RH awareness, information and education among adolescents and explored innovative approaches to provide accessible ARH services.

6. Simultaneously, UNICEF and SPC implemented the Pacific Stars Life Skills (PSLS) project to address the holistic education of young people on various social and health issues facing them. As the two projects progressed in their implementation of the ARH and PSLS initiatives, increased awareness and receptiveness of communities to ARH and PSLS issues and activities were generated. There was also greater recognition of the need to consolidate efforts and determine the collective and collaborative synergies between UNICEF, UNFPA and SPC to bring about improved results, expand project coverage, avoid overlaps and duplication of efforts and resources to ensure sustainability. Additionally, evaluation of the UNICEF/PSLS project in 2004 by UNICEF recommended the need to review the life skills training component and integrate this with the UNFPA/SPC supported adolescent reproductive health project.

### B2 AHD Project Phase-1 (2005-2007)

7. In 2005 UNFPA’s component of Adolescent Reproductive Health (ARH) was merged with UNICEF’s component of life skills education. Thus the Adolescent Health and Development (AHD) Project was created to support a more integrated and holistic development of young people and to strengthen project effectiveness. This joint initiative recognized the broader approach to adolescent needs and the more comprehensive approach to address the wider issues of adolescent health and development. This was considered a flagship joint programme between UNICEF and UNFPA with SPC as the implementing partner to address the sexual and reproductive health (SRH) of young people in the Pacific within the context of health, education and development. The AHD project initially had four strategies:

   a) Strengthening adolescent health information and education through the formal AHD educational programme and non-formal educational approach;
   b) Strengthening the life-skills approach;
   c) Expanding youth-friendly services; and
   d) Strengthening project management and delivery.

8. The first phase of the joint AHD project was managed and supervised by a regional team based at the regional office of the Secretariat of the Pacific Community (SPC) in Suva working in close collaboration with UNFPA and UNICEF. The project was implemented in ten (10) countries: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Republic of the Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

9. The aim of the joint AHD project was to promote the health and development of Pacific youths by providing information, education, life-skills training and services to meet adolescent developmental needs. It emphasized responsible behaviour and practices to prevent teenage pregnancy, sexually transmitted infections (STIs) including HIV.

10. In 2007, the Project Advisory Committee (PAC) recognized the need to review the project to determine amongst others the following:

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• achievements of the joint project, analysis of lessons learned, examination of the strengths and weaknesses, and, propose changes to the original project agreement;
• evaluate the level of integration between all elements of the ARH project, particularly the integration of the PSLS component and propose strategies for maximizing harmonization of the implementation of an integrated approach to delivering all components of the AHD project at the regional and country levels.

11. Recommendations of the review facilitated development of the 2nd Phase of the AHD project. This phase hoped to better reposition reproductive health and to provide a more strategic focus of the key elements of AHD, enhance synergies and the collective strengths of partner agencies and stakeholders to bring about greater results and impact at community level.

B3 AHD Project Phase-2 (2008 - 2012)

12. As recommended by the 2007 AHD Review, the project was strengthened with the development of the AHD Strategic Plan 2009 – 2012 outlining the outcome and outputs expected. SPC continued to be the main implementing agency with both UNFPA and UNICEF providing financial inputs, technical support and guidance. Other changes included strengthening the project and management unit within the regional office at SPC in Suva for coordination, monitoring and supervision; establishing of a new Project Management Committee (PMC) for oversight and accountability; and, appointment of AHD Coordinators in the 10 implementing PICs with the collective responsibility for implementation during the project cycle.

13. The AHD Strategic Plan (2009 – 2012) has the following four key components or outputs:
   - Output 1: Enhanced Supportive Policy Environment and an Enabling Community Environment;
   - Output 2: Strengthened gender-sensitive and life skills based SRH Education for Young People;
   - Output 3: Strengthened Youth-Friendly Services;
   - Output 4: Enhanced Programme Management and Delivery

14. The SP also provided guidelines for implementation including suggestions to expand and increase coverage to “most at risk young people” (MARYP) when planning interventions. Sets of policy direction and programme directions were also suggested for achieving each of the outputs. These included the use of policy dialogues, building partnerships and alliances, use of multi-sectoral approaches, youth participation, rights-based and gender-sensitive approaches and gender empowerment.

B4 Funding for the AHD Project (2008 – 2012)

15. The Strategic Plan 2009-2012 drew up a total estimated budget of $8 million through the joint contributions of UNFPA, SPC and UNICEF was drawn up for activities to be implemented over four years in order to achieve the desired outputs. This is outlined in Table 1 below:

| Table 1: ADOLESCENT HEALTH AND DEVELOPMENT (AHD): 2009-2012 Estimated Budget |
|------------------|-----|-----|-----|-----|-----|
|                  | 2009 | 2010 | 2011 | 2012 | TOTAL |
| OUTPUT 1: Improved Policy Environment & Enabling Community | 145,000 | 145,000 | 50,000 | 50,000 | 390,000 |
| OUTPUT 2: Improved Life Skills Based AHD Information & Education | 450,000 | 470,000 | 470,000 | 470,000 | 1,860,000 |
| OUTPUT 3: Strengthened Youth Friendly Services | 435,000 | 530,000 | 530,000 | 530,000 | 2,025,000 |
| OUTPUT 4: Strengthened Programme Management & Delivery | 899,500 | 938,000 | 974,500 | 913,000 | 3,725,000 |
| TOTAL | 1,929,500 | 2,083,000 | 2,024,500 | 1,963,000 | 8,000,000 |

Source: AHD Strategic Plan
C Purpose of the Evaluation

16. This is an end of project (EOP) evaluation of the UNFPA, UNICEF, SPC joint ADH Project 2008 – 2012 in 10 Pacific island countries (PICs) in the context of the “Adolescent Health and Development (AHD) in the Pacific: Strategic Plan 2009-2012” (see Annex 2). The EOP evaluation is intended to assess the relevance, validity of design, effectiveness, efficiency, impact, sustainability and leadership, management and institutional arrangements of interventions to guide decisions on development, management, coordination, monitoring and evaluation of similar projects in the future.

C1 Approach and Methodology of the Evaluation

17. The evaluation comprised six parts:

a) The inception stage, involving preparatory briefing, consultation and preparation and submission of an Inception Report;

b) Desk review of relevant documents especially the AHD Strategic Plan 2009 – 2012, AHD Annual Reports, other assessment reports on specific aspects of the project (e.g. FLE, MARYP, YFS) conducted by SPC, UNICEF and partners;

c) Analysis of the responses to the questionnaire sent by e-mail to AHD Coordinators of the six project countries not visited (Cook Island, Federated States of Micronesia, Marshall Island, Samoa, Tuvalu and Vanuatu);

d) Field work in four selected countries; Fiji, Kiribati, Solomon Islands and Tonga to interview and discuss with implementers and stakeholders on their perspectives in the implementation of the project. Stakeholders included MOHs, UNICEF, SPC, donors and other implementing partners;

e) The development of a draft evaluation report that addresses the key questions raised by the evaluation based on UNFPA guidelines and evaluation criteria;

f) Consultation on the draft report with UNFPA Fiji, Peer Review by UNFPA APRO and PSRO, and, revision of the draft report before finalization and its submission to UNFPA.

18. The criteria applied in conducting the evaluation were based on the 32-page TOR11 provided by UNFPA PSRO paraphrased below (see detailed criteria in Annex 1):

- **Relevance:** The extent to which the AHD project and interventions are suited and consistent with national policies, priorities and needs of the countries, given population dynamics, needs and issues for young people;

- **Validity of design:** the extent to which the project design was in line with national needs and priorities, including whether programme results (outcomes, outputs and impact) are clearly stated and describe solutions to identified problems;

- **Effectiveness:** Assess the extent to which the activities contributed to achievement of project outputs and in turn project outputs contributed to the achievement of project outcome “improved knowledge, attitudes, practices (KAP) and behavior regarding sexual and reproductive health”;

- **Efficiency:** In the implementation of the project, assess how efficient the inputs and resources were utilized to produce the results or

- **Impact:** Assess the extent to which the project and activities have made a real difference to the beneficiaries. Did the activities of the project and interventions by partners (UNICEF, UNFPA & SPC) contribute to the following achievements:
  - Reduction in teenage pregnancies;
  - Reduction in STI prevalence rate among young people;
  - Reduction in HIV prevalence rate among young people;
  - Increased CPR among young people;

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11 The TOR attached in the Annex has been shortened by deleting some pages such as the list of people to be met as an updated list is given in Annex-3
Reduction in unprotected sexual practices through increased use of contraceptives and condoms;
Reduction in the number of young people who have concurrent sex partners and multiple partners;
Increased young people accessing and utilizing SRH services; and
Increased young people visiting and utilizing clinical services provided by Youth Friendly Service Centres;

- **Sustainability:** In assessment of the sustainability of the project, determine the following:
  - the extent to which the positive impacts of the project and interventions justify continued investments by the partners;
  - the extent to which partners and stakeholders have financial capacity to maintain and sustain the benefits from the interventions when UNFPA PSRO’s, UNICEF’s and SPC’s support for the project ceases;
  - the extent to which Ministries of Health and Education have institutionalized strategies and activities of the project in their policies/procedures/corporate plans and organizational budgets?

- **Leadership, Management and Institutional Arrangements.**

19. Methodologies applied in conducting the evaluation were as follows:
- Meetings were held with Stakeholders, particularly with UNICEF, SPC, UNFPA, AusAID and some senior government officials during the country visits. A teleconference was held with NZAID in New Zealand (see Annex 4):
- A desk review of the AHD Strategic Plan 2009-2012, the AHD Annual Reports (AR) from 2008 – 2010 (the 2011 AR was not written/available at the time of the consultancy), and other AHD project assessment/review reports conducted between 2007 – 2010 by SPC, donor/partner agencies and regional reports; relevant national policies, plans and guidelines, HIV/AIDS surveillance reports; UNFPA’s project-related documents, reports, research and surveys; work plans of implementing partners and annual reports; related documents from UN partners and donors; evaluation reports; research papers; and various SPC/UNFPA reviews. (see Annex 5)
- Meeting with and conducting formal and informal discussions/interviews involving senior government officials, UNFPA staff, donors, implementing partners including UNICEF, SPC, NGOs and government counterparts, AHD Coordinators and their teams, and youths in addition to a questionnaire cleared by UNFPA PSRO e-mailed to the AHD Coordinators (see Annex 6).
- Traveled to Kiribati, Fiji, Solomon Islands and Tonga to meet with the AHD Coordinators and their teams and interviewed/conducted focus group discussions covering service providers, youth volunteers and implementing partners, observation during field work of hospital/clinic facilities, drop-in/youth centres (see Annex 7); and,

20. The evaluation was conducted over 25 working days with 18 working days spent on country visits to Kiribati, Fiji, Solomon Islands and Tonga covering at least one each country in the Melanesia, Micronesia and Polynesia clusters. A questionnaire to draw further insights on the four key result areas of the project was developed, cleared by UNFPA PSRO and sent out to the 10 National AHD Coordinators. Donors, partner agencies and regional stakeholders were also
interviewed both by face-to-face and telephone to elicit their views and recommendations regarding the approach best utilized to reach young people. During the country visits, interviews and focus group discussions were held with national stakeholders including senior officials from the Ministry of Health, Ministry of Education, NGOs, and field level workers/volunteers.

21. The evaluation was conducted with due regard for the welfare of those involved in the evaluation, and in accordance with the UNEG’s Ethical Guidelines for Evaluation. In line with UN Ethical Guidelines for Evaluation, the evaluation included verbal informed consent of participants. The evaluation’s purpose was outlined to government counterparts and other stakeholders. Target groups for the evaluation were informed of the evaluation purpose, rights and obligations of participating in the evaluation and agreed to participate voluntarily. The identities of persons making individual comments have been kept confidential as far as possible.

C2 Limitations

22. While every effort was made to collect reliable data and information for the evaluation, inevitably there were some limitations. Some of these are listed below:

- While the AHD Project covered 10 countries spread across the Pacific Ocean, UNFPA PSRO decided that the EC should visit only four countries, viz, Kiribati, Fiji, Solomon Islands and Tonga due to limitation of time and budget. Information from countries not visited were to be obtained from the desk review of Annual Reports and from a questionnaire sent to the AHD Coordinators in those countries;
- During the inception stage and preparatory briefing, the Evaluation Consultant pointed out to UNFPA PSRO that the TOR seemed to be a little over ambitious in requesting to measure impact when none of the implementing countries conducted a pre-project baseline survey of the KAPB of young people in the project areas they were to implement their activities. Since a project end-line survey was also not conducted, definitive conclusions on the outcome results attributable directly to the AHD project (as requested in the TOR) could not be determined;
- Each of the AHD Annual Report reviewed used a different reporting format and reported on different sets of data making it difficult to compare data over time to measure change;
- Reliability of some data reported in the AHD Annual Reports were questionable or unclear even after the EC made every effort to clarify them from SPC (see Section E1);
- Not all data required for the evaluation was readily available in published reports. Requests were made to UNFPA PSRO and SPC for them, particularly any baseline or endline data. The EC was provided a file with raw data in 78 spreadsheets from the DevInfo Data Entry Spreadsheets by UNFPA. SPC provided the EC with a file containing data from their “PACIFIC ISLAND POPULATIONS - Estimates and projections of demographic indicators for selected years” and other files containing over 100 spreadsheets with raw data from countries they were in the process of analyzing. It was not in the scope of the present evaluation for the EC to comb through the huge amount of raw data collected by SPC over the years to compile consolidated information such as the total number of schools conducting FLE in each country (which were not available in any case as confirmed by SPC), or to validate the total number of youths reached per country per year as reported in the ARs when there were either no information or contradictory data provided in different reports;
- Though requested in the TOR (see para 18, pg. 14 & 15 ), it was not possible to measure impact directly attributable to project activities due to a number of factors including the absence of project sites’ baseline and end-line data. One of the questions posed in the Evaluation Methodology Framework of the TOR was, “Has teenage pregnancies declined as a result of AHD activities?” The EC could not find any documented evidence that teenage pregnancies have declined as a direct result of the AHD activities either from the Annual Reports reviewed or from interviews with implementers and stakeholders in the four countries visited.
D Findings

23. The findings are presented in two sections. The first section is a general discussion of the overall findings of the AHD project while the second section discusses findings of each of the four key strategic project outputs. The UNFPA evaluation criteria of relevance, design, effectiveness, efficiency, impact, sustainability and leadership, management and institutional arrangements will be highlighted where appropriate.

24. Each of the 10 PICs has its own set of challenges while implementing the AHD Project in their respective countries. These challenges can be categorized into two groups – structural and functional. These in turn can be subdivided into institutional, capacity, operational, human resources, and funds management challenges in the first group while strategy, prioritization, and monitoring and evaluation falls into the second group of challenges and issues.

25. **Relevance:** The AHD Strategic Plan and project activities are consistent with UNFPA’s global priorities and the national RH policies, strategies and priorities that are set out in most of the Pacific island countries. The AHD Strategic Plan Phase 2 was developed at a time when the region was increasingly focused on poverty reduction and the achievement of the Millennium Development Goals (MDGs). Many of the MDG targets directly relate to young people’s health and development. Social investments in education, health and employment can enable countries to build a stronger economic base, thereby breaking or reversing the cycle of poverty. The AHD Strategy’s aim was to build country capacity towards national ownership, national leadership and national systems, and a holistic approach to addressing youth issues proactively pursuing partnerships with governments, development partners, NGOs, CSOs and the media for leveraging resources to support social investments in young people.

26. Due to the large numbers of youths in the PICs there is an urgent need to address youth development issues. While sexual and reproductive health (SRH) is one important aspect of youth development, education, livelihoods, employment and citizenship are equally important. Young people are a major resource in terms of promoting and advocating for sustained and sustainable national development and increased productivity if their potentials are harnessed. Their skills can be harnessed to contribute meaningfully to nations building, sustained economic growth and increased productivity. Without harnessing their skills and addressing their holistic development issues and needs, problems such as early marriage, teen-age pregnancies, STIs, and youth unemployment are bound to increase with the specter of an increased HIV pandemic. (see Chapter 2 of the Strategic Plan)

27. **Validity of Project Design:** As a planning document, the Adolescent Health and Development (AHD) in the Pacific Strategic Plan 2009 – 2010 outlined the visions, goals and programme directions that a regional AHD project in the Pacific should take. It’s stated purpose was out “to provide guidance and direction in the next phase of the AHD programme for the period 2009 to 2011.” There were no baseline indicators for any of the countries in the SP or for the region nor mention of specific results to be achieved in each country or the sub-region by the end of the project. As an example, one of the Objectively Verifiable Indicators (OVI) for Outcome 2 states, “Percentage of females & males 15-24 yrs who can identify risk taking behaviour (ie. who both correctly identify main modes of HIV transmission and reject major misconceptions about transmissions)” without providing a baseline percentage and the desirable percentage increase that the project is to achieve by the end of the project cycle. This has made it very difficult to measure any specific outputs/results. There was also no mention of the geographic coverage and population size to be covered in each of the 10 PICs nor a multi-year action plan with clear sets of annual indicators and targets to be met. Activities were decided through annual workplans (AWPs) with each of the 10 PICs implementing its own mini project with no reference check to a master multi-year action plan. The project was missing a critical project document that the 10 PICs could follow on a yearly basis as a planning document is different from a project document much like a CPD compared to a CPAP, one being a planning document the other an action plan (see Annex 2).
28. **Effectiveness:** The discussion on project effectiveness is under two categories: (a) programme effectiveness; and, (b) budgetary considerations affecting project activities. The following paragraphs discuss the budgetary considerations affecting project activities while programme effectiveness will be discussed more elaborately in the sections dealing with individual key strategic output findings.

29. While the Strategic Plan document estimated the requirement of $8 million over four years (see Table 1) with an estimated budget of $6,037,000 for three years (2009-2011), annual planned budget (Table-2) fell short by 41% with actual disbursement of funds received by the AHD Project falling short by over 56% for the same period. There was no indication of counterpart funding by any of the PICs and consequently most of them saw it as a donor driven project. However, Fiji and the Solomon Islands contributed in kind in the form of a regular MOH staff serving as the National AHD Coordinator. The huge shortfall of funding affected project implementation at the country levels and in turn significantly affected the progress towards achieving the outcome results desired.

| Table 2: Planned budget by Key Outputs 2009 – 2010 (US$) |
|------------------|---|---|---|---|---|
|                  | 2009 | 2010 | 2011 | TOTAL  |
| OUTPUT 1: Improved Policy Environment & Enabling Community | 103,806 | 72,760 | 133,113 | 309,679 | 8.64% |
| OUTPUT 2: Improved Life Skills Based AHD Information & Education | 769,350 | 80,284 | 104,074 | 953,708 | 26.61% |
| OUTPUT 3: Strengthened Youth Friendly Services | 503,100 | 135,969 | 164,900 | 803,969 | 22.44% |
| OUTPUT 4: Strengthened Programme Management & Delivery | 748,644 | 443,787 | 323,590 | 1,516,021 | 42.31% |
| **TOTAL** | **2,124,900** | **732,800** | **725,678** | **3,583,378** | **100%** |

Source: SPC

30. The budget was heavily weighted towards programme management, with the bulk of the funds going to the Programme Management Unit (PMU) located within SPC and a number of staff positions at regional level. New posts planned included a Communications Officer for Output 1, an FLE Officer for Output 2, a Research Officer for Output 3 while Output 4 sought two Development Officers and another FLE Coordinator. As UNICEF did not financially renew the life-skills component of the programme (the 2007 Review had recommended integration of CBLS with ASRH), the consequence was that due to the limited funding, most new posts identified by the SP were shelved as the PMU was already heavily budgeted. The unequal sharing of costs by contributing partners also had UNFPA bearing the larger burden. These are given in Table 3 below. It is to be noted that UNICEF, due to its bilateral country programmes, funded activities directly in some countries that had bearing on the outcome of the AHD Strategy.

| Table 3: Actual Funding provided by Agencies from 2008 – 2011 (US$) |
|------------------|---|---|---|---|---|
|                  | 2008 | 2009 | 2010 | 2011 | TOTAL  |
| UNFPA            | 814,477 | 734,712 | 919,746 | 497,011 | 2,965,946 | 75.7% |
| UNICEF           | 225,616 | 83,475 | 50,000 | 9,500 | 368,591 | 9.4% |
| SPC              | 216,183 | 126,920 | 77,841 | 161,748 | 582,692 | 14.9% |
| **TOTAL**        | **1,256,276** | **945,107** | **1,047,587** | **668,259** | **3,917,229** | **100%** |

Source: SPC and UNFPA

31. Due to the change in modality of funds disbursement by UNFPA in 2011, funds expended directly by UNFPA through the IPs were higher for 2011 than for previous years while the funds disbursed through SPC was correspondingly reduced for the year. This is reflected in Table 4 which gives the actual funds expended by UNFPA for the AHD project over the financial years from 2008 – 2011.

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12 Note: this is with respect to pooling of funds into the AHD Project and does not include UNICEF’s individual country programmes’ contributions to youth related activities in the different countries. A case in point is the direct funding by UNICEF for the MARYPs’ KAPB studies in Kiribati, Solomon Islands and Tonga. UNICEF also provided direct funding for drafting of the Youth Friendly Health Services Guidelines in a number of PICs.
Table 4: UNFPA Funds expended for AHD Project from 2008-2011 (US$)

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expended by SPC</td>
<td>780,001</td>
<td>721,398</td>
<td>903,669</td>
<td>119,688</td>
<td>2,524,756</td>
</tr>
<tr>
<td>Expended directly by IPs or by UNFPA for countries</td>
<td>34,476</td>
<td>13,314</td>
<td>16,077</td>
<td>377,323</td>
<td>441,190</td>
</tr>
<tr>
<td>TOTAL</td>
<td>814,477</td>
<td>734,712</td>
<td>919,746</td>
<td>497,011</td>
<td>2,965,946</td>
</tr>
</tbody>
</table>


32. The AHD Project Outcome states, “Improved Knowledge, Attitudes, Practices and Behaviour (KAPB) Regarding Sexual Health among Young People”. Outcome indicators provided include, among others:

- Percentage of females & males 15-24 yrs who can identify risk taking behaviour (ie. who both correctly identify main modes of HIV transmission and reject major misconceptions about transmission);
- Contraceptive prevalence rate by method and age;
- Unmet need for contraception (15-24 yrs);
- Condom use at last sex among males and females, 15-24 yrs;
- Number and percentage of 15-24 year olds receiving HIV test in last 12 months and know their results;
- Number of Adolescents and young people utilizing ASRH services;
- Number and percentage of 15-24 year olds who have had sex before age 15 and 18; and
- Proportion of young people who do not have concurrent and/or multiple sexual partners

33. Efficiency: From the AHD Annual Reports, communiques and reports of assessments, planning and review meetings, workshops reports, interviews and focus group discussion with stakeholders conducted, it was concluded that there were varying degrees of successes in the progress towards achieving each of the four key strategic outputs of the AHD project.

34. For example, as a direct result of the AHD Project, nine out of 10 PICs reported that the AHD Project influenced their national RH policies and strategies (Output-1). All the project countries reported varying degrees of integration of SRH issues into the regular school curriculum (Output-2). A number of countries expanded and integrated youth friendly services (YFS) for young people in both government clinics and those run by selected NGOs (Output-3), and, integrated SRH and HIV issues in the delivery of government health services (Output-4). No doubt these are process indicators but one can infer that they will hopefully lead to increased knowledge and change of behaviour towards SRH/STIs/HIV among young people resulting in the reduction of new incidents of STIs, unplanned and teen-age pregnancies and increased CPR in the long term.

35. Management & Institutional Arrangements: At times, there were confusing roles played by SPC, UNICEF and UNFPA in the management of the AHD project. As the main implementing partner of the AHD Project, SPC had a large project oversight role in relation to programme delivery extending over the 10 PICs. However, it has limited capacity to become fully be involved in delivery issues. In fact, the Consultant was informed that the PMU located within SPC would be disbanded by end February 2012 due to lack of funds for the management staff. This has implications for the overall management of the AHD Project for the remaining months of 2012.

36. On the other hand, due to it being the major funder for the project, UNFPA had oversight of SPC and the implementing countries as well with even less capacity to be involved in programme deliveries. Due to its field presence in a number of the implementing countries, UNICEF directly interacted with the respective Ministry of Health to implement some activities. Funds were bypassed from the project pool even while involving the local implementing partners in project deliveries. Feedback from the AHD Coordinators suggested that there should be a greater deal of attention paid to coordination of supervision and technical assistance and funding by UNFPA, SPC and UNICEF.
37. SPC and the Solomon Islands Government received qualified audit reports from UNFPA for the 2010 fund disbursements. This resulted in UNFPA suspending funds channeled through SPC to the project countries which in turn delayed project activities across the board in 2011. UNFPA’s direct funding to the project countries in 2011 also caused management issues with implementing partners as they had to learn new ways of financial requisition and reporting that were previously different from the reporting formats submitted to SPC when funds were channeled through SPC.

D1.1 Findings by Project Output-1: Enhanced Supportive Policy Environment and an Enabling Community Environment.

OVI: Number of countries that have integrated AHD into national youth policy, RH policy and HIV policy.

38. All the 10 Pacific island countries implementing the AHD Project reported varying degrees of supporting and enabling environments towards policy development, strategic plans, human resources and programme support. Due to efforts by the AHD Project and UNFPA, nine out of 10 PICs’ RH policies and strategies now include ASRH.

39. For example, as a direct result of the advocacy work done by the AHD Project, the Ministry of Health in the Kingdom of Tonga incorporated ASRH issues into the Reproductive Health Policy 2008 & Reproductive Health Strategy 2008 – 2011; the National Strategic Plan for HIV & STIs 2009 – 2012; the Tonga National Youth Strategy: 2007, and Science Syllabus for Class 7 & 8, and other grades. A similar scenario was enacted in Fiji where, due to the AHD project advocacy efforts, ASRH was included in the Health and RH policy and strategy document. Vanuatu, Cooks, Tuvalu and Samoa have also included ASRH in their national RH policy and strategy documents, while Kiribati has the done the same for the draft RH Policy and Strategy. RMI also has incorporated ASRH in its latest Health Strategy 2012 – 2014, with a focus on improving RH status of teenage mothers.

40. In the Solomon Islands, Policy Statement 3 in the National Reproductive Health Policy and Strategy (2011 – 2013) addresses adolescents and youth health issues including youth-friendly services, sexuality, reproductive health prevention of unplanned early pregnancy, STIs/HIV and high risk sexual behaviour. The Policy set clear targets and indicators in its M&E framework to be achieved by the end of 2013. These include providing life-skills education to at least 75% of young adults in high schools by 2013; at least 50% adolescents and young adults receive comprehensive RH and sexual health information; and, at least 75% men, women and adolescents aware of common STIs and HIV/AIDS prevention.

41. In the Marshall Island, the 33 Parliamentarians who participated in a national advocacy workshop on “Youth to Youth in Health” in 2010 committed to increased support to youth health issues including SRH. Vanuatu’s Reproductive Health Policy document listed AHD as a priority component for implementation.

42. Faith Based Organizations (FBOs) were reached in Tonga, Solomon Islands, Kiribati and other PICs to support the AHD project. For example, in Tonga, training workshops were held with FBOs to seek their support and involvement in the AHD project. Twenty youth leaders from different church groups attended the workshop at Moulton Hall in 2010. The Catholic Church provided its conference room in the Basilica of St. Anthony of Padua in the capital city of Nuku’alofa for an AHD sponsored meeting of new Parliamentarians and Government Directors to discuss issues on ASRH. The Anglican and Catholic Churches have now stepped in to offer mentoring programmes between older women and their teenage mums. In Suva, AHD Fiji joined YWCA to conduct a seminar for the young women on ASRH issues. In Kiribati, the Youth for Christian Living supports and partners with the AHD project to reach out to young people on ASRH issues.
Findings by Project Output-2: Strengthened gender-sensitive and life skills based SRH Education for Young People.

OVIs: Number of countries approving FLE policy
Number of situation analysis in FLE conducted
Number of countries establishing FLE

43. This is the most important output for achieving the desired outcome of the AHD Project. It was therefore not surprising that bulk of country project activities were centered on this component of the SP. The SP suggested seven strategic activities to achieve this. They included; (i) family life education [FLE], (ii) school-based counseling, (iii) introduction of FLE in Pre-Service Teachers Training Institutions, (iv) peer education [PE], (v) behaviour change communication [BCC], (vi) multi-channel media campaigns, and, (vii) use of edutainment. Most of the countries concentrated on strategic activities (i), (ii) and (iv) while the other strategic activities were scattered among some of the countries as supporting activities.

44. The annual reports indicated that though there was slow progress, most countries had integrated SRH, STIs/HIV prevention and life-skills into their regular school curriculum with Fiji piloting a stand-alone FLE curriculum. However, there is debate among the countries on what form the FLE/SRH curriculum should take to make it more effective for young students to gain the critical knowledge and life skills needed as they grow from teenagers to young adults (see discussion in Section E2). Gender-sensitive programming was conspicuously absent even though some data provided were disaggregated by the sexes.

45. An assessment of adolescent sexuality education in 10 PICs carried out by the AHD Section of SPC in 2010 pointed out that “FLE/SE is being integrated into the curriculum but very poorly delivered and in some cases none at all.”13 The report’s concluded that this was attributed to teachers’ lack of skills, understanding of fundamental SRH issues and self-confidence to teach the SRH and life-skills coupled to “the lack of support, resources and services for effective implementation of FLE/SE”. The report lamented that “there was a general lack of concern and awareness of the MoE/CDU and MoH and other stakeholders to nationalize the issue of Sexuality education.” Unfortunately, the document did not provide any quantified data such as the percentage of schools in countries that have fully integrated FLE/SE or the percentage of schools not teaching FLE/SE at all. The EC was informed by the Head of Curriculum Development Kiribati that the country will devote time for inclusion of FLE issues into the Physical Health Education (PHE) curriculum revision only in 2015.

46. While every country embarked on in-service teacher training to equip them to teach the sensitive subject of SRH in schools, very few countries included FLE topics in their pre-service teacher training courses. Only Solomon Islands and Vanuatu indicated that FLE is taught at the pre-service level to future teachers in their teacher training colleges. In fact, the curriculum writers for FLE in the Solomon Islands are lecturers from the Teacher Training College.

47. Impact: While it is not possible to provide impact data for all the project countries, information from some country reports do point to the project as having an impact on young people as illustrated by the mini survey conducted in a school in Fiji (see Box 1 for success story submitted to SPC).

48. A “Guide to Peer Education” manual was developed in 2009 and a total of 680 peer educators were trained under the AHD Project in the 10 PICs in the same year. Another 656 peer educators were trained in 2010 while the figures for 2011 were not available at the time of writing this report. Though there is limitative quantitative data on impact, the EC was told repeatedly in interviews with AHD Coordinators, youth volunteers and peer educators that peer education has an impact on the youth populations they served though they could not provide any documented evidence for them. The Peer

13 SPC, 2010: Assessment Report of Adolescent Sexuality Education (or Family Life Education) in ten PICTs.
Educators’ role in the country AHD programmes have been recognized over the past years. However, some AHD programme managers and peer educators themselves were still confused on what exactly their roles were in the prevention of STIs, HIV, and teenage pregnancy among adolescents (AHD Annual Report 2010).

Box 1: A Fiji School’s Success Story*

Laucala Bay Secondary School is a government co-educational facility located just outside Suva city opposite the USP campus in Laucala. The school caters for students who do not qualify for secondary education at the Form 3 level and also take in those students who have been forced to find another school (FAS) from all over Fiji for one reason or another. When it is able to accommodate students the school opens its doors to these cohort who seek a secondary education and also for those who seek a second chance at secondary schooling.

As a result of the FLE being taught in the school, the following results were noted over a two-year period:

<table>
<thead>
<tr>
<th>Common issues</th>
<th>2009</th>
<th>2010 (Term 1+2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Glue sniffing</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>Smoking (tobacco)</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>Marihuana (usage &amp; pushers)</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>STIs</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Fighting (brawls &amp; bullying)</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

The school also noticed the following among majority of students and this has been reflected in the external examinations as follows.
1. Fiji junior Exam: 93% Pass rate
2. Fiji School Leaving certificate: 75% Pass rate
3. Fiji Seventh Form Examination: 65% Pass rate

Apart from the improved exam results, Family Life Education has contributed tremendously to the following in the school. The following is worth mentioning
1. Improvement in academic work
2. Decline in:
   - Truancy
   - Lateness
   - Graffiti
   - Bullying
   - Vulgar Language
3. Community work
4. Leadership seminars
5. FLE drama, skirts, songs

49. In Fiji, since 1999, “Peer Educators” have become part of the public health team of the Fiji MOH and are based at sub-divisional health centres. The findings of a study\(^\text{14}\) showed that peer education in Fiji has been a strong tool in the delivery of information and education to support the AHD programme of the Ministry of Health. Peer educators understood sexual and reproductive health and were able to impart information to other young people. The overall assessment indicated that peer educators were competent in delivering peer to peer health education and counseling. However, given the small study population of only five peer educators living in South Tarawa in Fiji and a total of 40

\(^{14}\) An Assessment of Peer Educators’ Contribution to Adolescent Sexual and Reproductive Health in Fiji (2007). Ministry of Health, UNFPA, SPC.
students and 40 community youths that were assessed for the study through eight focus group discussions and a self-administered questionnaire, it would be useful to replicate similar studies in the other 9 PICs to ascertain if the statement remains true.

50. A 2007 study in Kiribati\textsuperscript{15} showed that peer educators have demonstrable content knowledge and understanding of ASRH issues to impart and share with peer groups. However, special skills were lacking among the peer educators – especially communication skills, and, training and facilitation skills to enhance the delivery of educational sessions using more interactive and participatory approaches. There is a general lack of IEC/BCC materials – in the variety of materials, in the use of local language, and in their supplies and distribution. The 2010 AR reported that the number of young people “reached” by the AHD project outreach activities in Kiribati by PEs increased from 989 in 2008 to 9,990 which is a substantial increase. It also reported that overall, a total of 61,418 young people between 10-24 years old were “reached” in 2010 as compared to just above 10,000 in 2009. Unfortunately the AR did not provide any data or information on the content, nature and method of this “reach” except for the figures stated. Thus it is not possible to analyse further the impact of this contact.

51. Since early 2007, the University of the South Pacific (USP) Counselling Centre and the Student Association (USPSA) resurrected the dormant USP Peer Education Programme in USP’s Laucala Campus in Suva, Fiji, with the support of SPC, UNFPA, UNICEF and the Fiji Ministry of Health with funding sourced from the joint regional AHD Project. The goal of the USP Peer Education Program is: “To safeguard and protect the sexual and reproductive health of University of the South Pacific students, thereby contributing to their holistic health and development to help them live to their full potential towards achieving socio-economically productive lives.” An internal note from USP raised concerns that the PE programme had not met its objectives in the last two years due to a number of factors including high drop-out rates of the student PEs due to lack of incentives, loss of interests, among others as well as internal management issues.

52. Behaviour change communication (BCC) is the key to reaching audiences with the right message at the right time in the right environment to provide them with the critical information, education and knowledge to enhance their life-skills. A number of AHD Coordinators indicated that they used radio talks. Cook Islands reported the use of radio programmes three days a week to reach out to young people with messages on reproductive health, NCDs and other health issues. Solomon Island had a weekly radio programme for youths which they found to be “quite effective”. However, it has since been discontinued for over a year due to lack of funds. Kiribati and Tonga used “edutainment” as a format for reaching young people in and out of schools through the use of drama/theatre. The drama not only provided entertainment but highlighted issues of sexual and reproductive health, prevention of STIs and HIV in an informal setting and humorous manner. They were performed in schools as well as in public stages. Advocacy and IEC materials are generally limited to project sites (AHD offices and youth centers) only. They are also distributed during events and workshops. Feedback from the AHD Coordinators indicated that IEC materials are not easily available in outer islands.

53. In all the AHD Annual Reports reviewed, gender sensitive programming was conspicuously absent while some data provided were disaggregated by the sexes.

\textbf{D1.3 Findings by Project Output-3: Strengthened Youth-Friendly Services}

\textit{OVI: Number of facilities providing youth friendly services, by type of facility in each country}

54. A number of Operational Researches conducted in selected PICs in 2006/7 as well as a recent assessment of youth friendly clinics in five AHD project countries\textsuperscript{16} carried out by SPC highlighted a

\textsuperscript{15}Metai, Maoto. The role of peer education in condom use among young people in Kiribati – Suva, Fiji : UNFPA Office for the Pacific, 2007

\textsuperscript{16}(no date). Report of the Youth Friendly Service Clinic Assessment in 5 Pacific Island Countries
number of deficiencies in the YFS clinics operated both by governments and NGOs that needed to be addressed in order to strengthen YFS. Some of these were observed and confirmed by the Consultant’s visits to clinics in Fiji, Kiribati, the Solomon Islands and Tonga.

55. **Effectiveness:** In general, all clinics need structural improvements if they are to be truly youth friendly. During the EC’s visits to clinics run by NGOs and government run clinics, it was observed that the former met the physical characteristics of YFS more than the government run clinics with the exception of the Fiji government run YFS clinic in Suva called “Our Place”. Most NGO clinics have separate counseling rooms for young clients while government clinics find it difficult to set aside separate space and facilities for youths due to limited existing physical infrastructure and lack of funds for renovation/expansion. Government clinics also operated on “regular” hours which are inconvenient for young people, particularly school going adolescents. Some NGO clinics such as those operated by TFHA in Tonga and KFHA in Kiribati informed the Consultant that when they extended their clinic hours, they found that more young people visited them for consultations and treatments. This was echoed by the government run clinic in Suva, Fiji “Our Place” as well as the Kiribati AHD clinic.

56. In the case of the Suva “Our Place” clinic, the EC was informed that when it was first started, due to the complementary staffing of a full time doctor, a nurse and peer educator coupled to the location and youth friendly infrastructural set up including extending the operational hours beyond the usual operating times of government clinics it became very popular for youths to visit to seek out information, counseling and treatments. However, this popularity has now waned as a doctor is no longer in the clinic on a daily basis. Besides, one of the advocated services for young people which is voluntary testing for HIV is no longer available due the fact that there is no attending phlebotomist on site to draw blood for HIV tests. The protocol does not permit the attending nurse to draw blood even though she is trained to do. A phlebotomist has to be called from another clinic across town should a young person want to have herself/himself tested which discourages the YP and an opportunity lost.

57. Reports also indicate that capacity of staff to provide YFS are also severely strained. Most are not sufficiently trained to identify needs of young people or how to provide counseling. Nurses interviewed in Kiribati, the Solomon Islands and Tonga all expressed their need for more training on communication skills to tackle specific issues such as sexual abuse, young clients’ emotional, social and/or physical development issues even though some of them had undergone basic VCCT training.

58. The EC was informed during a country field visit that nursing staff in a designated youth friendly clinic refused to provide contraceptives, including condoms, to single young persons whether they are males or females. Her attitude was that condoms and contraceptives are for married individuals only and that the “client” should be above the age of 20 years. In one case, the nurse informed school authorities that a girl was pregnant instead of informing and counseling the girl herself first. This resulted with the young female student being expelled from her school due to her pregnancy. This incident, though isolated, shows that just being friendly does not make a service provider “youth friendly”.

59. Despite the above gloomy scenario, considerable progress was made in strengthening YFS in both government and NGO clinics during the period under review (2009 – 2011). The total number of centres and clinics supported by the AHD project and designated as youth friendly increased from 55 to 63 across all the countries by the end of 2010 exceeding the target set at a regional meeting. Tonga expanded and integrated YFS in both the AHD funded and AusAID “Response Fund” sponsored schools and TFHA clinics. Nurses from the government health services visit school clinics twice a week to treat and counsel students. A Regional YFS guideline and standards was developed

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18 The figure of 55 covers only what is reported by the AHD Coordinators as the numbers they were responsible for and not YFS clinics set up by other projects or in regular government or NGO clinics which are not part of the AHD project. Hence the total number of YFS clinics may be higher.
19 (no date) Note on “Exploring Youth Networks to Expand Youth Friendly Services” shared by SPC
by the AHD project. Youth Friendly Health Services (YFHS) Clinic Guidelines have been drafted by the MOHs in Fiji, Kiribati, Solomon Islands and Vanuatu with direct support from UNICEF (outside the AHD funding envelop). These guidelines were all pending official approval and rolling out by their respective governments at the time of submission of this Report.

D1.4 Findings by Project Output-4: Enhanced Number of facilities Programme Management and Delivery

OVIs: Strategic Plan developed;
Annual Workplans and budget developed;
Implementation plans developed;
Monitoring and Evaluation plans developed;
List of Research Activities.

60. Management & Institutional Arrangements: Without exception, all in-country AHD project activities are driven by the AHD Coordinators who also play a big role in the management and delivery of the project in their respective countries. All the AHD Coordinators have dual roles of coordinator and implementer. Analysis of the questionnaire returned by the AHD Coordinators revealed that experience as the AHD Coordinator ranged from nine months to five years with a mean of 2.58 years on the job. Most of them have nursing and/or teaching background. All of them have had some counseling training.

61. The AHD Strategic Plan had envisaged a programme management unit (PMU) to undertake regional implementation functions based in the SPC headquarters in Suva, Fiji. The regional team was initially funded by UNFPA and from 2011 SPC funded the salaries of the PMU as part of its contribution to the joint AHD Project. The Consultant was informed by the Director-General of SPC that due to financial constraints within SPC, the PMU’s services would no longer be available from end February 2012 and that the team would be disbanded. This has implications for the overall project management for the remaining months of 2012 as UNFPA will have to take up this responsibility.

62. Management issues were raised when SPC and the Solomon Islands Government received qualified audit reports from UNFPA in 2010 for funds disbursed through them. This resulted in UNFPA suspending funds channeled through SPC to the project countries as well as to the Solomon Islands directly. This delayed project activities across the board in 2011. UNFPA’s direct funding to the project countries in 2011 also caused other management issues with implementing partners as they have had to learn new ways of financial requisition and reporting that were previously different from the reporting formats submitted to SPC when funds were channeled through SPC.

63. In response to the questionnaire sent out to the AHD Coordinators, one of them had this to say, “Funding mechanisms must be streamlined so that funds arrive on time, and if they do arrive late, programmes are given adequate time to carry out their planned activities. Furthermore, the chain of command for reporting must be made clear. We encountered numerous challenges because staff from SPC and UNFPA regional offices and our local UN staff in-country had conflicting instructions or failed to communicate with one another. We would also benefit from more help and support from our Ministry of Health by participating in each other’s programmes and standardizing our data collection so that we can reach more clients and avoid duplication.”

64. Sustainability: With the exception of Fiji and the Solomon Islands that have government funded AHD Coordinators in their respective MOHs, all other implementing countries relied on the AHD project to fund salary of their National AHD Coordinators, and, in some countries a Project Assistant’s and/or a Project Nurse’s salary as well. All government and NGO counterparts expressed the need to have this critical human resource continue to be funded to ensure sustained management and delivery of project activities.

65. All the countries visited informed the EC that the MOHs viewed the AHD project as “SPC/UNFPA’s project” and activities were totally dependent on project funds including the related
staff salaries. Many of the MOHs followed the principle of “No funds, no activities”. It is also noted that the PMU at SPC cost twice as much as any of the PICs’ annual AHD activity costs including local staff costs. This is a concern for sustainability of the project as it indicate lack of ownership even though there are commitments to the issues of ASRH and STIs/HIV prevention and reduction of teen pregnancies by the project countries.

66. While a number of countries made the effort to integrate AHD project activities into their regular MOH activities, many of the MOHs felt that this added on the extra responsibility for planning and implementing AHD activities to the tasks of the regular RH departments’ staffs who were already over whelmed. This is more acute for NGOs that are normally dependent on external funding for their project existence.

67. Over the last four years, a number of countries had high turn-over of AHD project staff due to staff retirement, lack of funding for human resources and/or staff leaving for “better jobs” due to insecurity of job permanence. Samoa did not have an AHD Coordinator for the entire year of 2009. The Solomon Islands took about 18 months to replace the National AHD Coordinator who retired at the end of 2009. Funding to the Solomon Islands AHD project in 2011 was delayed due to audit qualification of the Solomon Islands Government, which channeled project funds from UNFPA to SIPPA that in turn impacted on service delivery. Unfortunately the government did not inform UNFPA about this lapse, as direct payment could have been made to SIPPA. The Consultant was informed that funds used by SIPPA to pay the staff during this period would be reimbursed by UNFPA in 2012.

68. A silver lining in the sustainability issue is that Fiji will continue to expand its stand-alone FLE curriculum while other PICs will also continue to develop and expand their FLE curriculum in the formats that they are now comfortable with.

69. **Leadership:** As the AHD project is a multi-agency joint initiative between UNFPA, UNICEF and SPC, it would seem to make sense to establish a joint project managing unit (PMU) housed in one of the agencies. SPC was entrusted to be the lead implementing/managing partner with administrative, implementing, M & E and reporting responsibilities at the regional level. However, many of the government and NGO partners found the arrangement quite cumbersome as they often had to report to SPC, UNFPA and UNICEF separately using different formats/forms and at different times. This was more confusing and difficult for countries that had bilateral programme/project agreements with UNICEF and UNFPA. They all preferred to deal directly with the UN agencies instead as they saw no value added to having a second layer between themselves and the major project funders (particularly UNFPA).

70. A number of participating countries also expressed burn out with SPC/UN driven technical assistance (TA) due to the TA often not taking into account the actual needs on the ground. A National Coordinator had this to say about TA provided, “When TA comes in the country they (should) make sure they cover all their topics without rushing to get back on the plane.”

71. Even though most countries had already integrated life skills and SRH education into their regular school subjects in their primary to secondary curricula for a number of years with TA received from other donors (e.g. NZAID, AusAID, etc) there was a perception that SPC advised countries to introduce stand-alone FLE course following the “Fiji model” curriculum to fulfill the project activity instead of contextualizing the concept of teaching family life skills/education to the country’s needs and resources despite the fact that this was not SPC’s stance. Countries felt that it would have been more useful to provide TA for improving content and presentation to students in an age-appropriate manner, strengthening in-service and pre-service teacher training, and, learning from international experiences rather than pushing for major structural changes to scrap existing curricula and introduce a new stand-alone FLE course.
E1 Data / Outcome Reporting in the Annual Reports:

72. A project’s activities can only contribute to the national and/or regional goals and outcomes. Besides, a project such as the one under evaluation, can only be implemented in a small scale, limited to a small geographic area in each PIC to test out theories and assumptions and its results presented to governments for scaling up, if successful. It is up to the individual country’s government to take it to scale.

73. In order to be able to evaluate a project’s impact, it is imperative to have an inception baseline data of the project sites and its end-line data to compare and measure results. In the case of the current project, while there are a number of research reports on various aspects of the project such as KAPB of MARYPs, FLE and YFS, these were all done at various times, before and during the project implementation and not specifically to collect project baseline/end-line data. Furthermore, the venues for the data collection for these studies were not the same as where the project activities were implemented and thus the target populations were not the same even though they were similar. At the most, data from such reports can only be used as control data. This makes it more important that a project end-line survey is needed from a similar population and sample size if a comparison is to be made to assess/evaluate the project’s impact. This has not been done for the project under evaluation. Outcome results of a project cannot and should not be generalized to the entire country or region as the national or regional outcome. They can only point towards trends when compared to other reports.

74. Given the above scenario that the project activities are limited to small pockets of urban areas in each of the PICs, the outcome reporting given in the Annual Reports would seem to be in error and questionable. The AR used the total national and/or regional youth population figure as the denominator when calculating outcome percentages instead of youth population of the activity catchment areas. For example, the 2010 AR stated that “The overall STI rates was 0.05% (<1%) (report from above five countries)20” when most research reports point to STIs as very high in these same countries. The figure was arrived at by using recorded STI cases from the 27 YFS clinics of the AHD project sites in the five countries as the numerator and the entire national youth population of these countries as the denominator. The flaw in this calculation is that it did not take into account the recorded STI cases from the numerous uncounted government, NGO and private clinics.

75. Another example is the statement that “Only 0.08% of the young people age 10-24 years old went to seek counseling services at the youth friendly services” (2010 AR, pg.26). If this is indeed the result of YFS efforts after two cycles of AHD activities and a precursor ARH project amounting to over a decade of programming, then it would seem to indicate that YFS clinics are a dismal failure. This contradicted the numerous anecdotal reports from the AHD Coordinators and Counselors.

76. An examination of the countries’ annual workplans (AWPs) revealed that each country AWP specified output indicators, baseline data and targets to be reached for each of the four key Outputs in the country. However, the Annual Reports (ARs) did not report on them. For example, Tonga’s 2010 AWP (Table 5 below) listed the targets to be achieved at year end but the 2010 Annual Report did not report whether these targets were achieved or not. This makes it difficult to track countries’ progress.

77. The ARs reviewed21 did not have the same reporting format over time hence data could not be compared to conclusively attribute results/impact due to the AHD project except in the few cases of process results related to the number of activities carried out. Further, the ARs did not report on AHD activities carried out outside of the project areas by government and other NGOs programmes.

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20 The five countries are Fiji, Federated State of Micronesia, Republic of Marshall Islands, Kiribati and Cook Island.
21 AHD Annual Reports for 2008, 2009 and 2010 were reviewed. The annual report for 2011 was not yet finalized by SPC and hence unavailable during the consultancy period from 9 January – 10 February 2012.
Table 5: TONGA 2010 Annual Work Plan (extract)

<table>
<thead>
<tr>
<th>Output indicator(s)</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proportion of Schools teaching GS-LS based Family Life Education (FLE), incorporating Behaviour Change Communications, BCC</td>
<td>2%</td>
<td>Proportion of Primary and Secondary Schools teaching FLE from 2% to 10%</td>
</tr>
<tr>
<td>2. Percentage of schools that provided life skills-based HIV education within the last academic year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Number of Teachers Trained in GS-LS based FLE  
   Baseline: 20  
   Target: Increased from 20 to 30 by the end of 2010

4. Number of Peer Educators trained and delivering GS-LS based PE to bring about behaviour change  
   Baseline: 35  
   Target: Increased from 35 to 40

5. a.) Number of HSP trained in BCC  
   Baseline: 10 Trained HSP  
   Target: 30 Trained HSP

   b.) Number of BCC trainings conducted  
   Baseline: 1 Training  
   Target: 2 Trainings

7. Number and Types of MARYP (vulnerable) Groups identified/reached  
   Baseline: 2 defined target groups of MARYP to be addressed in 2010  
   Target: Increased from 2 communities to 4 communities that are being reached/identified

8. Number of media articles/programs on ASRH and AHD initiatives.  
   Baseline: 20  
   Target: 30

9. Number of Training Tools & Resources developed for Life Skills Based Trainings  
   Baseline: 3  
   Target: 10

10. Number of Youth Drop in Clients at the Youth Drop-in Centres  
    Baseline: 200  
    Target: 300

E2 Discussion on methods for imparting SRH/FLE to young people

78. All AHD project countries in the region have elements of FLE/LS/SRH in their school curricula. Some follow the approach of integrating them into other subjects while others decided to have a stand-alone FLE course which is made compulsory (e.g. Fiji). The debate still continues as to which is the better approach/strategy to have students learn to protect themselves from STIs, STI, and unplanned pregnancies.

79. Countries in the Pacific have been experimenting with various forms of Family Life Education, Life-Skills Education and Sexual Reproductive Health education for more than two decades. With the exception of Fiji, some countries introduced SRH education as stand-alone extra-curricular subjects in schools in the past. This strategy has both positive and negative aspects. On the negative side, being “extra-curricular” it is left up to schools and students to opt in which many may not. Besides, many communities and teachers themselves feel that SRH education is too sensitive a subject for them to teach children in schools. Then those schools that opt to teach this extra-curricular subject find it difficult to continue offering it when teachers are reluctant to teach the subjects. There are usually no dedicated or trained teachers to teach the extra-curricular subject and so it is mostly left till the latter part of the academic calendar. But due to the pressure of having to cover the prescribed syllabus of regular academic subjects such as mathematics, science, language, etc. FLE is often left in the wayside. On the positive side, if the stand-alone SRH curriculum is made compulsory as in the case of Fiji, and a dedicated teacher is trained to teach the subject, students will get the benefit of SRH knowledge to help them in life when they graduate from schools. It would also be easier to train the few teachers who are dedicated to teach the SRH subject than to train many teachers who do not have SRH as the focus of their teaching curriculum.

80. There are also cases in a number of countries where curriculum developers have integrated LS and SRH topics into mainstream subjects in graded age-appropriate curricula from primary to secondary levels. This has the advantage that the “sensitive” subject of SRH is introduced progressively following the mental and physical development of students. Besides, students become captive learners as the mainstream subjects are compulsory. This approach has a better chance of success in educating students on their sexual and reproductive health beside other aspects of life-skills such as communication and negotiation skills.
81. The WHO, in a recent 2010 publication commented that, “Age-appropriateness explains why the same topics in sexuality education may need to be revisited at different ages; with advancing age they will be explored more comprehensively.” The same document commented that “sexuality education is provided as a stand-alone subject, but it is more commonly integrated into other subjects. Biology seems the most obvious one, but depending on the country, type of school and other conditions, it may also be provided under citizenship education, social orientation or social skills, health (promotion), philosophy, religion, language or sports.” It also recommended that, “A good approach for guaranteeing more holistic coverage is to bring different aspects under the responsibility of different teachers, thus making it a multidisciplinary subject.” The WHO publication further commented that, “It is important to note here that sexuality education is hardly ever an exam subject, although some elements of it might be, because they have been integrated into a mandatory subject like biology. However, in order for it to receive sufficient attention, it is important that it should be an exam subject.”

82. However, key to successful teaching of LS and SRH to young students are the attitudes and aptitudes of teachers themselves. Many teachers are inhibited and reluctant to teach SRH as they themselves were not exposed to the teaching of SRH during their school days. They need to overcome this difficulty first. This is being addressed through in-service training of experienced teachers and in some countries, included in the pre-service teacher training courses as a subject for future teachers.

E3 Youth Friendly Services

83. The concept of youth friendly services were introduced to most of the AHD project countries more than a decade ago and efforts have been in place to increase the number of YFS clinics. The 2006 Operational Research on utilization of ARH Services conducted in Vanuatu pointed out that “Young people appear to be well informed about how to improve current SRH services for them” but what was needed was to access SRH services. A 2007 FSM report pointed out that half of the adolescents (interviewed) suggested the best clinic hours for them were from 7-9 pm which was echoed by the YFS centers in Tonga and Fiji. These recommendations should have been taken into account in enhancing the YFS in every country during. A study done by SPC reported that most of the countries did not involve young people in creating and making the space available.

84. Discussions with government YFS clinic staffs in Kiribati, Solomon Islands and Tonga revealed that adolescents are generally hesitant to come to their clinics due to them being ashamed, shy or fearful of what people would think or say about them if they were seen visiting health clinics. They reported that particularly young girls/males felt a stronger sense of embarrassment, and hence a greater hesitancy, about using AHD services as compared to males. These clinics did not have good youth friendly places either even though a room may be designated for servicing the young people. The YP would need to pass other patients to go to the room.

85. As mentioned in an earlier section, just being friendly does not make a service provider “youth friendly”. When nursing staff in designated youth friendly clinics refuse to provide contraceptives, including condoms, to single young persons they are not being youth friendly. Irrespective of how many training workshops on YFS they attend, if their attitudes are that condoms and contraceptives are for married individuals only and that the “client” should be above the age of 20 years to receive such services, they don’t belong in a YFS clinic.

E4 Peer Educators or Health Educators?

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22 Standards for Sexuality Education in Europe (2010): WHO Regional Office for Europe
86. In the PICs, peer educators are placed in and carry out their activities in two major locations; from government and NGO clinics and schools/universities. School/university based peer educators are students who advocate with and discuss issues among their fellow students who are their peers. However, the clinic and NGO based peer educator’s role is a little more complex and often place them outside the circle of their peers. For example, in Fiji, Kiribati and Tonga, clinic and NGO based peer educators are often requested to accompany nurses and other paramedical teams on their schools and community outreach activities. While the medical staff tend to medical needs of the students and community members, the peer educators go about to raise awareness on the various health issues, including prevention of STIs/HIV, NCDs and family planning.

87. Audiences can be students in their classrooms, groups of youths and/or mix group of adults and youths in the community. The peer educator and students relationship is not peer-to-peer. Students and their teachers see them more as health educators. Teachers take the advantage of their presence to have them teach the sensitive subject of SRH due to their own reluctance to speak about the topic to the students themselves. The PEs rarely return to the same schools for follow up with the students. In the case of community interaction, the adult-PE interaction is also not peer-to-peer either. Due to cultural factors, many young peer educators would be reluctant to challenge some of the attitudes and biases of their adult folks. However, they may be more effective when they discuss with other youths who are in their same age groups and thus their peers. Even then, youth groups may still see them as outsiders and not really their peers as, for example, from the same football/rugby clubs or gangs and do not take the PEs’ information too seriously as they know that these PEs only come to their village/community once in a while.

88. In the above scenarios, given that the clinic/NGO based PEs function more as health educators, one wonders whether it may be better to re-designate and upgrade them as health educators which will raise their profiles among other young people and the community. It will also lend credibility to their advocacy and health education efforts when older adults acknowledge them as more knowledgeable then themselves on health issues. The decision to upgrade these PEs to health educators will have implication on their training and official status as they would have to undergo more rigorous training than what has thus far been provided to them.

F Lessons Learnt

89. A number of valuable lessons were learnt from the evaluation of the AHD Project 2008 – 2012 project. These should be taken into account for future programming benefiting young people.

- A planning document such as the SP should be complemented by a project document with clearly defined geographic and population coverage as well as clearly stated baseline indicators and desired level of results to be achieved at the end of the project cycle. It is difficult to evaluate and measure a project’s impact without purposive pre-project and end of project surveys as with this End of Project Evaluation;
- Comments received from peer educators indicate that communities are more open to receiving sensitive SRH messages when presented in an edutainment format such as through drama form and story-telling;
- Information received from the field visits are that young people are generally shy and reluctant to go to regular out-patients departments (OPDs) to consult doctors and nurses about their sexual problems. Though there are no published data to confirm this, the EC was informed by many of the YFS staff that clinics that have extended hours beyond the normal working hours attracted more young people to access counseling and treatment;
- Staff of the Suva, Fiji drop-in center “Our Place” commented that when the clinic had its full complement of staffs in place and clinic hours were extended to 7:00 pm, it attracted many young people to avail of SRH services. It has a relaxed and informal ambient that young people feel comfortable to go into without feeling that they are going to a hospital or medical clinic. Instead, it feels more like a club house and gathering place for YP. The physical
structure could be a model that other YFS clinics can follow instead of designating a small room in a crowded OPD as a YFS place in many of the clinics that the EC visited;

• Communications and agreements with all partners, both government and NGOs, at the inception phase of a project is very important to avoid any misunderstanding as to the intent and purpose of the project including eventual absorption of any project staff and equipment into the regular GO/NGO programme;

• A risk assessment and an exit plan or strategy should be part of the project formulation for eventual ending of the project;

G Conclusions and Recommendations

G1 Conclusions

90. The project was missing a critical multi-year action plan that the 10 PICs could follow on a yearly basis as a planning document is different from a project document much like a Country Programme Document (CPD) compared to a Country Programme Action Plan (CPAP). The SP promised: “to address the wide range of young people’s issues the AHD Programme will cross boundaries between sectors and encourage new partnerships.” (see Annex 2). The project could have been enhanced with the inclusion of livelihood activities as an entry point for SRH, STIs/HIV information and education for out-of-school young people. This would have also addressed the question of expanding partnership and linkages with other partners to address the wider youth development issues beyond sexual and reproductive health. However, the Project failed to accomplish this.

91. Overall, the activities linked to Outputs 1, 2 and 3 on policy advocacy, enhancing FLE/SRH education and strengthening the YFS in clinics were consistent with UNFPA’s global and PSRO’s priorities and the national RH policies, strategies and priorities of the Pacific island countries. The project was able to achieve its advocacy goal by getting most PICs’ health policies and strategies to include ASRH issues.

92. However, it is one thing to have written policies but another to translate them into actions matched by national budget commitments and services to young people. The latter includes extending clinic hours and expanding staffing and/or equipping facilities to accommodate the needs of young people. These have been found wanting.

93. Progress was slow in most countries to integrate SRH, STIs/HIV prevention and life-skills into their regular school curriculum. Fiji is the only country piloting a stand-alone FLE curriculum. Gender-sensitive programming was conspicuously absent while some data provided were disaggregated by the sexes.

94. “Peer Educators” who are clinic based (as in Fiji) as well as some of those are placed within implementing MOH and NGO partners in other countries function more as lowly paid health educators since they are not paid a salary but incentives only. Their duties are to impart SRH information and education including HIV and AIDS to teenage school children when they visit schools and to the community at large during outreach sessions whether they are older or younger than themselves. The EC concluded these PEs do not really work in their own peer environment as a peer is one who is approximately in the same age group, education level or occupation. These PEs contrast with the University of the South Pacific (USP) student PEs who operate among the student community and are thus true peers.

95. Funding available for implementation of the project fell short of the planned figures of $6,037,000 by 56 percent to $2,660,953 for three years (2009-2011). Over 42 percent of total financial resources expended were spent on Output 4 over the same years to “Strengthen Programme Management and Delivery” with the bulk going to the Programme Management Unit (PMU) located within SPC and a number of staff positions at regional level. This was an excessive imbalance in the
use of total financial resources whereas more financial and human resources were needed in the field for activities to reach intended target populations particularly those linked to Output 2 and Output 3.

96. It was not possible to measure impact directly attributable to project activities as requested in the TOR due to lack of project sites’ baseline and end-line data. One of the questions posed in the Evaluation Methodology Framework of the TOR was, “Has teenage pregnancies declined as a result of AHD activities?” The EC could not find any documented evidence that teenage pregnancies have declined as a direct result of the AHD activities either from the Annual Reports reviewed or from interviews with implementers and stakeholders in the field.

97. With the exception of Fiji and the Solomon Islands appointing regular government staff as AHD Coordinators, all other implementing countries depended 100 percent on AHD Project funding to pay salaries of the staffs involved in the activities as well as for the activities themselves. In cases where regular MOH funds were provided for AHD activities, they were minimal and such activities were isolated from mainstream MOH programmes. There is a strong concern that most of the AHD project activities will cease at the end of the project cycle without continued external financial support as there were no firm commitments to continue the project when funds dry up.

98. Adding to the sustainability issue mentioned above, the EC was informed by the Director-General of SPC that due to financial constraints within SPC, the PMU services would no longer be available from end February, 2012 and that the team would be disbanded. This has implications for the overall AHD project management which will now fall on UNFPA as the major funder of the project.

G2 Recommendations

99. Based on the findings, the following are some recommendations for improving programmes for young people. These are not necessary in order of priority:

**Sustainability**

- To ensure sustainability and ownership, there is an urgent need to revisit the MOUs with a number of governments concerning the AHD project (or similar projects) as they (governments) see such projects as not part and parcel of their regular health programmes but as extra-budgetary, donor-funded stand-alone activities. It should be made clear to governments from the very beginning that such project activities are of a limited duration to complement their regular national programmes and/or that they are experimental to test out theories and strategies without risks to government budgets. That the governments should build in a strategy to absorb and sustain the project staff and activities and even to scale them up nationally when it is proven that the project activities are beneficial to the target populations. A risk analysis should be done before launching a project;
- It is recommended that immediate negotiations be initiated with governments to take over the projects at the end of the project cycle;

**Management**

- In small countries that have limited resources, it is better to work with all stakeholders and agencies together so as to complement each other’s activities rather than duplicate them – targeting the same group with similar/same activities at different times during the year;
- Instead of increasing the number of YFS clinics, it is recommended that the existing clinics be made truly youth friendly by improving their existing infrastructures, equipping them and to extend their operating hours to attract young people. Youths of the community should be involved to help make spaces designated for youth centers and YFS clinics truly youth friendly;
- Based on the experience in the implementation of the AHD Project, it is recommended that UNFPA should reconsider using the joint programming approach in similar future projects;
M & E

- In order to be able to measure impact at the end of a project, it is imperative to establish project baseline data and set target milestones during inception of the project. End of project surveys should be done to collect end-line data for comparison and measurement of achievements. National indicators and data should not and cannot be used as the project’s baseline unless the project is national in scope, which in most cases are not. Quality reviews and M&E should be built in to ensure that projects do not go off-track;
- Annual Reports should report on the annual targets set in the AWPs to measure annual output achievements. Before finalizing a multi-country AR, it would be useful to share the draft with project countries for information quality checks related to their country implementation;
- There is a need to review and evaluate the concept and application of “Peer Educators” placed in the health clinics and NGOs. UNFPA could consider recommending to the MOHs to retrain and upgrade some of these PEs to Community Health Educators;
- Similarly, schools and universities should evaluate their peer education programmes to measure their impacts against measurable indicators such as reduction of STIs and pregnancies among the student communities where such PE programmes have been taking place for some time;

Opportunities for UNFPA

- As an entry point to providing SRH/FLE information and education to unemployed young people in the PICs as well as meeting the economic and social development issue of the region, UNFPA should consider introducing livelihood-skills training and micro-financing to attract them to youth centres; and,
- UNFPA does not have the full complement of human resources to implement and monitor country level projects as well as to help build capacity in countries where there is no UNFPA presence. To overcome this, it is recommended that UNFPA explore with bilateral agencies that sponsor placing of volunteers at their own costs with future similar projects. Such agencies include the Australian Volunteers International (AVI), Volunteer Service New Zealand (VSA) and Volunteer Service Overseas (VSO) of UK who pay for their own volunteers.
PROJECT EVALUATION TERMS OF REFERENCE
“ADOLESCENT HEALTH AND DEVELOPMENT IN THE PACIFIC”

1. Project Rationale and Background

The World population has reached the 7 billion mark. According to population projections by the Secretariat of the Pacific Community (SPC) the total Pacific island country (PICs) population has reached 10 million in June 2011. Of this 10 million, young people under the age of 24 accounts for an estimated 56% of most of the PICs population and about 20% are youth and between the ages of 15-24 years. Youth unemployment continues to be a major concern and challenge for the Pacific region. Of the 10 million PICs population, it is also estimated that 23% of the potential youth labour force are unemployed.

The 2011 Pacific Regional MDG Tracking Report highlighted that for those countries that tend to have high adolescent birth rate (ABR) they also recorded high maternal mortality ratio (MMR) because of the strong relationship between high teen age pregnancies and increased maternal complications highlighting the increased risks of child bearing among adolescent women within the 15-19 years age group. For instance, the Republic of the Marshall Islands (RMI), the ABR was approximately estimated at 150% while MMR was recorded at almost 300 per 100,000 live births, whilst in Kiribati the ABR was recorded at 60% and MMR was estimated at 200 per 100,000 live births and in Tonga the ABR was estimated at 20% with a recorded MMR of 80 per 100,000 live births. Thus, one could conclude that the high MMR is also contributed largely by the high adolescent birth rates as a consequence of increased pregnancy complications and higher risk to the health of adolescent mothers.

The increase in Pacific population to 10 million of which youths comprise 20% will put significant pressures on natural resources, land, food security, government goods and services (health, education, housing, water supply, electricity, telecommunications) and its fragile pristine environment. This underlines the greater need to addressing youth issues and their needs.

Importantly, results from demographic health surveys (DHS) reveal that some youths in the Pacific have multiple sex partners, practice pre-marital and unprotected sex and some have reported that they had sex.

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1 SPC – Pacific Island population projections data sheet, June 2011
2 Young people – defined as between the age range 10-24 years
3 “Regional Youth Initiatives with a focus on youth unemployment”, A Joint Paper by SPC and the Pacific Islands Forum Secretariat tabled at the Pacific Plan Action Committee meeting, 16-17 August, 2011.
4 Youth: the UN General Assembly defines “youth” as those persons between 15 and 24 years. The definition was adopted during the International Year of the Youth in 1985 and is the one generally used by UN agencies and other partners. However, it is important to note that respective national governments would have its own definitions and age threshold for adolescents, young people and youth.
5 2011 Pacific Regional MDG Tracking Report, Pacific Islands Forum Secretariat, Page 53, Figure 11.
6 Adolescents are defined as between the age group 10-19 years. These overlapping age groups (young people 10-24 years and adolescents 10-19 years) are combined in the age group of young people 15-24 years.
7 Adolescent birth rate – measures the annual number of births to women 15-19 years age per 1,000 women in that age group. It represents the risk of child bearing among adolescent women 15-19 years of age.
under the influence of alcohol and consequently are extremely vulnerable to HIV/AIDS, increased STI transmission and teen age pregnancies. On the other hand, youths can become a major resource for the PICs in terms of promoting and advocating for the sustained and sustainable national development and increased productivity. Their skills must be harnessed properly for them to contribute meaningfully in nation building, sustained economic growth and increased productivity. Without harnessing their skills and addressing their holistic development issues and needs, problems such as early marriage, teen age pregnancy, HIV and STIs, and youth unemployment are bound to increase. Young people or youths have special needs in terms of health, sexual and reproductive health and education.

UNFPA with the support of SPC established the adolescent reproductive health (ARH) project in 2001 to address amongst other things the reproductive health needs of young people. The project was implemented in nine (9) countries. The project resulted in increased government and community support for the implementation of ARH activities, expanded ARH awareness, information and education among adolescents and explored innovative approaches to provide accessible ARH services.

At the same time, UNICEF on the other hand also supported the Pacific Stars Life Skills (PSLS) project to address the holistic education of young people to address various social and health issues facing young people. As the two agencies progressed in their implementation of the ARH and PSLS initiatives and increased awareness and receptiveness of communities on ARH and PSLS issues and activities had been generated, there was greater recognition of the need to consolidate efforts and determine the collective and collaborative synergies amongst UNICEF and UNFPA, the funding agencies and SPC being the implementing agency to bring about improved results, expand project coverage, avoid overlaps and duplication of efforts and resources and ensure sustainability of the project. Hence there was great recognition and push by the agencies for a joint programming to support the project.

Additionally, the project evaluation of the PSLS project in 2004 by UNICEF recommended the need to review the Life Skills training component and integrate this with the UNFPA/SPC supported adolescent reproductive health project.

**AHD Project 1st Phase**

Therefore, to support a more integrated and holistic development of young people and strengthen project effectiveness, the UNFPA component of Adolescent Reproductive Health (ARH) and was merged with the UNICEF component of life skills education in 2005 and was renamed Adolescent Health and Development (AHD). This joint initiative recognized the broader approach to adolescent needs and the more comprehensive approach to address the wider issues of adolescent health and development. This was considered a flagship joint programme between UNICEF, UNFPA and SPC as implementing partner to address the sexual and reproductive health (SRH) of young people in the Pacific within the context of health, education and development. The AHD project initially had four strategies or outputs: (1) Strengthening adolescent health information and education through the formal AHD educational programme and non-formal educational approach (2) Strengthening the life skills approach; (3) Expanding youth-friendly services; and (4) Strengthening project management and delivery.

The first phase of the joint AHD project was implemented over three year duration, 2005-2007. It was implemented by a regional team based at the regional office of the Secretariat of the Pacific Community (SPC) in Nabua, Suva and working in close collaboration with UNFPA and UNICEF. Initially, the project was implemented in ten (10) countries: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Republic of the Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.
The aims of the joint AHD project was to promote the health and development of Pacific youth by providing information, education, life skills training and services to meet adolescent developmental needs. It emphasized responsible behaviour and practices to prevent teenage pregnancy, sexually transmitted infections including HIV/AIDS as well as other related youth health issues.

In 2007, the Project Advisory Committee (PAC) recognized the need to review the project to determine amongst others the following:

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

The recommendations of that review facilitated the development of the 2\textsuperscript{nd} Phase of the AHD project in the next programme cycle (2008-2012) to better reposition AHD in the context of reproductive health and to provide a more strategic focus of the key elements of the AHD to enhance synergies and collective strengths of the agencies and stakeholder to bring about greater results and impact at community level.

\textbf{AHD Project – 2\textsuperscript{nd} Phase}

Based on the recommendations of the 2007 AHD review, the AHD project was further strengthened with the development of a Strategic Development Plan outlining key components and outputs, a management structure within the regional office at SPC, Suva, a new Project Management Committee (PMC) for oversight and accountability, AHD Coordinators based in the 10 countries with the collective responsibility for implementation of the project during the 2008-2012 programming cycle. Although it was recognized that the project will reach all young people, the title Adolescent Health and Development was retained for continuity. Furthermore, the strategic plan also highlighted the need to strengthen monitoring and evaluation with the development of an M&E and results framework\textsuperscript{9}, outlining the goals of the project, outcome and outputs and relevant indicators at the various levels.

\textbf{Project Components}

The strengthened AHD project had the four (4) key components or outputs:

- Output 1: Enhanced Supportive Policy Environment and Enabling Community Environment;
- Output 2: Strengthened SRH Information and Education for Young People;
- Output 3: Strengthened Youth Friendly Services
- Output 4: Enhanced Programme Management and Delivery

\textbf{Funding and Budget}

The funding for the AHD project for the 2008-2012 programming cycle is outlined in the table below:

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
\hline
UNFPA & 750,000 & 750,000 & 612,800 & 413,398 \\
UNICEF & 250,000 & 50,000 & 50,000 & 50,000 \\
SPC & 250,000 & 250,000 & 50,000 & 195,470 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{9} AHD Results Frameworks is attached as Annex 1
The funding allocated to key Outputs is also outlined in the table below during the project period:

<table>
<thead>
<tr>
<th>Project Funding (US$)</th>
<th>Outputs</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Budget</td>
<td>Budget</td>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Output 1 – Policy &amp; Advocacy</td>
<td>242,050</td>
<td>271,150</td>
<td>72,760</td>
<td>70,748</td>
<td></td>
</tr>
<tr>
<td>Output 2 – Strengthened information for young people - FLE</td>
<td>181,000</td>
<td>241,150</td>
<td>80,284</td>
<td>96,609</td>
<td></td>
</tr>
<tr>
<td>Output 3 – Improved Youth Friendly Services</td>
<td>208,500</td>
<td>148,550</td>
<td>135,809</td>
<td>10,990</td>
<td></td>
</tr>
<tr>
<td>Output 4 – Programme Management &amp; M&amp;E</td>
<td>447,035</td>
<td>342,300</td>
<td>443,947</td>
<td>213,774</td>
<td></td>
</tr>
<tr>
<td><strong>Total (B)</strong></td>
<td><strong>1,078,585</strong></td>
<td><strong>1,003,150</strong></td>
<td><strong>732,800</strong></td>
<td><strong>392,121</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Results Matrix and M&E Framework**

The results matrix/logframe upon which the project was to be monitored and evaluated is attached as Annex 1 to this TOR.

2. **Purpose/Objective of the Evaluation**

The purpose of the evaluation is to assess the impacts and results achieved in the implementation of the AHD project in line with the goal, outcome and outputs of the project as outlined in the results and M&E framework of the project and document lessons learnt and best practices and strengths and weaknesses of the project in order to inform how best to reposition and integrate AHD and SRH needs of young people (including adolescents) in the development of the next MCPD.

In the assessment of impacts and results achieved, the evaluation will closely examine the following evaluation criteria: relevance, effectiveness, efficiency, impact, sustainability and leadership and management and institutional arrangements.

Secondly, related to the above, the evaluation should also assess the modalities of partnering with countries and/or regional organizations. It should consider the total pool of donors that contribute to AHD programming in country, and make recommendations in this regard.

Thirdly, determine the integration of AHD/SRH in national health and youth policies and strategies and national development plan policies and strategies. Identify emerging good practices, suggest methodology and some minimum standards for programming in this area.

Lastly, identify UNFPA’s comparative advantage in relation to AHD and SRH integration and management in partnership with governments, other UN agencies and regional organizations such as SPC, US Government Compact Programming, Global Fund and/or NGOs for maximum results at the country level.

3. **Scope and Focus of the Evaluation**

*Differences in Total (B) from Total (A) could be attributed to reporting and acquittal issues and can be best explained by SPC. It is important to note however that SPC programme management budget - Output 4 was around 40% in 2008, 34% (2009), 60% (2010) and 54% (2011) of the total funds/budget provided by agencies over the period 2008-2011 respectively.*
The evaluation will cover the 2nd Phase of Project (2008-2012) while not neglecting the lessons learned from the first phase. This will involve extensive consultations and discussions with stakeholders (UNICEF, SPC, UNFPA, AHD Coordinators, RH Coordinators in MoH and staff of MoE) and beneficiaries of the project in the 10 countries. It is not possible to travel to the 10 countries for consultations and discussions. However, priority and focus will be given to 11 countries; Tonga, Solomon Islands and Kiribati. For the remaining 7 countries, consultations will be undertaken through a quick online survey using survey monkey.

The evaluation will assess the achievement of results (outputs, outcomes) and impact of the AHD project at regional and national levels. The evaluation will also review the extent to which policy and enabling environment in countries and partner agencies, programming direction, partnerships and alliances and advocacy has been strengthened through the project.

Furthermore, in view of policy and programming direction, the evaluation will examine overall programme performance through review of respective management structure (programme staff structure & programme management committee and country staff), the programme implementation modality, funding for the programme and in particular for the delivery of outputs.

The evaluation will also consider the repositioning and upscaling of ASRH services and its integration and implementation and the appropriate modality of funding and partnerships with countries, regional organizations and other UN agencies and future sustainability of the project, in cognisance of the strategic focus of the revised UNFPA Strategic Plan 2012-2013 Outcome 6 on “Improved access to SRH services and sexuality education for young people (including adolescents)” and the need to strengthen programming for essential sexual and reproductive health services to marginalize adolescents and young people and strengthen national capacity for the design and implementation of comprehensive age-appropriate sexuality education in policies and curricula.

Lastly, the evaluation should at least attempt to identify crucial emerging issues for young people (including adolescents) in view of the global population of the 7 billion people and PICs population of 10 million people, the share of youth population in PICs population and its implications for SRH services, household resource planning and management, sustainable livelihoods and poverty reduction and provide some options on how UN agencies and regional organizations can collaborate together through joint initiatives and programmes to address these challenges.

3.1 Relevance

11 The three countries: Solomon Islands, Tonga and Kiribati have been chosen to represent the three sub-regional groupings of Melanesia, Polynesia and Micronesia, the three countries have large AHD programmes and activities in-country and AHD is priority in the three countries. Solomon Islands is representative of the Melanesian sub-region, Tonga is representative of the Polynesian sub-region and Kiribati is representative of the Micronesian sub-region. Travel and flight connectivity to islands in the Northern Pacific which falls under the Micronesian sub-region such as the Republic of the Marshall Islands, Federated States of Micronesia and Palau has limited the choice to only Kiribati because it is easier to reach given flight connectivity and schedules.

12 Currently, the implementation modality of the AHD project is through the AHD Unit of the Secretariat of the Pacific Community (SPC) as executing agency. UNFPA PSRO and its partner UNICEF provide funds to the AHD Unit at SPC and it implements the AHD programme on behalf of the partners. Additionally, they also have AHD Coordinators in-country who work closely with the AHD unit at SPC in the implementation of the programme.

13 The assessment of relevance examines the degree to which the outputs/outcomes of the project are in line with national priorities and needs, UNFPA PSRO CP priorities and relevant to stakeholders. It considers whether the strategies and interventions are relevant for the environment under which UNFPA PSRO operates.
The evaluation will examine the extent to which the AHD project and interventions are suited and consistent with national policies, priorities and needs of the 3 countries, given population dynamics, needs and issues for young people:

(i) the extent to which the project design was in line with national needs and priorities?

3.2 Effectiveness

Assess the extent to which the activities contributed to achievement of project outputs and in turn project outputs contributed to the achievement of project outcome “improved knowledge, attitudes, practices (KAP) and behavior regarding sexual and reproductive health”;

(i) the extent to which the project outputs and outcomes targets were achieved;
(ii) highlight the major factors that influenced the achievement or non-achievement of the outputs, outcomes of the project;
(iii) did the current implementation modality contributed to the effectiveness in achieving the outputs, outcomes and overall project objective;
(iv) did the project contribute to enhancing supportive policy environment and enabling community environment including advocacy, social mobilization and youth participation have contributed to the effectiveness in achieving project outcomes and overall objective;
(v) did the project contribute to enhancing SRH information and education, including sexuality education, peer education and behavior change communication such as multi-channel media campaigns and edutainment have contributed to the effectiveness in achieving project outcomes and overall project objectives;
(vi) did the project contribute to strengthening youth friendly services including capacity building and standardization of services have contributed to the effectiveness in achieving project outcomes and overall objectives;
(vii) did the project contribute to supporting the integration of ASRH in youth policies, RH policies and AHD/SRH in national health policies and national strategic development plans;
(viii) Was there any change over time in rates of teen pregnancy where the project was implemented? If there was a reduction in teen pregnancy, can the causal pathways be tested?

3.3 Efficiency

In the implementation of the project, assess how efficient the inputs and resources were utilized to produce the results or outputs in respect of the following:

(i) the extent to which the country project has utilized the skills and expertise of UNICEF, UNFPA and SPC staff/human resources?

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14 The assessment of effectiveness considers or examines the extent to which the AHD project has achieved its planned results, including outputs and outcomes and the extent to which the achievement of outputs and outcomes were as a consequence of UNFPA PSRO’s, UNICEF and SPC collaborative assistance and support other than other interventions and factors.

15 Where ever possible in the KAP, the evaluation should test whether female and male beneficiaries had equal opportunities in accessing AHD & YFA services.

16 The assessment of efficiency considers or examines how economically optimal inputs of the project (financial, human, technical and material resources) have been used to produce outputs. The assessment of efficiency attempts link outputs to resources expended and assesses whether this happened as economically and as feasible as possible and the extent to which the quantity and quality of the results justify the quantity and quality of the means used for achieving them and whether they were achieved on time.
(ii) Is the staffing setup of the UNFPA AHD project, SPC AHD Regional Office and AHD Coordinators appropriate for the effective and efficient implementation of the project?

(iii) What measures were taken during planning and implementation phase to ensure that resources were utilized efficiently?

### 3.4 Impact

In the evaluation of the project impact, the assessment should determine the positive and negative changes produced by the intervention directly or indirectly, intended or unintended. Assess the extent to which the project and activities have made a real difference to the beneficiaries:

(i) Did the activities of the project and interventions by partners (UNICEF, UNFPA & SPC) contribute to the following achievements, and how (test causality chain assumptions):
   a. Reduction in teenage pregnancies;
   b. Reduction in STI prevalence rate among young people;
   c. Reduction in HIV prevalence rate among young people;
   d. Increased CPR among young people;
   e. Reduction in unprotected sexual practices through increased use of contraceptives and condoms;
   f. Reduction in the number of young people who have concurrent sex partners and multiple partners;
   g. Increased young people accessing and utilizing SRH services; and
   h. Increased young people visiting and utilizing clinical services provided by Youth Friendly Service Centres;

(ii) Did the activities of the project and interventions by partners (UNICEF, UNFPA, SPC) contributed to increased awareness and policy uptake of governments through the following:
   a. Number of youth friendly service centres established in countries;
   b. Increased budgetary allocation for SRH services for young people;
   c. Increased policy and strategy on young people published by governments;
   d. Integration of SRH policies and strategies on young people in national health policies and strategies and national strategic development plans;
   e. Inclusion of family life education (FLE) and sex education in school curriculums;
   f. Increased number of schools offering FLE;
   g. Increased number of teachers trained to teach FLE;
   h. Increased number of schools offering counseling services
   i. Increased number of certified teacher counselors;
   j. Number of peer education programmes introduced in schools.

(iii) The extent to which UNFPA PSRO’s, UNICEF and SPC’s interventions through the project have contributed to capacity development and strengthening AHD coordinators, peer educators and youth friendly service centres in countries.

### 3.5 Sustainability

Assessment of the impact of the project considers the longer term and ultimate results attributable to the AHD project or interventions that were being implemented. It considers the positive and negative long term effects, which may be economic, socio-cultural, institutional, technological and environmental or other effects. What has happened or is likely to happen as a consequence of UNFPA PSRO’s, UNICEF and SPCs assistance and support.

Sustainability considers the likelihood of the continuation of the stream of benefits produced by the project following the ending of the external assistance. It is concerned with measuring whether the benefits of the intervention are likely to continue...
In the evaluation and assessment of the sustainability of the project, determine the following:

(i) the extent to which the positive impacts of the project and interventions justify continued investments by the partners;
(ii) the extent to which partners and stakeholders have financial capacity to maintain and sustain the benefits from the interventions when UNFPA PSRO’s, UNICEF’s and SPC’s support for the project ceases;
(iii) the extent to which Ministries of Health and Education have institutionalized strategies and activities of the project in their policies/procedures/corporate plans and organizational budgets?

3.6 Leadership, Management and Institutional Arrangements

In the evaluation of the project, determine the following in consultations with all stakeholders:

**UNFPA PSRO**

(i) did the project contribute to leadership and support provided by UNFPA PSRO in terms of technical advise and directions, funding and disbursements and reporting and feedback to SPC and other stakeholder partners that contributed to the success or otherwise of the project and results achieved. Were the SPC and country AHD Coordinators and partners satisfied on the level of leadership, technical advice and support provided by UNFPA PSRO? If not why?
(ii) Identify/define some of the areas UNFPA PSRO could do better or address to improve overall project implementation;

**SPC**

(i) did SPC provided the expected administrative and management expertise and services required as project implementing agency throughout the entire process? The extent to which SPC has provided the expected UN/SPC technical expertise (especially related to sexual reproductive health and the needs of young people) during project implementation, by accessing the available UN/SPC TA in and out of the region, particularly when developing training strategies, and conducting training. Was it relevant and of acceptable quality that contributed to the attainment of results or otherwise of the project?
(ii) what were the most effective mechanisms to support coordination and what could have been strengthened? Was there equal input and contribution across the partner agencies?
(iii) the extent to which SPC has continued to develop local/regional partnerships with other agencies/NGOs working in relevant areas (such as AHD/SRH, FLE) and used these partnerships during implementation;

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after the assistance and support from UNFPA PSRO, UNICEF and SPC has ceased. What has happened (or is likely to happen) to the positive effects of UNFPA’s intervention after its support or involvement has ended or will come to end? It considers how durable has been the support to stakeholders and beneficiaries in building internal systems and processes, structures, training, building capacity and transferring knowledge, expertise and information about reproductive health, sexual reproductive health, family life education programme, peer education programme, and school based counseling and youth friendly services centres.

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19 Leadership, management and institutional arrangements considers the governance structure of the project, the leadership and management of the project by SPC, UNICEF and UNFPA in terms of technical advice, coordination, consultations, reporting, support and backstopping, funding modality and arrangements, and reporting in respect of the project and how it has contributed to the relevance, effectiveness, efficiency, impact and sustainability of the project.
(iv) the extent to which SPC has developed capacity with AHD coordinators and Peer Educators in monitoring and evaluation, surveys and data collection in the ten countries;
(v) the extent to which SPC has prudently and effectively managed financial resources provided to it by UNFPA PSRO and UNICEF in implementing activities and ensuring the achievement of results and providing regular acquittals and reporting of funds to UNFPA PSRO;

4. **Stakeholder Participation**

The success of the evaluation hinges on a full stakeholder consultation and participatory evaluation that provides meaningful participation of all project partners, beneficiaries of the project and other interested parties. Stakeholder participation forms a critical component of the evaluation design and planning, information collections, the documentation of findings and development of the evaluation report and dissemination of evaluation results through a participatory approach. A stakeholder consultation and participation list is attached as Annex 2.

Additionally, stakeholder participation is also strengthened through participation of partners/stakeholders in the Evaluation Management Committee (EMC). The TOR of the evaluation has been shared with SPC and AHD Coordinators. Their comments have been incorporated in the final TOR.

5. **Evaluation Methodology**

The evaluation will adopt the following methodologies and will be undertaken in conformity with UNFPA evaluation guidelines and the norms and standards of the UN Evaluation Group:

(i) Desk review of project documents, AHD project quarterly reports and donor reports, past review/evaluation reports, training/advocacy/BCC materials for SRH, IEC materials and brochures, workshop reports and other related literature on AHD/SRH in the Pacific; evaluation reports and related literature on Men as Partners in Reproductive Health;

(ii) Interviews with partners and stakeholders listed in the stakeholder consultation and participation list; and,

(iii) Focus group discussions with project stakeholders and beneficiaries to determine implementation of activities and possible results of these activities as per the project outcome and output indicators.

In accordance with UNEG’s Standards for Evaluation in the UN System evaluation quality standards, the Consultant/Evaluator should also discuss how it would control bias and/or acknowledge limitations due to uncontrolled bias, in the absence of control groups or counterfactuals.

The evaluation will undertake triangulation and consolidation of the data obtained from the methodological processes outlined in the evaluation methodology framework. It will also align objectives or outputs of the project and evaluation to the specific questions, performance indicators, data sources and data collection requirements to facilitate the evaluation proper.

The evaluation methodology framework which is attached as Annex 3 and is just a guide that the evaluator should consider and strengthen/develop it based on the understanding of the project and what is being evaluated and submit a revised and strengthened evaluation methodology framework as part of the inception report.

The Evaluation team will review and be conversant with the following reference works provided by the PSRO (i) UNFPA Evaluation Guidelines; UNEG ethical guidelines for Evaluation; UNEG Standards for Evaluation in the UN System; and 2 DOS EQA forms (Annex 7).
6. **Ethics**

The evaluation of the project will be conducted ethically, legally and with due regard for the welfare of those involved in the evaluation, especially women, children and members of other vulnerable or disadvantaged groups and in accordance with the UNEG’s Ethical guidelines for Evaluation. Due consideration will also be given to beneficiaries and other stakeholders on confidentiality of information and privacy during consultations and personal interviews.

7. **Documentation**

The documents that will be made available to the Consultant/Evaluator to facilitate the evaluation is attached as Annex 4.

8. **Evaluation Management – Roles and Responsibilities**

The evaluation will be managed by an Evaluation Management Committee (EMC) comprising of the following staff:

(i) Jone Navakamocea – Planning, Monitoring and Evaluation Programme Coordinator
(ii) Dr Annette Robertson – Deputy Rep and Deputy Director, UNFPA PSRO;
(iii) Dr Wame Baravilala – Technical Adviser, Reproductive Health;
(iv) Ms Virisila Raitamata – Assistant Representative, Programmes
(v) Dr Adriu Nadaua – Programme Analyst and Youth/AHD Focal Point
(vi) Dr George Malefoasi – AHD Adviser, Secretariat of the Pacific Community; and,
(vii) Dr Annefrida Kisesa Mikusa – Chief HIV and AIDS, UNICEF

The EMC will be responsible for the following roles:

(i) provide overall technical guidance and quality assurance on every process of the evaluation;
(ii) review and endorse the terms of reference of the evaluation;
(iii) recommend the TOR to the UNFPA PSRO Representative and Director for approval before submission to APRO and DOS for review and approval and in accordance with UNFPA evaluation guidelines;
(iv) selection and initial endorsement of the consultant;
(v) review and approve inception; and
(vi) review and approve evaluation reports.

The project focal point or project manager will be responsible for the following:

(i) coordination and setting up of meetings schedules with beneficiaries and all stakeholders in consultation with SPC;
(ii) facilitate the Consultant or evaluation team’s access to all background documents;
(iii) make travel arrangements and in-country consultations with project beneficiaries and partners; and
(iv) allocation of an office space to the Consultant/evaluator for work and review.

The PM&E Programme Coordinator shall be the Evaluation Manager and will responsible for the following:

(i) overall coordination of the evaluation roles and responsibilities with the Consultant/Evaluator;
(ii) facilitate the Consultant’s/Evaluator’s access to background documents;
(iii) coordinate UNFPA PSRO’s internal review processes; and
(iv) coordinate with UNFPA PSRO’s management approval of all evaluation deliverables.

The Deputy Representative and Deputy Director, UNFPA PSRO shall be responsible for overall quality assurance of the evaluation in accordance with UNFPA and DOS Evaluation guidelines.
9. **Deliverables**

*Inception Report*

Within 6 days of the award of contract, the Evaluator shall submit an electronic copy of a draft inception report to UNFPA PSRO’s evaluation manager. The inception report provides an opportunity for UNFPA PSRO and the Consultant/Evaluator to ensure that their interpretations of the TOR are mutually consistent. The Evaluation Manager will coordinate the internal review and approval of the inception report from the Evaluation Management Committee and the UNFPA Representative which will serve as an agreement between UNFPA PSRO and the Consultant/Evaluator how the evaluation shall be conducted. This inception report shall:

- Explain the evaluator’s understanding of what is being evaluated and why;
- Describe the strategy for ensuring the evaluation’s utility and applicability to the needs of UNFPA and those of key stakeholders;*
- Review and strengthen the evaluation methodology, describing the plans to engage and involve stakeholders in the design (e.g., questions, objectives, methods, data-collection instruments), data collection, data analysis, and development of recommendations;*
- Explain how the evaluation questions will be addressed with respect to all evaluative criteria indicated above by way of proposed methods, evaluation designs, sampling plans, proposed sources of data, and data-collection procedures;*

*Note: The Consultant/Evaluator is encouraged to suggest refinements to the TOR and to propose creative or cost-saving or time-saving approaches to the evaluation and explain their anticipated value.

- For each of the evaluative criteria, describe the measurable performance indicators or standards of performance that will be used to assess progress towards the attainment of results, including outcomes;*
- Discuss (a) the limitations of the proposed methods and approaches, including sampling, with respect to the ability of the evaluation team to attribute results observed to UNFPA’s efforts especially in the absence of a valid counterfactual and (b) what will be done to minimize the possible biases and effects of these limitations;*
- Explain the Consultant’s/Evaluator’s procedures for ensuring quality control for all deliverables;
- Explain the Consultant’s/Evaluator’s procedures to ensure informed consent among all people to be interviewed or surveyed and confidentiality and privacy during and after discussion of sensitive issues with beneficiaries or members of the public;*
- Indicate familiarity with and agreement to adhere to (a) the requirements of the *Standards for Evaluation in the UN System*, especially standards 4.1 through 4.18 and (b) UNFPA’s Evaluation Quality Standards, which will be provided to the evaluator; and,
- Provide a proposed schedule of tasks, activities, evaluation methodologies and deliverables consistent with this TOR.

The Consultant/Evaluator shall make an oral briefing of the inception report to UNFPA PSRO and its stakeholders. UNFPA PSRO’s Evaluation Manager shall obtain written comments on the inception report from the EMC to the Consultant/Evaluator within 2 days of the report’s submission or completion of the oral presentation, whichever comes later. The Inception Report will also be submitted to APRO for their review and comments. UNFPA PSRO reserves the right to modify the TOR in response to the inception report.

*Note: Items marked with an asterisk should also be discussed in the evaluation report.*
Draft Evaluation Report

The evaluator shall submit an electronic copy of an initial draft evaluation report to UNFPA’s evaluation manager no later than **Friday 10th February, 2012**. The draft report should be thoroughly copy edited to ensure that comments from the UNFPA and other stakeholders on content, presentation, language, and structure can be reduced to a minimum. The final report incorporating comments from UNFPA PSRO and partners can be submitted on **17th February, 2012**.

The Consultant/Evaluator shall make a debrief presentation to the UNFPA PSRO Representative and Director and Deputy Representative/Deputy Director on submission of the draft evaluation report. After UNFPA PSRO and APRO and stakeholders’ review of the draft report, the evaluation manager shall coordinate written comments on the draft report from UNFPA PSRO, SPC/UNICEF and in-country partners and shall submit these to the Consultant/Evaluator. Based on these comments, the evaluator shall correct all factual errors and inaccuracies and make changes related to the report’s structure, consistency, analytical rigor, validity of evidence, and requirements in the TOR. The evaluator will not be required to make changes to conclusions and recommendations unless they are regarded as qualitative improvements. After making the necessary changes, the evaluator will submit a revised draft evaluation report, which may lead to further comments from UNFPA. After the second round of review and, if necessary, further revision to the draft evaluation report, the evaluator can then submit the final report pending UNFPA’s approval.

**Final Report**

The recommended structure of the final report is provided in **Annex 5** and the Consultant/Evaluator should follow this as closely as possible. The report must contain a self-contained executive summary that provides a clear, concise presentation of the evaluation’s main conclusions and key recommendations and reviews salient issues identified in the evaluation. All deliverables must be in English.

10. Consultancy/Evaluation Schedules

The duration of the consultancy is expected to be five (5) weeks beginning Monday 9th January, 2012 and will last for 25 working days. **Annex 6** outlines the detailed evaluation schedule. The Consultant/Evaluator is expected to submit a draft evaluation report with a debriefing with the UNFPA PSRO Representative and Director and Deputy Representative and Deputy Director no later than **Friday 10th February, 2012**.

The evaluator will be remunerated according to the following schedule:

(a) 20 percent of payment upon completion of a satisfactory inception report – 13th January, 2012
(b) 30 percent upon successful completion of field work and submission of first draft report – 10th February, 2012
(c) 50 percent upon submission of a satisfactory final report – 17th February, 2012.

11. Budget

The budget for the evaluation is estimated at a bolt up figure of US$29,500.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Duration (days)</th>
<th>Total (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel + DSA to Fiji &amp; return</td>
<td></td>
<td>$5,000</td>
</tr>
<tr>
<td>Fiji Consultations</td>
<td>5 days</td>
<td>$1,000</td>
</tr>
<tr>
<td>Solomon Islands Consultations</td>
<td>Travel and DSA (5 days – 2 days travel and 3 days in-country)</td>
<td>$3,049.90</td>
</tr>
<tr>
<td>Kiribati Consultations</td>
<td>Travel and DSA (5 days – 2 days travel and 3 days in-country)</td>
<td>$2,379.50</td>
</tr>
<tr>
<td>Tonga Consultations</td>
<td>Travel and DSA (5 days-2 days travel and 3 days in-country)</td>
<td>$3,008.00</td>
</tr>
</tbody>
</table>
Consultancy Fees @ US$600/day for 25 working days | US$15,000
---|---
Total | US$29,437.40

12. Consultant/Evaluator Qualification and Experience
The Consultant/Evaluator must have the following mandatory qualifications and expertise: education, evaluation experience, ASRH experience, knowledge of the region, excellent written and verbal communications skills and past experience with the UN System:

- minimum Master’s Degree or equivalent in Development Economics, Social Sciences [expert in AHD/ASRH] business management, development studies or related field. PhD is an advantage but not required;
- at least 5 years evaluation experience;
- proven record of writing evaluation reports;
- At least 8 years of relevant work experience in the field of Adolescent Reproductive Health/Reproductive Health/Health with emphasis on Family Life Education, Management and Monitoring and Evaluation
- Working experience in the Pacific in ASRH desirable
- Previous experience on evaluation in the Pacific and a good understanding of Pacific culture and context will be an advantage but not necessarily required;
- Good understanding of following approaches: Human Rights, gender, participatory evaluation and processes and results based management for monitoring and evaluation;
- Ability for the compilation of data and its quantitative and qualitative analysis within the logical framework approach and problem tree analysis;
- Ability to work in partnership with various stakeholders: partners, governments, beneficiaries on sensitive issues like sexual reproductive health;
- Excellent oral and written communication skills;
- Computer literacy; and
- A good command and knowledge of the English language is essential.

13. Annexes

- Annex 1: AHD Strategic Plan Results Framework/Logframe
- Annex 2: Stakeholder Participation List
- Annex 3: Evaluation Methodology Framework
- Annex 4: Documentation
- Annex 5: Final Report Structure
- Annex 6: DOS EQA Form 1 and 2
- Annex 7: Detailed Evaluation Schedule
# Program Summary

## 1. GOAL

**IMPROVED HEALTH AND DEVELOPMENT OF YOUNG PEOPLE, ESPECIALLY SEXUAL AND REPRODUCTIVE HEALTH**

(results at impact level)

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Means/Sources of Verification</th>
<th>Risks &amp; Important Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adolescent fertility rate (15-19 ASFR)</td>
<td>• Demographic health surveys (DHS)</td>
<td>• National and regional political stability</td>
</tr>
<tr>
<td>• Percentage of all births to teenage mothers</td>
<td>• Population Census Reports</td>
<td>• Governments maintain support for integrated youth and adolescent program and services.</td>
</tr>
<tr>
<td>• Percentage of male and females (15-24yrs) who are HIV infected</td>
<td>• Health Statistics &amp; Records</td>
<td>• Funding available to support DHS, surveys and census.</td>
</tr>
<tr>
<td>• Prevalence of any STI in Males and females aged 15-24 yrs</td>
<td>• Second generation surveillance on STIs (SGS)</td>
<td></td>
</tr>
</tbody>
</table>

## 2. OUTCOME

**IMPROVED KNOWLEDGE, ATTITUDES, PRACTICES AND BEHAVIOUR (KAPB) REGARDING SEXUAL HEALTH AMONG YOUNG PEOPLE**

(results at behaviour level)

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Means/Sources of Verification</th>
<th>Risks &amp; Important Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Percentage of females &amp; males 15-24 yrs who can identify risk taking behaviour (ie. who both correctly identify main modes of HIV transmission and reject major misconceptions about transmission)</td>
<td>• Demographic health surveys (DHS)</td>
<td>• A supportive socio-cultural environment for adolescent program continues to exist in each country.</td>
</tr>
<tr>
<td>• Contraceptive prevalence rate by method and age</td>
<td>• KAPB Studies on sexual and reproductive behaviour</td>
<td>• Resources are available to support studies</td>
</tr>
<tr>
<td>• Unmet need for contraception (15-24 yrs)</td>
<td>• Community-based Youth Studies</td>
<td></td>
</tr>
<tr>
<td>• Condom use at last sex among males and females, 15-24 yrs</td>
<td>• Clinic Reports and utilization data</td>
<td></td>
</tr>
<tr>
<td>• Number and percentage of 15-24 year olds receiving HIV test in last 12 months and know their results.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Number of Adolescents and young people utilizing ASRH services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Number and percentage of 15-24 year olds who have had sex before age 15 and 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Proportion of young people who do not have concurrent and/or multiple sexual partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinic Utilization records by age, sex and type of services provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Summary</td>
<td>Performance Indicators</td>
<td>Means/Sources of Verification</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>3. OUTPUTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Output 1</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **STRENGTHENED POLICY ENVIRONMENT AND ENHANCED ENABLING COMMUNITY ENVIRONMENT** | Number of countries that have integrated AHD into national youth policy, RH policy and HIV policy. | • Youth Policy  
• RH policy  
• HIV Policy or strategy | A supportive political and socio-cultural environment for adolescent program continues to exist.  
Resources are available. |
| **Activities under Output 1** | | | |
| **1.1 Advocacy for AHD** | (1) AHD Advocacy packages and Information-communication tools developed to facilitate policy dialogue.  
(2) Number of meetings to facilitate policy dialogue at regional and country level.  
(3) Number of partner agencies at different levels that work with AHD program.  
(4) Number of communities participating in social mobilisation for AHD, in each country | • AHD Advocacy and information communication packages in place  
• List of advocacy tools  
• List of partners & stakeholders mobilized to support AHD  
• Reports of meeting and events to support advocacy and social mobilization – eg PPAPD meetings. | A supportive socio-cultural environment for adolescent program continues to exist in each country.  
Resources are available. |
| **1.2 Social Mobilisation** | | | |
| **Output 2**    |                         |                               |                               |
| **STRENGTHENED INFORMATION AND EDUCATION FOR YOUNG PEOPLE** | Number of countries approving FLE policy  
Number of situation analysis in FLE conducted  
Number of countries establishing FLE | FLE Policy statement in place  
FLE Situation Analysis reports  
Other FLE Reports | Ministry of Health supports and endorses Family Life Education. |
| **Activities under Output 2** | | | |
| **2.1 Establishment of skills-based Family Life Education Program (FLE)** | (1) Number of countries developing and introducing FLE syllabus in schools  
(2) Number and % of schools teaching FLE by countries  
(3) Number and % of Teachers trained to deliver FLE curriculum in each country  
(4) % of students receiving FLE classes by country/year  
(5) List of FLE resources developed and distributed to support FLE delivery by country.  
(6) KAPB Baseline study conducted as pre-intervention assessment tool, by country | FLE curriculum in place  
FLE reports in place about FLE status in each country  
FLE resources and materials  
Pre-FLE implementation KAPB Survey Report | Ministry of Education is supportive of introduction and integration of AHD program and FLE syllabus in schools  
Teachers are available to teach FLE.  
Resources are available  
Parents & church are supportive of sexuality education in schools |
<table>
<thead>
<tr>
<th>Program Summary</th>
<th>Performance Indicators</th>
<th>Means/Sources of Verification</th>
<th>Risks &amp; Important Assumptions</th>
</tr>
</thead>
</table>
| 2.2 School-based Counselling                         | 1) Number of schools introducing counselling services  
2) Number of teachers trained in basic counselling  
3) Number of certified trained counsellors in schools  
4) Training guideline/manual in counselling developed | • Reports on school-based counselling  
• Counselling guideline in place  
• List of trained counsellors                                         | Teachers are available and are interested to be trained in counseling.                        |
|                                                      | 2.3 FLE for Pre-Service Teachers Training institutions                                | Reports of Teacher training institutions  
FLE curriculum in teacher syllabus                                                                 | Teacher institutions are agreeable to incorporating FLE.                                   |
|                                                      | 2.4 Peer Education Program (Youth)                                                    | • PE manual in place  
• Peer education country reports.  
• List of PEs in each country  
• Models for Peer education  
• Youth participation list                                           | Peer education is accepted by communities  
Funding available                                                        |
|                                                      | 2.5 Behaviour Change Communication (BCC)                                               | • BCC package in place  
• BCC reports                                                                                     | Expertise and funding to support BCC available                                      |
|                                                      | 2.6 Edutainment and Media                                                             | • Reports of review of Edutainment Activities  
• Edutainment Plans in place  
• List of AHD messages  
• Catalogue of Media packages and Edutainment Activities in place | Edutainment and Media are accepted by communities.                                   |
### Program Summary

#### Output 3

**IMPROVED YOUTH FRIENDLY SERVICES**

### Performance Indicators

- Number of facilities providing youth friendly services, by type of facility in each country

### Means/Sources of Verification

- List of centres and clinics providing YFS
- Facility reports.

### Risks & Important Assumptions

- Religious, community and parents support access to youth-friendly services

#### Activities under Output 3

3.1 **Youth Facilities for youth-friendly services (YFS) established**

- Criteria for Youth-friendly Services developed and applied
- Number of youth facilities by countries that meet the standard criteria of YFS
- Number of countries implementing Standard YFS package
- Number of govt. PHC facilities providing YFS
- Number of NGO, private and community-based facility providing YFS in each country
- List of service delivery outlets delivering YFS

#### Output 4

<table>
<thead>
<tr>
<th>Program Summary</th>
<th>Performance Indicators</th>
<th>Means/Sources of Verification</th>
<th>Risks &amp; Important Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMPROVED YOUTH FRIENDLY SERVICES</td>
<td>Number of facilities providing youth friendly services, by type of facility in each country</td>
<td>List of centres and clinics providing YFS Facility reports.</td>
<td>Religious, community and parents support access to youth-friendly services</td>
</tr>
<tr>
<td>Activities under Output 3</td>
<td>• Criteria for Youth-friendly Services developed and applied</td>
<td>Standard criteria for YFS established Standard YFS package available YFS Reports in place for each country Site Visits and monitoring missions. Catalogue of YFS models in place</td>
<td>MOH and NGO facilities are supportive of integrating AHD youth-friendly services. Funds and resources are available to support YFS</td>
</tr>
<tr>
<td>3.1 Youth Facilities for youth-friendly services (YFS) established</td>
<td>• Number of youth facilities by countries that meet the standard criteria of YFS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of countries implementing Standard YFS package</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of govt. PHC facilities providing YFS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of NGO, private and community-based facility providing YFS in each country</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• List of service delivery outlets delivering YFS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Training of Service Providers</td>
<td>• Training package and guidelines for YFS developed</td>
<td>YFS Training Package and Guidelines in place</td>
<td>Youths are motivated to access and use available services</td>
</tr>
<tr>
<td></td>
<td>• Number of service providers (nurses and doctors) trained in youth-friendly services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Number of PEs trained in youth-friendly services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Percentage facilities that have a PE programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of activities that involve participation of young people in service delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Management of YFS facility</td>
<td>• Recording and Reporting system of health services data established in each YFS facility</td>
<td></td>
<td>Resources for supporting YFS are available</td>
</tr>
<tr>
<td></td>
<td>• Monitoring and Evaluation plans established</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• List of clinic equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Treatment Guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of staff meetings held for clinic management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Program Summary

<table>
<thead>
<tr>
<th>IMPROVED PROGRAM DEVELOPMENT, MANAGEMENT, MONITORING AND EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Strategic Plan developed</td>
</tr>
<tr>
<td>2) Annual Workplans and budget developed</td>
</tr>
<tr>
<td>3) Implementation plans developed</td>
</tr>
<tr>
<td>4) Monitoring and Evaluation plans developed</td>
</tr>
<tr>
<td>5) List of Research Activities</td>
</tr>
</tbody>
</table>

### Performance Indicators

#### Activities under Output 4

**4.1 Recruitment of Program staffing**

- 1) Percentage of staffing positions filled
- 2) Positions filled at regional level
- 3) Positions filled at country level

#### 4.2 Development of AHD program management documents

- 1) AHD Strategic Plan 2008-2012 finalized
- 2) Annual Workplans and budgets developed each year – regional and country
- 3) Monitoring and Evaluation framework developed

#### 4.3 Development of Monitoring and Evaluation Framework

- AHD ME framework established
- Annual programme reviews conducted
- Number of PMC, PAC and PCC meetings held – regional and country level

#### 4.4 Country missions

- 1) Number of missions undertaken per country per year
- 2) Check-list for country missions developed

### Means/Sources of Verification

- Strategic Plan in place
- Annual workplan and budgets are updated
- Implementation plans in place
- M & E plans in place
- Research reports

### Risks & Important Assumptions

- Funds made available by UNFPA and UNICEF to support activities proposed under the project.
- Staffing personnel available
- Funding available for personnel
- Country participation secured
- Responsible officers are available for meetings.
- Staff are committed to undertake country missions
List of Key Stakeholders

UNFPA Pacific Sub Regional Office

Mr Dirk Jena  UNFPA Representative/Director
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Dr. Annefrida Kisesa-Mkusa Chief, HIV & AIDS
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Suva, Fiji
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Email: avakacegu@unicef.org

**Country AHD Coordinators**

**Fiji**

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Dr Francis Bingwor Family Health Advisor
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## Evaluation Methodology Framework

<table>
<thead>
<tr>
<th>Objective / overarching question</th>
<th>Specific question</th>
<th>Performance indicator</th>
<th>Data Source</th>
<th>Evaluatio n design</th>
<th>Sampling plan</th>
<th>Data collection instruments</th>
<th>Data analysis plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine the relevance and importance of the AHD project in Governments national priorities.</td>
<td>Are specific policies and strategies on AHD/SRH reflected in Government’s national strategic development plans and health sector plans?</td>
<td>AHD/SRH policies/strategies reflected in national strategic development plans and health sector plans</td>
<td>NSDPs, Health Sector Plans</td>
<td>Time series review of NSDPs and health sector plans/corporate plans</td>
<td>Facility survey questionnaires</td>
<td>Review of NSDPs and Sector Plans/Corporate Plans</td>
<td>Trend analysis and scope of coverage</td>
</tr>
<tr>
<td></td>
<td>Is government allocating any resources/budgets for implementation of AHD and SRH activities?</td>
<td>Government funds allocated for AHD/SRH project/initiatives</td>
<td>Annual report, Budget documents</td>
<td>Time series review of budget allocated for AHD/SRH activities</td>
<td>Facility survey questionnaires</td>
<td>Face to face questionnaires</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How many staff are employed under the project?</td>
<td># of staff under the project</td>
<td>KAP survey, Attendance/participation list, YFS Utilization data</td>
<td>Facility survey and questionnaire on coverage areas</td>
<td>Face to face interview and questionnaires</td>
<td></td>
<td>Trend analysis</td>
</tr>
<tr>
<td>Determine the extent to which the project has increased knowledge, change attitudes, practices and behavior in relation to AHD/SRH?</td>
<td>Did the advocacy and training reach the target population?</td>
<td># of youths trained</td>
<td>KAP survey</td>
<td>KAP questionnaire</td>
<td>Facility survey and questionnaire on coverage areas</td>
<td>Face to face interviews and questionnaires</td>
<td>Trend analysis</td>
</tr>
<tr>
<td></td>
<td>How accessible were the IEC and advocacy materials?</td>
<td># of youths sensitized on AHD/SRH issues</td>
<td>Facility survey data/DHS, Facility survey data</td>
<td>Time series</td>
<td>Facility survey questionnaire</td>
<td>Face to face interview and facility survey questionnaires</td>
<td></td>
</tr>
<tr>
<td>Determine the extent to which the AHD project has generated positive results and increased policy uptake by Governments</td>
<td>Has teenage pregnancies declined as a result of AHD activities?</td>
<td># of teenage pregnancies</td>
<td>Facility survey data/DHS</td>
<td>Time series</td>
<td>Facility survey questionnaire</td>
<td>Face to face interview and facility survey questionnaires</td>
<td>Trend analysis</td>
</tr>
<tr>
<td></td>
<td>Has number of young people accessing and utilizing SRH services</td>
<td># of young people accessing and utilizing SRH services</td>
<td>Facility survey data</td>
<td>Time series</td>
<td></td>
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Annex 3
<table>
<thead>
<tr>
<th>Question</th>
<th>Method</th>
<th>Source</th>
<th>Time series</th>
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</thead>
<tbody>
<tr>
<td>How many YFS centres have been established?</td>
<td># of YFS centres established</td>
<td>Facility data survey Annual reports</td>
<td>Time series</td>
</tr>
<tr>
<td>How many schools are offering FLE?</td>
<td># of schools offering FLE</td>
<td>Facility data survey Annual reports</td>
<td>Time series</td>
</tr>
<tr>
<td>Has internal/national capacity been adequately developed?</td>
<td>Improved knowledge and skills on AHD/SRH</td>
<td>KAP survey</td>
<td>Time series</td>
</tr>
<tr>
<td>Is the implementing partner able to fund and sustain the project?</td>
<td>Funds allocated for AHD/SRH initiatives</td>
<td>Budget documents</td>
<td>Time series</td>
</tr>
<tr>
<td>How many FLE and Peer Educators have been trained?</td>
<td># of teacher trained in FLE</td>
<td>Annual reports</td>
<td>Time series</td>
</tr>
<tr>
<td>How many schools have introduced FLE?</td>
<td># of Peer Educators trained</td>
<td>Annual reports</td>
<td>Time series</td>
</tr>
<tr>
<td>Has internal/national capacity been adequately developed?</td>
<td># of schools introducing FLE?</td>
<td>Annual reports</td>
<td>Time series</td>
</tr>
<tr>
<td>Is the implementing partner able to fund and sustain the project?</td>
<td></td>
<td></td>
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<tr>
<td>Determine the absorptive capacity of Governments/Implementing Partners in sustaining and implementing the AHD project.</td>
<td></td>
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</tbody>
</table>
EOP Evaluation: Pacific ADH Project 2008 - 2012

Annex 4

Documentation

With UNFPA [L-drive]

i. AHD Evaluation TOR;

ii. AHD Strategic Plan 2009 – 2012

iii. AHD programme review report 2007


vii. Minutes of PAC and PMC meetings 2008-2010

viii. AHD operational research reports publications 2007 [this is separate publications from each 10 PIC]

ix. AHD info-share contributions

x. Nadi communiqué with Pacific Directors of Public Health 2010

xi. 4 Situation Analysis Reports in ASRH for Kiribati, Samoa, Solomon Islands, and Vanuatu 2006

xii. ASRH Pacific Experiences Before it’s too late Publication 2005

xiii. ASRH Research Manual 2006

xiv. Desk review of MARYP in 6 PIC, 2009,

xv. AHD Youth Friendly Service Clinic Assessment in 5 Pacific Island Countries,

xvi. Assessment Report of Adolescent Sexuality Education (or Family Life Education) in ten PICTs, 2010, SPC


xix. Urban Youth in Pacific, 2010, UNDP

xx. MARYP Report in Kiribati 2010, UNICEF

xxi. MARYP Report in Vanuatu 2010, UNICEF


xxiv. Youth stakeholders meeting report 2008, SPC

xxv. Fiji Ministry of Education Curriculum Map 2008

xxvi. FLE study tour report 2008

With UNICEF


With SPC

xxx. AHD mission reports to countries undertaken by SPC 2008 - 2011

xxxi. Annual AHD Coordinators Work Plans 2008-2011

xxxii. AHD Coordinators Quarterly Monitoring reports 2008-2011
Structure of Final Report
The final evaluation report should contain the following and should be no more than 30 pages:

- Title Page
- List of Acronyms and abbreviations;
- Table of Contents, including list of annexes;
- Executive Summary
  - The executive summary should be brief (1-2 pages) and contains key information needed by decision makers. It should contain the following:
    - Brief description of the project
    - Evaluation purpose, questions and scope of evaluation
    - Key findings
    - Conclusions
    - Key recommendations
- Introduction: background and context of the project and project evaluation
- Description of the project – its logic theory and change theory, results framework and external factors likely to affect success;
- Purpose of the Evaluation
- Key questions and scope of the evaluation with information on limitations and delimitations
- Approach and methodology of the evaluation
- Findings
- Summary and explanation of findings and interpretations
- Conclusions
- Recommendations
- Lessons Learned, generalizations and alternatives
- Annexes

At a minimum, the final report shall contain the following annexes:
- List of persons interviewed (if confidentiality permits) and sites visited;
- Data-collection instruments (copies of surveys, questionnaires, etc.);
- A bibliography or list of references; and,
- The TOR for the evaluation.
FORM 1: DOS EQA template

Overall Assessment:

<table>
<thead>
<tr>
<th>Quality Assessment criteria</th>
<th>Very Good 4</th>
<th>Good 3</th>
<th>Poor 2</th>
<th>Unsatisfactory 1</th>
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</thead>
</table>

1. Structure and Clarity of Reporting

*To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards.*

Checklist of minimum content and sequence required for structure:

- i) Acronyms; ii) Exec Summary; iii) Introduction; iv) Methodology including Approach and Limitations; v) Context; vi) Findings/Analysis; vii) Conclusions; viii) Recommendations; ix) Transferable Lessons Learned (where applicable)

- Minimum requirements for Annexes: ToRs; Bibliography List of interviewees; Methodological instruments used.

2. Executive Summary

*To provide an overview of the evaluation, written as a stand-alone section and presenting main results of the evaluation.*

Structure (paragraph equates to half page max):

- i) Purpose, including intended audience(s); ii) Objectives and Brief description of intervention (1 para); iii) Methodology (1 para); iv) Main Conclusions (1 para); v) Recommendations (1 para). Maximum length 3-4 pages

3. Design and Methodology

*To provide a clear explanation of the following elements/tools*

Minimum content and sequence:

- Explanation of methodological choice, including constraints and limitations;
- Techniques and Tools for data collection provided in a detailed manner;
- Triangulation systematically applied throughout the evaluation;
- Details of participatory stakeholders’ consultation process are provided.
- Whenever relevant, specific attention to cross-cutting issues (vulnerable groups, youth, gender equality) in the design of the evaluation

4. Reliability of Data

*To clarify data collection processes and data quality*

- Sources of qualitative and quantitative data have been identified;
- Credibility of primary (e.g. interviews and focus groups) and secondary (e.g. reports) data established and limitations made explicit;
### 5. Findings and Analysis

*To ensure sound analysis and credible findings*

**Findings**
- Findings stem from rigorous data analysis;
- Findings are substantiated by evidence;
- Findings are presented in a clear manner

**Analysis**
- Interpretations are based on carefully described assumptions;
- Contextual factors are identified.
- Cause and effect links between an intervention and its end results (including unintended results) are explained.

### 6. Conclusions

*To assess the validity of conclusions*

- Conclusions are based on credible findings;
- Conclusions are organized in priority order;
- Conclusions must convey evaluators’ unbiased judgment of the intervention.

### 7. Recommendations

*To assess the usefulness and clarity of recommendations*

- Recommendations flow logically from conclusions;
- Recommendations must be strategic, targeted and operationally-feasible;
- Recommendations must take into account stakeholders’ consultations whilst remaining impartial;
- Recommendations should be presented in priority order

### 8. Meeting Needs

*To ensure that Evaluation Report responds to requirements (scope & evaluation questions/issues/DAC criteria) stated in the ToR (ToR must be annexed to the report).*

---

**FORM 2: DOS  EQA template: Explanatory notes**

### 1. Structure and Clarity of Reporting

Does the report clearly describe the evaluation, how it was conducted, the findings of the evaluation, and their analysis and
subsequent recommendations?

Is the structure *logical*? Is the report *comprehensive*?

Can the information provided be *easily understood*?

<table>
<thead>
<tr>
<th>2. Executive Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does it read as a stand-alone section, and is a <em>useful</em> resource in its own right?</td>
</tr>
<tr>
<td>Is it brief yet <em>sufficiently detailed</em>, presenting the main results of the evaluation, and including <em>key elements</em> such as methodology and conclusions and recommendations?</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>3. Design and Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the <em>methodology</em> used for the evaluation clearly described and is the rationale for the methodological choice justified?</td>
</tr>
<tr>
<td>Have cross-cutting issues (vulnerable groups, youth and gender equality) been paid specific attention (when relevant) in the design of the evaluation?</td>
</tr>
<tr>
<td>Are key processes (tools used, triangulation, consultation with stakeholders) discussed in sufficient detail? <em>Are constraints and limitations</em> made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.) and discussed?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Reliability of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are <em>sources</em> of data clearly stated for both primary and secondary data?</td>
</tr>
<tr>
<td>Is it clear why case studies were selected and what purpose they serve?</td>
</tr>
<tr>
<td>Are all relevant materials related to case studies, interviews (list of interviewees, questionnaires) etc. annexed to the report?</td>
</tr>
<tr>
<td>Are the limitations, and methods to address them, discussed?</td>
</tr>
<tr>
<td>What other <em>data gaps</em> are there and how have these been addressed?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Findings and Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings</td>
</tr>
<tr>
<td>Is there a <em>clear pathway</em> from data to findings, so that all findings are <em>evidence-based</em>?</td>
</tr>
<tr>
<td>Are <em>biases</em> stated and discussed?</td>
</tr>
<tr>
<td>Are <em>unintended</em> findings reported and discussed?</td>
</tr>
<tr>
<td>Analysis</td>
</tr>
<tr>
<td>Are <em>interpretations</em> of the findings understandable? Are <em>assumptions</em> clearly stated and extrapolations well explained?</td>
</tr>
<tr>
<td>Are their <em>limitations</em> (or drawbacks) discussed?</td>
</tr>
<tr>
<td>Does the analysis respond to <em>all</em> evaluation questions?</td>
</tr>
<tr>
<td>If not, are <em>omissions</em> (of both evaluation criteria and questions) recognized and explained?</td>
</tr>
<tr>
<td>Has the analysis examined <em>cause and effect</em> links between an intervention and its end results?</td>
</tr>
<tr>
<td><em>Are contextual factors</em> identified and their influence discussed?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Conclusions</th>
</tr>
</thead>
</table>
Are the conclusions organized in priority order?

Do the conclusions amount to a reasonable *judgment* of the findings and are their links to evidence made clear?

Are there any limitations and are these made clear?

Do they present an *unbiased* judgment by the evaluators of the intervention or have they been influenced by preconceptions or assumptions that have not been discussed?

### 7. Recommendations

Is there a *logical flow* from the conclusions to recommendations?

Are they strategic and clearly presented in a priority order which is consistent with the *prioritization* of conclusions? Are they *useful* – sufficiently detailed, targeted and likely to be implemented and lead to further action?

How have the recommendations *incorporated* stakeholders’ views and has this affected their *impartiality*?

### 8. Meeting Needs

Does the report adequately address the information needs and responds to the *requirements stated in the ToRs*?

In particular does the report respond to the evaluation questions, issues or criteria identified in ToR?
Adolescent Health and Development (AHD) in the Pacific

Strategic Plan
2009–2012

Jointly supported by UNFPA, UNICEF and SPC
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<table>
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHD</td>
<td>Adolescent Health and Development</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
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<td>CDU</td>
<td>Curriculum Development Unit FHA Family Health Association</td>
</tr>
<tr>
<td>FLE</td>
<td>Family Life Education</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
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<td>International Planned Parenthood Federation</td>
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<td>Life Skills</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>Non-Governmental Organisation</td>
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<td>Primary Health Care</td>
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<td>PICT</td>
<td>Pacific Island Countries and Territories</td>
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EXECUTIVE SUMMARY

The strategic plan for the Regional Adolescent Health and Development (AHD) programme was developed to provide guidance and direction in the next phase of the AHD programme for the period 2009 to 2012. It is a roadmap for partners to set priorities and realistic strategies to address the sexual and reproductive health of young in the context of the ICPD and MDGs; it serves as a tool for expanding partnership and mobilizing donor assistance to further support youth initiatives. The plan builds on the experiences and achievements of earlier phase and reinforces the commitment of the joint UNFPA-UNICEF-SPC partnership programme to continue supporting a multi-country integrated AHD programme.

The Regional AHD Programme – Phase 1 (2005-2008)

The Adolescent Health and Development (AHD) Programme is a joint initiative among UNFPA, UNICEF and SPC to address the health and development issues of young people in the Pacific, especially their sexual and reproductive health. It is implemented in 10 Pacific Island countries: Cook Is, Federated States of Micronesia, Fiji, Kiribati, Marshall Is, Samoa, Solomon Is, Tonga, Tuvalu and Vanuatu. Phase 1 built on initial efforts made by the UNFPA-SPC Adolescent Reproductive Health (ARH) project and the UNICEF-supported Life Skills project. The merge of the two projects in June 2005 resulted in the development of the joint AHD project. Incorporating a life skills approach was designed to strengthen the delivery of information and education and youth-friendly services. The project adopted a multi-sectoral approach and worked with communities, government sectors and NGOs. The joint project comprised four components:

1. Strengthening information and education through life skills training
2. Strengthening youth-friendly services
3. Creating a supportive and enabling environment
4. Strengthening project management and delivery.

The independent evaluation of the AHD programme carried out in 2007 showed that considerable achievements had been accomplished. These included the establishment of a multi-country programme in 10 Pacific island countries; community awareness and advocacy resulting in increased national support for AHD initiatives; establishment of peer education, life skills training and school-based family life education as tools for delivering information and education; establishment of youth facilities for youth-friendly services; training and capacity building for youth trainers and service providers; and the development of wide stakeholder networks and partners that support the programme.

While considerable achievements have been made during Phase 1, more efforts need to be made to strengthen and to build on these early initiatives to expand coverage and to strengthen linkages. Approaches for increased coverage and expansion will require greater policy involvement and allocation of more resources to address the gaps highlighted in the evaluation of Phase 1. The major gaps are associated with greater national commitments for investing in AHD; increased coverage and accessibility of educational programmes and youth-friendly services to reach both urban and rural communities; the need to strengthen monitoring and evaluation mechanisms; to document lessons learned and best practices; and to strengthen the use of data for evidence-based programming. Specifically targeting
vulnerable, at risk and marginalised groups needs to be better articulated in programme development. Efforts are required to consolidate the achievements made under Phase 1, carry out a gap analysis, apply lessons learned, identify opportunities for strengthening and replication of successful approaches, and work towards expansion, increased coverage, and institutionalisation of activities to move towards sustainability.

Phase 1 of the Regional AHD Programme ended in December 2007 and 2008 AHD programme constituted a bridging period between the two phases. This strategic plan (AHD Phase 2) covers the period 2009-2012 and represents the joint vision of three organisations (UNFPA, UNICEF and SPC) in addressing health and development issues of young people within the wider context of youth development, the ICPD and the MDGs.

In the next four-year period (2009-2012), three agencies intend to strengthen the partnership and build on the achievements made during the earlier phase. Renewed and strengthened collaboration among the partner agencies will provide further opportunity to appropriately respond to emerging AHD-related challenges; apply lessons learned; identify innovative approaches and interventions; and to continue seeking donor support for advancing AHD initiatives in the region. Greater efforts will be made towards strengthening programme implementation to achieve greater results, working in partnership with other organisations and development partners whose core business is related to adolescent health and development.

The Regional AHD Programme – Phase 2 (2009-2012)

The AHD Strategic Plan Phase 2 has been developed at a time when the region is increasingly focused on poverty reduction and the achievement of the MDGs. The plan acknowledges that programmes for young people must contribute towards the comprehensive development of adolescents and youth. While sexual and reproductive health (SRH) is one important aspect of youth development, education, livelihoods, employment and citizenship are equally important. Therefore, there is a need to position AHD more holistically and to take into account the environment in which young people live, their education, health and employment status in the context of poverty reduction.

Expanding partnerships will be strengthened to help address a broader approach to AHD. There are plans to engage wider partnerships with other international partner agencies, regional partners and national stakeholders so that linkages to other youth issues beyond sexual and reproductive health can be facilitated. The plan incorporates the findings of the 2007 programme review to further consolidate current activities, improve programme effectiveness and address existing gaps. Opportunities for expanding to other countries will also be explored. The plan encompasses a broader mandate on youth that includes a common vision based on a common frame of reference, which has the scope for flexibility and adaptation at country level. It aims to translate international and regional commitments into nationally-driven initiatives that support overall national development and poverty reduction. Interventions will aim to maximise opportunities for young people while minimizing risks to their health and development.
**Vision and Goal**

The vision of the Regional Pacific AHD Programme adopts the UNFPA’s vision\(^1\) for adolescents and youth, as quoted:

“A world fit for adolescents and youth is one in which their rights are promoted and protected. It is a world in which girls and boys have optimal opportunities to develop their full potential, to freely express themselves and have their views respected, and to live free of poverty, discrimination and violence” (UNFPA 2006).

The strategic plan articulates this vision and takes a holistic approach to engage policy dialogue and policy analysis in order to secure policy support for adolescent health and development. It facilitates synergy and complementarity among key partners, stakeholders and collaborating agencies and works to leverage resources of national governments and development partners for adolescents and youth.

The goal of the multi-country initiative is to safeguard and protect the sexual and reproductive health of young people, thereby contributing to their holistic development and helping them live to their full potential towards achieving a socio-economically productive life.

**Programme Outputs**

The strategic plan focuses on intervention strategies around four key areas or “key outputs”. Strategies under these key areas are designed to support the delivery of a multi-sectoral adolescent health and development programme focusing on sexual and reproductive health. The four strategic areas will further strengthen and build on initiatives achieved under Phase 1.

**Output 1** aims to establish an enhanced Supportive Policy Environment linking population structure and poverty dynamics. Strong arguments for investing in young people will be developed and communicated to national leaders and policy-makers as basis for policy dialogue. Advocacy and Mobilisation efforts will be strengthened to gain an enabling community environment.

**Output 2** aims to strengthen the delivery of gender-sensitive life skills based reproductive health education through formal and non-formal approaches including school-based Family Life Education, peer education, community based outreach activities, behaviour change communication (BCC) and the use of multi media.

**Output 3** aims to strengthen, expand and up-scale sexual and reproductive health services for young people. Key actions include defining an essential package of youth-friendly services; supporting clinic facilities; training of service providers; integrating SRH and STI/HIV services; and using multiple delivery channels and effective referral mechanisms.

**Output 4** aims to strengthen programme management and delivery and will support human resources for adequate programme staffing; monitoring and evaluation; health systems strengthening and capacity development; and support for evidence-based programming through operational research.

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\(^1\) UNFPA Framework for Action on Adolescents & Youth: 4 Keys to open doors with Young People
To ensure a comprehensive approach in identifying the best mix of strategic interventions and activities under each Output, two approaches\(^2\) will be applied under each Key Output: *policy direction* and its articulation into *programme direction*. The implementation of the AHD Strategic Plan will be facilitated by a number of *cross-cutting areas* including: targeted interventions, youth participation, gender empowerment, equality and equity, inter-sectoral action, capacity building, responding to emerging issues, and on-going data collection for improved evidence-based programme planning.

The main partners in this joint initiative are UNFPA, UNICEF and SPC working in collaboration with governments and NGOs in Pacific island countries. While SPC remains the main implementing agency, UNFPA and UNICEF will provide technical support and guidance in the spirit of partnership. Results-based mechanisms will be put in place to monitor the programme on an on-going basis and to facilitate its evaluation.

The AHD Programme will expand dialogue with other regional organisations, donors, multilateral agencies, civil society and community-based networks, academic and research institutions and others to explore opportunities for wider partnership and joint innovations, mobilise additional resources and expertise, and facilitate improved coordination for better use of resources to achieve greater impact in line with the Paris Declaration on aid effectiveness.

To be able to address the wide range of young people’s issues, the AHD programme will cross boundaries between sectors and encourage new partnerships. The sector wide approach aims to contribute to the comprehensive development of adolescents and youth. To fully address SRH in young people, other issues of concern must be addressed. Therefore this strategic plan aims to position AHD with the broader framework of the holistic development of young people.

An estimated budget to fund the 4-year strategic period is presented in the following table:

\[
\begin{array}{|c|c|c|c|c|c|}
\hline
\text{OUTPUT 1: IMPROVED POLICY ENVIRONMENT & ENABLING COMMUNITY} & 2009 & 2010 & 2011 & 2012 & \text{TOTAL} \\
\hline
& \text{YEAR1} & \text{YEAR2} & \text{YEAR3} & \text{YEAR4} & \\
\hline
145,000 & 145,000 & 50,000 & 50,000 & 390,000 \\
\hline
\text{OUTPUT 2: IMPROVED LIFE SKILLS BASED AHD INFORMATION & EDUCATION} & 450,000 & 470,000 & 470,000 & 470,000 & 1,860,000 \\
\hline
\text{OUTPUT 3: STRENGTHENED YOUTH FRIENDLY SERVICES} & 435,000 & 530,000 & 530,000 & 530,000 & 2,025,000 \\
\hline
\text{OUTPUT 4: STRENGTHENED PROGRAMME MANAGEMENT & DELIVERY} & 899,500 & 938,000 & 974,500 & 913,000 & 3,725,000 \\
\hline
\text{TOTAL} & 1,929,500 & 2,083,000 & 2,024,500 & 1,963,000 & 8,000,000 \\
\hline
\end{array}
\]

\(^2\) Section 4.5 is adapted from UNFPA Framework for Action on Adolescents & Youth: 4 Keys to open doors with Young People

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1. THE NEED FOR A STRATEGIC PLAN

In the present time of scarce resources and rapidly changing priorities, strategic planning is an essential tool to redefine common vision and mission statements on adolescent health, identify programmatic priorities and areas of focus, reinforce partnerships, and to plan effective use of resources to maximise opportunities and minimise constraints. The strategic plan for the Regional Adolescent Health and Development (AHD) programme provides guidance and direction in the analysis, development, implementation and coordination of AHD initiatives at regional and country level for the period 2009 to 2012. Beyond this main purpose, the strategic plan has a number of other uses including the following:

1) Guides and assists countries in designing national AHD Strategic Plans.
2) Acts as a roadmap for AHD partners and project countries to set priorities and realistic strategies to address the SRH issues of young people and their linkages with education, livelihoods and health.
3) Provides a structure for the development of annual workplans and mechanisms for reporting, monitoring and evaluation.
4) Acts as a tool for expanding partnership and mobilizing donor assistance to further support youth initiatives.
5) Acts as a communication and a marketing tool for stakeholders, development partners, private sector and the general public.
6) Reinforces the commitment of the joint UNFPA-UNICEF-SPC partnership programme to support a multi-country integrated AHD package.
7) Identifies programme outputs, activities and indicators that can be used to generate performance information and promote transparency and accountability.

1.1 BACKGROUND

The Adolescent Health and Development (AHD) Project is a joint initiative among UNFPA, UNICEF and SPC to address the sexual and reproductive health (SRH) of young people in the Pacific in the context of health and development. The programme aims to provide awareness, life-skills based information and education, counselling and youth-friendly services and programmes to help young people make responsible decisions in matters related to sexual and reproductive health and related issues.

Phase 1 of the project (2005-2007) was implemented in ten Pacific Island countries through a regional team based at the regional office of the Secretariat of the Pacific Community (SPC) in Suva, working in collaboration with UNFPA and UNICEF. The ten countries are Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

Phase 1 built on the initial UNFPA-SPC Adolescent Reproductive Health (ARH) project and the UNICEF-supported Life Skills project, both of which started during 2000-2001. The merge of these two projects in June 2005 resulted in the development of the joint AHD project under the partnership of three agencies – UNFPA, UNICEF and SPC with SPC as the implementing agency. Incorporating life skills training was designed to strengthen and add value in the
delivery of ARH information and education and youth-friendly services. The joint project comprised four components:

1. Strengthening ARH information and education through life skills training
2. Strengthening ARH youth-friendly services
3. Creating a supportive and enabling environment
4. Strengthening project management and delivery.

1.2 PHASE 1 EXPERIENCES: ACHIEVEMENTS, LESSONS LEARNED AND GAPS

The joint project was designed to build country capacity, mobilise partners and stakeholders and adopt a multi-sectoral approach. It allowed for regional level and country level implementation and worked with communities, government sectors and NGOs. In collaboration with UNFPA and UNICEF, the SPC regional team coordinated and managed the project while efforts were made to build local AHD teams in all participating countries. Mechanisms for the development of joint annual workplans and ongoing planning, monitoring and reviewing were established at both regional and national levels to support the implementation of the project and gauge the production of outputs.

An external review of the AHD project conducted in May 2007 found that its objectives and components were well chosen and in synchrony with international and regional frameworks on sexual and reproductive health. A large range of activities were implemented under four programme components. Some of the best practices under Phase 1 included:

- formation of wide stakeholders network and partnerships for support and advocacy;
- community mobilisation and participation;
- development of models for establishing youth-friendly services;
- establishment of NGO-based youth clinics;
- integration of adolescent services in existing health clinics;
- development of school-based family life education (FLE);
- integration of life skills in youth training;
- establishment of peer education both in-school and out-of-school.

A success story that emerged out of Phase 1 has been the establishment of youth-friendly services, albeit its small scale in comparison to size and distribution of youth population. A number of NGO-based youth clinics, school-based and institution-based clinics were established where youth-friendly services were packaged and offered. Most of the clinic support activities involved reorganisation and renovation of an existing NGO or government health facility in order to establish a youth-specific clinic. Due to limited funding, support for youth clinics have been small in scale. Lessons learned recommend that a youth clinic should be built alongside other educational and entertainment activities that attract young people.

Phase 1 also identified the need to build evidence-based programming by incorporating operational research on an on-going basis. Initiation of operational research begun in 2006; this resulted in the conduct of ARH studies in IEC materials, teenage pregnancy, peer education and youth-friendly services. Findings of these small-scale studies have been used to strengthen the development of a number of AHD interventions in 2007. However, it was noted...

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3 Project Document on Joint UNFPA/UNICEF/SPC project on Adolescent Health and Development
4 The external review was conducted by two independent consultants who drafted a review report
that research capacity was weak in the region and in order to fully incorporate research to support evidence-based programming, adequate expertise is required both at regional and country level.

Another promising intervention initiated in Phase 1 that has the potential to capture wide populations of young people and also has greater chances for sustainability is in the area of Family Life Education (FLE). The slow progress in its development has been attributed to weak technical resources and the need to align FLE development processes with revised national curriculum frameworks (NCF) as a result of major educational reforms in Pacific countries. More technical support and funding are required to strengthen the progress of FLE programmes.

Peer Education was an achievement in Phase 1 with all participating countries establishing peer education programmes. In the next phase, there is a need to review these early initiatives and set standards for life-skills based peer education. Specific interventions that target vulnerable, at risk and marginalised groups are inadequate and therefore need to be reviewed and strengthened.

While considerable achievements and best practices were initiated during Phase 1, more efforts are needed to build on lessons learned and experiences. Country-specific interventions need to expand for greater coverage while up-scaling in educational and youth-friendly approaches is required for improving quality of services. The major gaps in the provision of sexual and reproductive health are associated with coverage, service availability and accessibility, quality of care and sustainability of interventions developed under the four key outputs. Analytical analysis is required to consolidate Phase 1 achievements, identify the gaps, apply lessons learned, identify opportunities for strengthening and replication of successful approaches and best practices, and work towards institutionalisation of activities to assist sustainability.

1.3 PHASE 2: AHD STRATEGIC PLAN

Phase 1 of the regional AHD Project ended in December 2007; and 2008 was designated a bridging period between two developmental phases. This strategic plan “Pacific AHD Strategic Plan Phase 2” covers the period 2009-2012 and represents the joint vision of the three partner agencies (UNFPA, UNICEF and SPC) in addressing SRH issues of young people within the wider context of youth development and linkages to ICPD and MDGs.

Phase 1 recognised that while issues of sexual and reproductive health are crucially important in the health and development of young people, other development issues are equally important – particularly education, livelihood skills and employment. It therefore recommends that in order to address youth development in a more holistic approach, Phase 2 of the AHD programme should expand its partnership and cultivate linkages with other partners to address the wider youth development issues beyond sexual and reproductive health, where and when appropriate.
The AHD Strategic plan will strengthen the existing partnership among UNFPA, UNICEF and SPC and aim to expand partnership to other partner agencies such as WHO, IPPF, ILO, UNESCO and other stakeholders. In particular, partnerships to expand SRH initiatives with NGO-based family health associations will be explored with IPPF while mental health, healthy lifestyles, life skills, and youth employment will be explored with WHO, SPC Human Development programme, ILO, respectively. Opportunities for expanding to other countries beyond the initial ten project countries will also be considered.

The plan aims to build on the achievements made during the earlier phase through analytical reviews of past experiences, best practices and lessons learned for formulating cost-effective approaches, while avoiding less effective and costly interventions. Renewed and strengthened collaboration among partner agencies will provide further opportunity to appropriately respond to emerging AHD-related challenges; identify innovative approaches and interventions; apply evidence and research data to improve programming, and to continue seeking donor support to expand and up-scale AHD initiatives in the region. The programme will work towards strengthening programme implementation to achieve greater results, and work in partnership with other organisations and development partners whose programme areas are related to adolescent health and development. Ongoing review of strategies and activities will be undertaken to continuously improve programme effectiveness and address existing gaps.

The AHD-SPD Phase 2 has been developed at a time when the region is increasingly focused on poverty reduction and the achievement of the MDGs. The plan acknowledges that programmes for young people must contribute towards the comprehensive development of adolescents and youth. While SRH is one important aspect of youth development, other areas are equally important – including education, livelihoods, employment and citizenship. Therefore, there is a need to position AHD more strategically so that opportunities are open for linkages to be made with other youth development areas and to share vision, resources, experiences and expertise.

Many of the MDG targets directly relate to young people’s health and development. Social investments in education, health and employment can enable countries to build a stronger economic base, thereby breaking or reversing the cycle of poverty. It aims to build country capacity towards national ownership, national leadership and national systems, and advocates a holistic approach to addressing youth issues and proactively pursues partnerships with governments, development partners, NGOs, CSOs and the media for leveraging resources to support social investments in young people.

The AHD-SDP encompasses a broader youth mandate that includes a common vision based on a common frame of reference, which has the scope for flexibility and adaptation at country level. It aims to translate regional commitments into nationally-driven initiatives that support national development and poverty reduction. Interventions will aim to maximise opportunities for young people while minimizing risks to their health and development.
1.4 PROCESS OF DEVELOPING THE AHD STRATEGIC PLAN

The development of the SPD engaged wide consultation with Pacific island countries and ongoing dialogue among UNICEF, UNFPA, SPC and potential partners. The process incorporated information derived from programme reviews, operations research, situation analysis and findings from country missions. It is guided by regional and international frameworks; incorporated findings of an external review conducted in 2007; and built on an earlier SPD draft developed by an international consultant at end of 2007. The 2007 and 2008 annual AHD review meetings provided a unique forum for consultations with representatives of governments and civil society of ten PICs together with UNFPA, UNICEF and SPC. The development of the SPD consulted a number of publications and reports, as follows:

- The UNFPA Framework on “Action for Adolescents and Youth: 4 Keys to open doors with Young people (2006)”
- A Draft AHD Strategic Plan by an international consultant, 2007
- Country mission Reports by UNFPA, UNICEF and SPC, 2005-2008
- Operational Research on selected areas of AHD & ASRH, 2006-2007
- Situation Analysis of Adolescent Health and ASRH, 2006-2007
- Situation Analysis of Family Life Education, 2007
- The SPC Pacific Youth Strategy 2010
2. ADOLESCENT DEVELOPMENT – CONTEXT, ISSUES AND CHALLENGES

Adolescence is a period of complex development as young people go through a transitional phase to adulthood and are challenged by physical, psychological, economic and social changes. This transitional phase of development is mixed with challenges and choices which are strongly influenced by expectations of societies, cultures and families. Navigating through adolescence depends on how well young people are informed, guided, empowered and supported by families, institutions, society and the surrounding environment at large.

This strategic plan addresses the issues and needs of young people aged 10-24 years. Adolescents are individuals between 10-19 years old (also referred to as teenagers) while Youth covers the range of 15-24 years. These are globally accepted definitions although there may be country-specific variations. For the purpose of this document, young people include adolescents and youth from 10 to 24 years, the target group for the joint initiative.

2.1 THE VALUE OF INVESTING IN YOUNG PEOPLE

Young people form a large proportion of a country’s population; most of them are still in school and largely dependent. A small proportion enter the labour force each year while an increasing number discontinue school and contribute to increasing youth unemployment rates. Neglecting the development needs of young people can lead to high social and economic costs, both immediately and in the years ahead6.

Investing in the development of young people in the areas of education, health, livelihoods and employment impacts positively in the achievement of the MDGs and constitutes a sound intervention for poverty reduction. Education, health and employment form the basic foundation for working towards the attainment of other socio-economic development goals. Youth and adolescents represent a priority group given their social, economic and health vulnerabilities, especially in the area of sexual and reproductive health. Enhancing their capacities can yield larger returns during the course of their economic lives and ensure full productive and healthier lives thereby reducing ill health. Investing in young people can also enable them to develop skills and abilities for contributing to poverty reduction and the development of society. Hence, they are assets and opportunities to be nurtured.

Improving sexual and reproductive health of young people reduces the likelihood of teenage pregnancy, STIs, HIV/AIDS and their social and economic costs. It also encourages couples and individuals to decide freely and responsibly the number, spacing and timing their children. It enables higher household savings and investment, and facilitates higher productivity. Delayed marriage (and co-habitation) and parenthood allows for greater educational achievements which contributes to better career and employment opportunities. Well-educated, healthy and employed young people achieve a favourable start early in life and are likely to contribute to national economic growth6.

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6 The State of Pacific Youth, 2005: a joint publication by UNICEF/UNFPA/SPC funded by NZAID
6 Adding it up: The benefits of investing in sexual and reproductive health care. UNFPA, 2004
One of the most important commitments a country can make for future economic, social and political progress and stability is to address the development needs of its young people as a sound investment for the future\(^7\). In the absence of guidance and an enabling environment to support the health and development of young people, serious socio-economic circumstances will continue to occur, such as increasing criminal activities, delinquency and civil unrest, youth suicide, increasing rates of STIs and HIV, sexual exploitation, prostitution amidst increasing rates of unemployment and youth poverty.

### 2.2 YOUTH DEVELOPMENT ISSUES

Today adolescents and youth represent the largest generation in human history. One third to almost half of the population in developing countries is under 20 years. In the Pacific, the development of young people takes place in the context of increasing unemployment, social inequalities, poor access to education and health services, gender discrimination, and increasing poverty. In addition, the era of HIV and AIDS poses severe threat to the lives of young people today. The effects of globalisation are shaping the values, attitudes and cultures of young people. All these factors hamper the region’s progress towards achieving the MDGs.

In the Pacific, young people make up a large proportion of a country’s population. About 65% of the total population are 25 and below while 28% fall in the vulnerable ages between 10-25 years\(^8\). A high proportion of them are in schools and largely dependent while many have left school but do not have any form of paid employment. Youth poverty due to lack of employment opportunities is a major problem in the Pacific and constrains the implementation of youth development programmes.

Poverty makes it difficult to obtain the basic resources for living – food, shelter and water. It fuels other development challenges such as poverty-driven crimes and violence, risk behaviour, and compromised health. In order to realise the MDG targets, investing in young people and addressing poverty issues are critical.

#### Challenges for young people

<table>
<thead>
<tr>
<th>The challenges for young people making the transition to adulthood are greater today than ever before. In the past young men and women tended to move directly from childhood to adults roles. But today the interval between childhood and taking on adult roles is lengthening. Compared to 20 years ago, young people are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Entering adolescence earlier</td>
</tr>
<tr>
<td>☐ Likely to spend adolescence in school</td>
</tr>
<tr>
<td>☐ More likely to postpone entry into labour force</td>
</tr>
<tr>
<td>☐ More likely to delay marriage</td>
</tr>
</tbody>
</table>

As a result of these changes, on average, young people in the developing world have more time and opportunities than ever before to acquire the information and skills for better decision making and choices.

The continuing growth in the absolute numbers of young people and the lengthening period of years they remain unmarried are grounds for increasing and strengthening youth programmes and services – especially education, health and livelihoods.

#### Youth Diversity and Vulnerability

Young people are not a homogenous group and can be categorised according to a number of factors. Their experiences to safely and successfully navigate their transition to adulthood are

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\(^7\) Investing in our Future: a framework for accelerating action for sexual and reproductive health of young people. A joint WHO/UNICEF/UNFPA publication, 2006

\(^8\) Pacific demographic data, 2007: SPC Demography and Statistics Programme
diversified by age, sex, marital status, educational levels, residence and socio-economic status. These experiences are quite different among young people, therefore programming needs to take into account the diverse nature of this group. Based on age, a classification is necessary for planning effective interventions because the needs and priorities of different age groups are different. Four distinct subgroups emerge:

- Early adolescents: 10-13 years old
- Mid adolescents: 14-16 years old
- Late adolescents: 17-19 years old
- Young adults: 20-24 years old

Adolescent health and development (AHD) encompasses the holistic development of young people, particularly during the vulnerable period from 10-24 years. The development approach recognises that social, cultural and economic factors influence the health of individuals. Poor health is the outcome of many factors beyond a young person’s control. However, individual behaviour is a factor of growing importance in the health of young people. Unprotected sex which can lead to STI, HIV and unplanned pregnancy carry many risks for young people. STI-HIV surveillance studies in Pacific island countries reveal low condom use among sexually active young people while teenage pregnancy studies show low contraceptive use. The risks of mortality and morbidity related to unplanned pregnancy and childbirth including unsafe abortion are highest among young women. Children of young mothers generally face poorer health and socio-economic outcomes.

Culture, religion and families play a major part in shaping the development of peoples of the Pacific. The positive relationship among these factors provides a safety-net for young people. However, with increasing globalisation, developmental changes, national instability, rising corruption and poverty, this safety-net has been weakened through the dilution of cultural and moral values. Family life education in the homes and in schools, if delivered and facilitated effectively, can restore and retain the value of culture and religion and educate families to maintain family values.

2.3 GENERAL STATUS OF YOUNG PEOPLE – HEALTH, EDUCATION AND LIVELIHOODS

Among PICs, access to health, information, education services is lacking. This is also true within countries between urban and rural areas. Women and girls are generally more disadvantaged in Melanesian countries because of the social status they inherit. Due to the effects of globalisation and changing lifestyles, disadvantaged and marginalized groups are emerging in increasing numbers.

With scarce quantitative and qualitative data, it is difficult to quantify the magnitude, the diversity and complexity of social and health problems affecting young people in the PICs.

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9 Second Generation Surveillance Surveys (SGSS) of HIV, STIs and Risk Behaviours in six Pacific island countries (2004-2005), WHO, SPC, UNSW, Global Fund
10 Teenage Pregnancy studies in Fiji, Tonga and Tuvalu, AHD Project
11 A study on clinical outcomes of births to teenage mothers in CWM Hospital in Fiji (2007)
Available information shows great variations among countries but some inter-related youth problems stand out, listed as follows:\(^\text{12}\):

- Unemployment among school leavers
- Early discontinuation of school
- Motor vehicle injuries – mostly related to alcohol consumption
- Youth Substance Abuse and Smoking (including marijuana and betel nuts)
- Unsafe sexual behaviour and practices resulting in increasing STIs and HIV/AIDS and teenage pregnancy
- Youth living on streets
- Youth crime and involvement in civil unrest
- Lifestyles and nutrition-related conditions such as obesity, diabetes, high blood pressure, cardiovascular and other system diseases

The education systems in the Pacific island countries are heavily academic in nature and concentrate on preparing students for attaining the highest level of academic achievements. They do not adequately prepare young people with life skills to help them deal with everyday challenges, and the livelihood skills to prepare them earn a living. Very few schools have adopted student centred education and participatory learning methods. Incomplete attainment of both primary and secondary education is common. While educational standards and enrolment are highest in Fiji and Polynesian countries, they are quite low in Micronesian and other Melanesian countries, especially Marshall Islands, PNG, Solomon Islands and Vanuatu where the rate of primary school enrolment can be as low as under 50%. Low education constrains youth development and limits livelihood and employment opportunities.

Increasing idleness and unemployment among young people is a major socio-economic problem in all Pacific island countries. Young people who are idle and do not have paid employment become increasingly vulnerable and at risk of dangerous behaviour and practices that can harm their health and development. Limited education is a major factor towards increasing unemployment rates among young people and prevents them from gaining livelihoods. Young people who remain idle are more prone to engage in other problems such as crimes, drugs, prostitution, violence and other delinquent activities.

### 2.4 SEXUAL AND REPRODUCTIVE HEALTH ISSUES (SRH)

Many adolescents are engaged in unprotected sexual practices. Data confirms that large proportions of young people become sexually active during middle and late adolescence and put them at risk of SRH problems, particularly early pregnancy and STIs.

**Sexually transmitted infections (STI) and HIV**

Chlamydia, gonorrhoea and syphilis are the most common STIs in the region. The diagnosis of an STI is a sensitive marker for risk sexual behaviour. A joint study by WHO, UNSW and SPC in six island countries\(^\text{13}\) showed STI prevalence as high as over 40%. The same study showed STI prevalence was higher among younger women below age 25years than older women. Chlamydia infection was found to be particularly high with rates as high as over 30% in some

\(^\text{12}\) The State of Pacific Youth (2005): a joint publication by UNICEF/UNFPA/SPC, funded by NZAID

\(^\text{13}\) The six countries include Fiji, Kiribati, Samoa, Solomon Is, Tonga and Vanuatu - SGSS
countries. The study also revealed that Chlamydia prevalence rate was higher among younger women below 25 years than it was for older women. The study also showed limited knowledge about how HIV is transmitted, low rates of condom use particularly among young people, and increasing commercial sex.

**HIV** is a cause for concern even though it has a slow growing rate among young people in the Pacific. Except for Papua New Guinea which has reached epidemic rates of approximately 2% of adult population, followed by New Caledonia, Fiji, French Polynesia and Guam, the rest of Pacific island countries remain low (below 100 cumulative cases per country). Low HIV rates can also be due to under-diagnosis due to limited VCCT sites; poor accessibility of at-risk populations to VCCT; low perception of risk and therefore poor uptake of testing; and limited professional and institutional capacity in HIV diagnosis. In spite of the low prevalence, PICs cannot afford to be complacent because there are significant risk factors for HIV transmission in all countries.

**Unplanned Teenage Pregnancies**
Most teenage pregnancies occur outside marriage and constitute a significant risk factor for unsafe abortion, perinatal and infant mortality, and maternal morbidity. Hospital service data shows that the proportion of births to teenage mothers range from a relatively low rate of 5-6% of total births in Tuvalu and Tonga to as high as over 20% in Marshall Islands and Federated States of Micronesia. The teenage fertility rate\(^\text{14}\) ranges from as low as below 20 per 1000 in Tonga, increasing to 70 per 1000 in Kiribati and Solomon Islands and to a high 90 per 1000 in Vanuatu and Marshall Islands. While the majority of young mothers were single when they fell pregnant, many of them got married by the time they gave birth to remover stigmatisation. Marriage by convenience is a way of gaining social acceptance.

In PIC countries, abortion is illegal and therefore unplanned/unwanted pregnancies carry a high risk for young women some of them resorting to dangerous methods of abortion. Many cases of out-of-wedlock pregnancies force young people to enter marriage and assume parental roles early, setting an early phase of socio-economic difficulties and the likelihood of breeding poverty. The consequences of adolescent pregnancy are many; hence young women need to be protected. Small scale studies of teenage pregnancy in the region indicate that many cases are the result of forced sex and sexual abuse.

**Sexual Abuse**
Largely under-reported, sexual abuse is increasing in Pacific communities. Young people, both girls and boys are being sexually exploited and abused. Often, abuse is fuelled by poverty. Children subjected to sexual abuse in childhood lose self-esteem and feeling of control over their lives, which increases their risks of substance abuse and involvement in sex work later in life. Accurate and meaningful data on violence and sexual abuse of early adolescents are not easy to obtain. Research could shed light on the extent of sexual abuse among young people in the Pacific. Current SRH programmes are weak in incorporating strategies to address sexual abuse, exploitation and violence. Laws requiring mandatory reporting are also weak.

\(^\text{14}\) Number of births per 1000 females aged 15-19 yrs
Sex work largely fuelled by increasing poverty and social problems is on the rise. Young people become victims of such situations where they are forced to carry out sex work as a means for livelihood and survival. Strategies to address the long-term protection of young people from such poverty-driven practices will have to address the root causes of poverty and provide practical options and alternatives for job opportunities and earning a living among young people.

2.5 SEXUAL BEHAVIOURS AND PRACTICES

This sub-section summarises common behaviours that contribute to sexual and reproductive health practices while the next sub-section discusses the underlying factors within these behaviours, such as knowledge, attitudes, skills, environmental opportunities and barriers. In planning strategic interventions, it is important to take all these factors into account.

Sexual Debut: There is increasing evidence that age of sexual debut among Pacific youth is decreasing, as young as early adolescence. In general the education system does not adequately discuss safety and protection regarding early sexual activity.

Low use of Contraception: Contraceptives are generally considered for married couples and therefore use by young unmarried people is seen as immoral. The continuing high rates of unplanned pregnancy reflect non-contraceptive use among sexually active young people.

Use of Condoms: In general, condoms are not used enough to prevent STIs, HIV and pregnancy. Slow uptake of female condoms is beginning to show in some countries (Solomon Is and Fiji). Studies have illustrated the links between condom use and prevalence of STIs15. Regular and consistent use of condom is low and therefore sexually active young people are vulnerable to STI, HIV and unplanned pregnancy.

Multiple and concurrent partners: Although viewed as risk behaviours, young people often engage in more than one partner either at one time or over time. Extramarital and premarital sex occurs at high levels, especially among vulnerable and at risk groups. Partners of pregnant women are vulnerable to having other partners with risks of transmitting STIs which in turn, has the potential for causing secondary infertility.

Forced sex including gang rape: While this type of sexual behaviour is increasing in the Pacific region, it is largely under-reported due to shame and stigma. Exploitation of young girls and boys needs to be explored further. Sex Work: Both male and female sex work exist in the region largely fuelled by poverty but there is little information about the nature and extent of commercial sex.

Health seeking behaviours
Generally young people know about unsafe sexual practices and the risks involved but they are hesitant to seek or take preventive measures. Thus a huge gap exists between knowing and practising safe behaviours. Clinic records indicate that the main reason for attending clinics is to check for STI and pregnancy. This shows that they seek health services only when a problem has occurred – mostly when they suspect they have an STI or are likely to be pregnant.

15 Second Generation Surveillance Surveys of HIV, STIs and Risk Behaviours (WHO, SPC, UNSW: 2006)
2.6 DETERMINANTS OF YOUTH BEHAVIOUR & PRACTICES

The factors that explain why young people engage in certain behaviours are not conclusive. It is likely that a number of factors interplay for a certain behaviour or practice and include: knowledge, skills, attitudes and values, environmental opportunities, and barriers. In planning strategic interventions, it is important to take all these factors into account.

(a) Knowledge-Practice Gaps: Although lots of information and educational activities have been implemented, there are still wide gaps between knowledge and practices, indicating that the process of “behaviour change” in young people has not been accomplished. Even then, studies show that basic knowledge about contraception and prevention of pregnancy and STI transmission is still lacking. Hence, in planning strategic interventions, the issues of inadequate knowledge and knowledge-practice gap have to be addressed through practical BCC strategies.

To know the sources of SRH information and ways to protect themselves, young people need to have access to this information through the most effective channels and taking into consideration literacy level, educational systems and cost-effectiveness of approaches. The range of information channels including mass media, community advocacy, community mobilisation, non-formal and formal educational approaches and peer education programmes. The effectiveness of these programmes, if they have been implemented, will need to be objectively reviewed.

(b) Skills Development: Life skills building to help translate information and knowledge to make responsible decisions have been lacking in many youth development programmes. While young people may have adequate knowledge about SRH, they do not necessarily have the skills to make right choices. This knowledge-skills gap affects their behaviour.

(c) Attitudes and Values: Societal values surrounding sex before marriage do affect young people’s perception about SRH issues and ultimately their health seeking behaviours and practices. STIs, HIV and pre-marital pregnancy are generally viewed negatively and are stigmatised. Societal attitudes towards family planning and contraception greatly influence use of contraception and methods used. Contraception outside marriage is viewed as immoral while condom promotion is associated with promiscuity and multiple partners and therefore immoral as well. In the Pacific where culture, tradition and religion shape society’s value system, it is important that this context is considered when in programme planning.

(d) Environmental Factors:

Beyond those factors at the individual level, there are environmental factors that also affect behaviour. These factors may offer opportunities for, or pose barriers against responsible decisions to protect and safeguard against SRH problems. Environmental opportunities include enabling policies that support youth-friendly services, competent service providers, easy access to SRH services including condoms and contraceptives, effective peer education, and policies that support social marketing and community-based distribution of condoms and contraceptives.

Most countries have in place national youth policies that address youth development in support for achieving national development goals. However, many policies are not well
implemented as they do not translate effectively into operational plans and interventions that respond to the needs of young people. Constraints to developing a comprehensive plan of action for youth programmes may be related to inadequate national commitment and leadership; lack of drive; and inadequate local capacity to mobilise partners and resources.

National AHD strategic plans need to be built on existing youth and SRH policies where they exist. Revisiting these plans may be required in some countries to strengthen their focus on AHD priorities and ensure that the principles of rights-based approach and non-discrimination practices are incorporated in accordance with international guidelines and commitments. Adequate operational and behavioural research need to be considered to inform policy making.

Beyond individual and environmental factors, other broad developmental factors also contribute to youth issues. Therefore, in planning for achieving long-term outcomes, it is important to take into consideration factors that contribute to the issues facing young people.  

16 The State of Pacific Youth (2005): joint publication by UNICEF, UNFPA and SPC; funded by NZAID
3. VISION, MISSION, GOAL AND OBJECTIVES

3.1 VISION STATEMENT

The vision of the Regional Pacific AHD Programme adopts the UNFPA’s vision\(^{17}\) for adolescents and youth, as quoted below:

“A world fit for adolescents and youth is one in which their rights are promoted and protected. It is a world in which girls and boys have optimal opportunities to develop their full potential, to freely express themselves and have their views respected, and to live free of poverty, discrimination and violence” (UNFPA 2006).

3.2 MISSION STATEMENT

The Joint AHD Programme is a multi-country initiative is designed to safeguard and protect the sexual and reproductive health of young people, thereby contributing to their holistic health and development and helping them to live to their full potential.

3.3 GOAL

The goal of the AHD Strategic Plan is to support the safe and healthy development of young people through information, education, counselling and provision of youth-friendly services designed to achieve a healthy and a socio-economically satisfying life.

The joint AHD programme aims to assist national governments and partners in the implementation of AHD initiatives in the Pacific region, with a special focus on sexual and reproductive health. Other related areas of youth development will be taken into account in partnership with other agencies such as IPPF, ILO, WHO and UNESCO. Drawing on its vision, mission and goal, and through collaboration with partner agencies and stakeholders, the joint AHD programme will work to:

i. Enhance a supportive policy environment for adolescent health and development

ii. Enhance a supportive community environment for youth health and development

iii. Empower youth with knowledge, attitudes and skills for informed choices through adoption of the rights-based approach

iv. Provide access to youth-friendly health services

v. Encourage young people to participate fully in development plans

vi. Connect young people to livelihood and employment programmes

vii. Recognise the special needs of vulnerable and high risk groups, including the economically disadvantaged and the socially marginalised, for their right to a fair share of education, skills and services.

\(^{17}\) UNFPA Framework for Action on Adolescents & Youth: 4 Keys to open doors with Young People
3.4 OBJECTIVES AND RESULTS

The AHD programme will adopt a results-based management (RBM) approach and achievement of programme results will take place at four different levels: input, output, outcome and goal levels. Inputs are required for planning and implementing activities and interventions in order to produce outputs. Results and achievements at output level are intended to feed into results at outcome level (behaviour change), which will ultimately contribute to achievements of the overall goal of the programme (impact level).

I. Results at Goal level (impact level)

Results at goal level reflect programme contribution to the overall long-term impact. They are measured by the following indicators which can be derived from population-based socio-behavioural research and health studies:

1) Reduction in teenage pregnancy rates
2) Reduction in STI rates among young people
3) Reduction in HIV infection rates
4) Improvement in general health status – eg reduced infant/child/maternal deaths.

II. Results at Outcome level (behaviour level)

Results at outcome level reflect programme contribution to the intermediate effects on changed behaviours among service providers for improving provision of quality services, reduced risk behaviours among young people, positive attitudes and behaviours for using services, and general improvement of quality of life. Indicators to measure results at outcome level can be derived from population-based socio-behavioural research and health studies. Common Indicators and include:

- Changed behaviour among service providers to providing youth-friendly service
- Changed attitudes, behaviour and practices among YP to accessing and using SRH services
- Increased clinic utilisation rates in established youth facilities
- For Adolescents not yet sexually-active: delayed sexual debut in different age groups
- For sexually-active Adolescents: Reduced rates of unprotected sex through increased use of contraceptives & condoms; Reduced numbers of concurrent partners.

III. Results at Output level

Results at output level reflect the results of utilising resources and inputs in implementing activities, interventions and service delivery. Indicators to measure results at output level are more tangible and measurable than results at outcome and goal levels. They can be derived from programme-based and service-based data. Specific indicators will fall under each of the four Outputs in the SDP and include (refer to logframe for list of indicators under each output).

IV. Results at Activity and Input level

Inputs include personnel, funds, materials, methods, tools, facilities, commodities and supplies required to implement activities and interventions. Implementation of activities is designed to produce the expected outputs which in turn are expected to contribute towards the achievement of outcomes and goal.
4. KEY OUTPUTS OF THE STRATEGIC PLAN

Strategies will be developed under four programme areas designed to support the delivery of a comprehensive multi-sectoral AHD programme. The four areas are described below as key programme outputs. Interventions and activities under each Output are described in the next Section.

![KEY AHD OUTPUTS](image)

### 4.1 APPROACHES TO DELIVERY OF OUTPUTS

To ensure a comprehensive approach is taken in identifying the best mix of strategic interventions and activities, two approaches\(^{18}\) will be applied for each Key Output. Firstly, an exploration of the issues at policy level is necessary to guide the policy direction of each strategic output. Secondly, a careful analysis of the key programme areas is required to guide the programming direction. A number of guiding principles and cross cutting issues will facilitate the implementation of programmes and these are described under programming direction.

The strategic direction will build on Phase 1 achievements to roll out programmes at country level to expand and increase coverage so that rural and outer island provinces gain access to AHD programmes and services. In order to achieve this, there is a need for increased national capacity so that country teams can take expanded roles in moving towards programme expansion, up-scaling, ownership and sustainability.

The concept of focusing on “most at risk young people” (MARYP) and most at risk populations (MARP) will be applied when planning interventions. Efforts will be made to reach these groups with targeted interventions so that programme benefits reach those who are in greatest need.

#### 4.1.1 Policy Direction

The strategic policy direction on adolescents health and development is defined at two levels—firstly by addressing policy dialogue and secondly by fostering partnerships.

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\(^{18}\) Adapted from UNFPA Framework for Action on Adolescents &Youth: 4 Keys to open doors with Young People
**i) Policy Dialogue:** This involves rationalising the issues of young people in the overall development context guided by the ICPD and MDGs, and supporting their inclusion in national policies and development frameworks. The programme will strengthen its participation at policy level in order to position AHD more strongly as a sound investment for the achievement of national development and poverty reduction. Activities under policy dialogue will include:

1) Position AHD using demographic and research data (e.g. DHS, AHD operational research, situation analysis, programme reviews) that relate population dynamics to overall development, the MDG and ICPD frameworks and other regional goals. This will provide a political impetus for galvanizing governments and partners to increase their support for adolescents and youth.

2) Build capacity at national and regional level to be able to undertake policy analysis aimed at identifying the extent to which adolescents and youth issues are addressed in national policies, mapping of vulnerable and marginalised groups, and addressing constraints to implementation.

3) Facilitate a conducive policy environment by supporting laws that protect youth and promote their rights – e.g. raising age of marriage, mandatory school up to a certain age, support non-discrimination of pregnant girls in schools, and ensure access of young people to SRH information and services.

4) Review youth policies to incorporate SRH, gender equality, youth empowerment, employment, education and highlight their linkages with other youth development issues and ensure that policies are translated to operational plans.

5) Ensure that youth issues are mainstreamed at all levels of development, extending from policy level to community-based implementation.

**ii) Partnerships and Alliances:** This involves fostering partnerships with sectors in addition to those traditionally devoted to adolescents and youth – such as youth ministry labour ministry, and other government sectors, NGOs, religious and community leaders, private sector and other stakeholders including young people themselves. Undertaking a multi-sectoral approach will include these activities:

a) Widen the partnerships to include other regional youth programmes such as the SPC youth section of the Human Development Programme, Commonwealth Youth Programme, NGOs, youth councils, community-based youth groups and other youth-serving organizations.

b) Build alliances with key national actors, leaders and parliamentarians to mainstream youth development in national development plans and poverty reduction strategies (e.g. Pacific Parliamentary Assembly on Population and Development (PPAPD)).

c) Build synergies with other development partners, including WHO, ILO, IPPF, UNESCO, AusAID and NZAID, and other interested partner agencies including SPC’s Public Health Programme.

d) Incorporate the broad issues related to Education and Employment as key factors in the lives of young people – use them as entry points for SRH education and services.
e) Document successful stories and lessons learned for best practices to showcase AHD programme and to form the basis for replication, expansion and scaling up.

The plan acknowledges that policy dialogue, policy analysis and partnerships must translate into field action and that adequate resources are allocated. Experiences from programme implementation and evidence-based information must continuously inform policy dialogue and partnerships.

4.1.2 Programming Direction

The implementation of interventions and activities under each Output will integrate a number of key cross-cutting approaches and apply selected guiding principles to improve delivery and strengthen effectiveness of programme delivery. These are described below:

a) Multi-sectoral Approach – To be able to address the wide range of young people’s issues, the AHD programme will cross boundaries between sectors and encourage new partnerships with other agencies to link SRH issues with other adolescent development issues. The sector-wide and inter-sectoral approach aims to solicit support and participation from other sectors, noting that the determinants of health and development are broad and cuts across different sectors. The value of working with other sectors should be realised as this helps to address young people’s needs in totality rather than fragments. It is becoming more evident and well documented that programmes that target young people need to highlight the importance of addressing the underlying causes of youth problems rather than just the symptoms.

b) Youth Participation – The ICPD plan of action emphasize involving young programme design and implementation as a way to increase the relevance of interventions. This promotes the participation of young people in programme delivery from policy dialogue to programme planning, implementation and monitoring with special attention to the application of rights-based approach and youth-adult partnerships. Young people will be given the opportunity to participate at appropriate levels of programme the planning cycle so that their views and voices are taken into consideration and applied as appropriate.

c) Health Systems Approach – To work towards sustainability of programmes and services, it is essential that there are long-term plans for supporting health systems and capacity building. Capacity building in AHD programmes should focus on all aspects – advocacy methods, development of educational approaches including Family Life Education, provision of youth-friendly services, operations research, and health systems management. AHD should be recognised as an integral part of the national reproductive health programme within the broader public health division, and delivered using the primary health care approach.

d) Programme Focus – this plan attempts to move away from “project focus” which often implies a short-lived period of intervention and lacks sustainability. Therefore, the focus is to define and design interventions that can be absorbed into existing programmes in the long run. Efforts will be made to enhance and harmonize programming processes through collaboration with governments and NGOs.
e) **Evidence-based Information** – Analysis of available demographic data, operations research information, report findings and information from other sources will be used to strengthen evidence-based youth programming. Efforts will also be made to review Phase 1 activities and to use the findings in this process.

f) **Inter-generation Dialogue and Community Mobilization** – To engage communities including parents, families and religious leaders to understand and support AHD issues and promote dialogue between elders and young people, activities that encourage inter-generation communication should be incorporated into community-based interventions. Community participation involving parents, community leaders and influential groups allows improves effective parent-child communications and relationships.

g) **Risk Approach and Targeted Intervention** – AHD programmes and services should be equitable, inclusive and do not discriminate. Young people are not a homogenous group and to develop effective interventions, they can be grouped as young adolescents 10-14; middle adolescents 15-17; late adolescents 18-19; and young adults 20-24. The health and development needs and priorities of each group are different in certain aspects although overlaps are recognised. Young people can also be sub-grouped based on vulnerability and level of risk factors. The programme will target vulnerable groups engaged in high risk behaviour and marginalised groups by mapping out places where they converge and plan targeted activities. Special focus will also be made for young adolescents below age 14years who are often left out from the programme.

h) **Guiding principles** – A number of recognised guiding principles will guide the implementation of the AHD Strategic Plan, where applicable. Briefly they include:

- **Rights-based Approach**: The rights-based approach to sexual and reproductive health adopted at the 1994 ICPD is a global policy consensus on the need to empower both men and women to understand these rights. Exercising them will help make responsible reproductive health decisions that have the potential to improve quality of life.

- **Gender-sensitive approach** implies that intervention for sexual and reproductive health should take into consideration gender equality and equity. The needs of the most disadvantaged and marginalised should be taken into account when formulating policy, programmes and services. In AHD gender equality means equal treatment of young women and men to have access to resources and services, without discrimination. Gender equity means fairness and justice in the distribution of benefits and responsibilities between women and men.

- **Gender Empowerment**: Understanding gender roles and expectations and how they impact on hindering equal rights and status of women with adverse consequences that affect family, socioeconomic status and health is crucial for young people from an early age. Therefore recognition of gender issues and promoting gender empowerment in all strategies and activities will help contribute to the achievement of the long-term goals of advancement for young women.
Health Promotion Approach The strategic plan adopts the application of five core actions of health promotion endorsed under the Ottawa Charter\(^{19}\). The core actions of Health Promotion include:

1. Building Healthy Public Policy
2. Creating Supportive Environments
3. Strengthening Community Action
4. Developing Personal Skills
5. Reorienting Health Services

Strategies and programmes should be adapted to local needs and take into account differing socio-economic, cultural and political systems.

Primary health care\(^{20}\) Approach (PHC): The implementation of the AHD Strategy at country level will adopt the principles of PHC comprising health promotion, community participation, collaborative partnership and resource mobilisation.

4.2 DESCRIPTION OF OUTPUTS

This section describes the major interventions and activities under each Key Output. It must be emphasised that these do not form a conclusive list of interventions and countries may design other innovative country-specific strategies not described in this document. Each intervention can only be implemented effectively if it is well planned and coordinated. It is therefore important that detailed descriptions of intervention strategies and activities are documented in the country-specific annual workplans with its accompanying logframe.

### Output 1: Supportive Policy Environment and Enabling Community Environment

(1) Rationale

The joint AHD programme will work alongside national youth policies and incorporate youth issues in national development plans and poverty reduction strategies. To create a supportive policy environment, strong arguments for investing in young people will be identified, packaged and communicated to national leaders and policy-makers as basis for policy dialogue with ministries of youth, women, education and health. The arguments are based on the following analysis:

(a) Demographic reasons – A number of Pacific countries\(^{21}\) (Fiji, Samoa, and Cook Is) are going through a demographic transition where there is increasing concentration of population in the productive ages, particularly the 15-25 age groups. The so-called demographic window

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\(^{19}\) The Ottawa Charter is the outcome document of the first International Conference on Health Promotion (1986) and comprises five key health promotion actions, adopted as guiding principles to achieve better health.

\(^{20}\) Primary Health Care is essential health care made accessible at a cost which the country and community can afford, with methods that are practical, scientifically sound and socially acceptable (WHO, 1998).

\(^{21}\) Pacific Demographic Data, 2007: SPC Demography & Statistics Programme
of opportunity, brought about by falling fertility and mortality rates, allows governments to reap the benefits of having a growing segment of working-age adults relative to dependent population. To make this a reality, more investment in education, employment, delaying early parenthood and supportive adolescent health services are needed. Countries should be encouraged to take this opportunity to make the right socio-economic investments to overcome the poverty trap. The demographic health surveys (DHS) recently completed by UNFPA and SPC for Solomon Is and Marshall Is are sources of useful data to facilitate policy dialogue.

(b) **Economic Gains** – The prospect of achieving economic development is connected to potentials for increasing productivity and investments if young people are better educated, gain employment and are in good health. A declining fertility rate and slower population growth provides a unique chance to spur economic development as the workforce increases and the dependency ratio decreases.

(c) **Sexual and Reproductive Health Issues** – Early pregnancy interferes with educational opportunities for young mothers because they are unlikely to return to school and complete their education. Poor education curtails employment opportunities. There is considerable evidence that children of young mothers are generally disadvantaged from an early start regarding health status and socio-economic circumstances. Early and unplanned parenthood increases the burden for their families and diminishes their chances for escaping from poverty. Half of STIs and HIV occur in young people below 25 years while the majority of new HIV infections fall in the under-29 age group. An AIDS epidemic in small Pacific island countries can potentially cause widespread poverty and wipe out large populations.

(d) **Gender Issues** – Gender discrimination hinders prospects for escaping poverty and development. The single factor consistently associated with lower child mortality and lower fertility rates is female education. National data systems often show gaps in highlighting the disadvantages women face while their contributions to family and national economy are under-reported. Such gaps need to be addressed to generate a strong basis for investing in and empowering women and young girls as strategies for poverty reduction and sustainable development.

(2) **Policy Direction for Enhancing Policy Environment**

The strategic plan will work towards initiating policy dialogue and advocacy to ensure that the implications of population dynamics are incorporated in poverty reduction strategies and other relevant policies (e.g. youth policy). The issues of young people will be included in policy dialogue while linking processes in youth policy development with discussions on poverty reduction and other development frameworks. In these policy dialogue processes, efforts will be made to engage other partners and stakeholders (especially with Statistics & Demography programme of SPC and national statistics offices in project countries) to discuss the need to:

1) Consolidate and utilise relevant youth-related data (e.g. DHS, census and research data) to facilitate policy dialogue on the need to invest in youth and poverty reduction.

2) Utilise data to illustrate how lack of youth programmes and services contributes to the poverty cycle.
3) Establish and use evidence-based information to illustrate the dynamics between Gender, SRH, education and poverty reduction.

(3) Programming Direction

The plan will build on past efforts of AHD Phase 1 to further mobilise support of key stakeholders through:

1) Mapping key partners and stakeholders influencing AHD at different levels (regional, national, provincial, household level). Linkages will be made with the Pacific youth mapping exercise undertaken earlier by SPC’s human development programme (HDP).

2) Developing advocacy packages to support the investment in young people and highlighting the long-term benefits for poverty reduction and contribution to MDGs related to education, gender equality, maternal mortality, and HIV prevention (MDGs 2, 3, 4, 5, and 6).

3) Organising sensitisation programmes to mobilize stakeholders – governments, NGOs, CBOs, FBOs and communities.

4) Sharing and using data on youth that illustrates the relationships between population dynamics, issues of young people and the implications for youth poverty reduction.

5) Developing advocacy models on issues of education, sexual and reproductive health, gender equality, and unemployment to demonstrate how changes in population structures affect youth development.

6) Leverage data on youth for development and poverty reduction.

(4) Creating an Enabling Community Environment

Creating an enabling environment at community level is necessary before other strategies can be conducted. Sustained behavioural change needs a supportive enabling environment within which communities and individuals can exercise changed behaviour. These include government policies, national structures, systems, and participatory programmes. An enabling environment may need to change values and practices, cultural beliefs, perception and views on AHD issues, and changes in socio-economic status and gender relationships of people.

For building an enabling and supportive community for AHD, on-going community-based meetings, seminars and consultations with influential community groups will be conducted. Further, two strategies will be undertaken to provide ongoing support for sustaining an enabling environment – Advocacy and Social Mobilisation.

Advocacy

This is a continuous and adaptive process of gathering, organising and formulating information into argument for supporting adolescents and youth. The information is to be communicated to policy level through various interpersonal and media channels with a view to influencing their decision towards raising resources, political and social leadership, and thereby influencing societal acceptance and support for AHD initiatives. There is a need to review advocacy activities undertaken in Phase 1 before embarking on new initiatives. Based on this review, models for advocacy will be developed.
AHD Advocacy Package
An information package containing a variety of AHD fact sheets, behaviour change communication (BCC) materials, and advocacy tools using print and audio-visual materials will be developed to support programme implementation. Expertise in this field will be required. BCC strategies will aim to address changed policy and community behaviour under Output 1 and changed adolescent behaviour under Output 2 and 3, and take into account socio-cultural norms and other issues which can foster, or inhibit a supportive environment.

Social Mobilisation
Social mobilisation is a process of bringing together all feasible and practical inter-sectoral social partners and allies to determine a felt need and to raise awareness of and demand for a particular development objective. It involves enlisting the participation of such actors, including institutions, groups, networks and communities in identifying, raising and coordinating human, material and financial resources thereby increasing and strengthening self-reliance and sustainability of achievements. Mobilisation approaches and processes, including stakeholder analysis will build on Phase 1 which already has set the scene for multi-sectoral approach.

(5) Resources to support Output 1
In order to implement activities under OUTPUT 1 and achieve results, funding support is required. Funds estimated at $390,000 over 4 years will be required to support Output 1 activities. A communications officer will be required during Year 1 & 2 to develop advocacy tools and communications package, standardised at regional level and then adapted to suit needs of participating countries.

The main activities include:

☐ Develop and package advocacy and communication materials, tools and approaches to facilitate policy analysis and dialogue.
☐ Develop methods and approaches for conducting Advocacy and Mobilisation activities at policy level and at community level in all countries.
☐ Recruitment of a Communications Officer to facilitate the planning, coordinating and the production and delivery of Output 1. The Officer will also provide inputs for the implementation of BCC activities under Output 2 and will work in close collaboration with expertise in this field from UNFPA and UNICEF to share experiences and resources. The position is funded for the first two years only. A programme review at end of year 2 will determine if the position should be continued.

The budget estimate to support Output 1 is summarised as follows:

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Output 2: Strengthened SRH Information and Education for Young people

Effective information, education and communication are essential for attitudinal and behavioural change. Programmes require better understanding of educational and communication strategies and their application to change attitudes and behaviour. Communication is essential to address responsible sexual behaviour, responsible parenthood, teenage contraception, prevention of STI and HIV, gender-based violence, gender discrimination, male responsibility in SRH, reproductive rights and other related topics.

(1) Rationale for Supporting AHD Information and Education

The benefits of achieving universal coverage of primary and secondary education are well known. Every person’s right to education is the key to gain employment and access to healthcare, nutrition, income for well-being and exercise of civil and political rights. Education allows young people to better understand the linkages between behaviour and outcomes, and the importance of preventive measures. It enhances competencies to assertively demand for services and exercise human rights.

There should be a link among schools, families and communities to allow individuals to function effectively in a range of social roles. Schools are seen as institutions where young people can best develop their capacity for lifelong learning and thus are best environments for creating enabling conditions for successful transition to adulthood. They can be instrumental in developing life skills among young people; especially critical thinking, decision-making and negotiation skills that help them cope with positive and negative life experiences.

While it is ideal to teach SRH as part of the school curriculum, not all young people gain opportunities to complete secondary school level and many are not at school by age 15. In the formal setting, the AHD Programme will work with the Ministry of Education to deliver family life education (FLE) as part of the school curriculum. In the non-formal setting, the learning and teaching of SRH will be delivered through Peer Education.

FLE is an educational programme designed to build knowledge, skills and attitudes in young people about sexual and reproductive health and related topics in the context of youth development. It aims to assist young people make informed choices to help them live a safe and healthy life. Unprotected sexual activity poses the risks for STIs, HIV and unplanned pregnancy. While girls are more vulnerable, intervention strategies should ensure that both girls and boys are educated and sensitized to responsible behaviour. Special attention should be paid to younger adolescents who are often missed out because programmes largely target older adolescents. Extracurricular educational activities targeting younger adolescents can supplement in-school FLE programmes.

(2) Policy Direction

The plan proposes strong policy dialogue to increase access of young people to education and to address gender equality for boys and girls. The dialogue should highlight the importance of investing in education as a fundamental strategy for poverty reduction. Policy dialogue with
Ministry of Education should provide the rationale for FLE as a long-term strategy for addressing SRH issues among youth and the achievement of the MDGs. It is important to document the processes undertaken to solicit agreements at policy level for reference and for sharing best practices among countries. FLE should adopt the rights based, gender-sensitive, and culturally-sensitive approaches.

Data and research information are important for documenting accomplishments and gaps of the education system, useful for policy decisions. A multi-sectoral collaborative approach is essential for maintaining and strengthening the commitments and partnerships of government ministries, NGOs and partner agencies for FLE and other educational activities.

(3) Programming Direction

The two main subcomponents under Output 2 are Family Life Education and Peer Education. Efforts will be made to build on Phase 1 experiences to apply lessons learned and best practices. Two tools for supporting the delivery of FLE and Peer Education include Life Skills approach and the use of Behaviour Change Communications model (BCC). Both tools will be applied in implementing FLE and Peer Education programmes.

(i) Family Life Education

The terms “Sexuality education, reproductive health education, family life education, population education” – all refer to the same type of intervention that aims to educate adolescents and youth about sexual and reproductive health information, using a life skills approach to protect themselves and make wise choices in life. The core elements of FLE include: growth and development, family life and relationships, human sexuality and reproductive health, society and culture, gender, STIs and HIV, alcohol and substance abuse, mental health, Life Skills and responsible parenthood.

FLE is a key focus of the strategic plan which aims to establish itself in schools through a life skills-based, gender-sensitive and culture-appropriate approach designed to enable young people to develop their identities, values, critical thinking skills and to understand their rights to knowledge and access to services. Life skills-based FLE will be promoted either as a stand-alone subject or integrated into the existing school curriculum. The learning and teaching of FLE will start at primary level and delivered in an age-appropriate manner. Countries will be assisted in FLE curriculum development, institutional capacity strengthening to teach FLE, materials development, teacher training, and development of tools for monitoring and evaluation purposes.

Efforts will be made to critically review, analyse and replicate best practices and effective models of various initiatives implemented during Phase 1, with particular reference made to
the findings of the AHD programme review undertaken in 2007. Countries will systematically undertake this review in year 1 of the strategic period and use the findings to expand the programme. Countries that have undertaken the FLE situation analysis (e.g. Vanuatu and Solomons) will be given first priority in accessing support and funding to further develop FLE programmes.

The development of FLE curriculum will adopt a life skills-based approach and apply the concepts of BCC. It will be taught either as a separate subject or integrated into other subjects. The teaching of FLE will start at primary school and progress through secondary school in an age-appropriate manner. This will ensure that all students will learn adolescent health and development issues in a consistent manner while attending school.

A major challenge with family life education (FLE) is the lack of capacity and resources for developing and teaching comprehensive FLE in schools, and this should be taken into account when planning FLE programmes. Activities will build on early initiatives conducted in Fiji, the findings of FLE situation analysis, and other country assessments related to FLE.

The Life Skills-based approach is a style of teaching and learning that aims to develop social skills that help young people to manage the demands and challenges of their daily situations. Life skills are applied in different settings to cope with the range of demands in various situations. Life skills can be used during childhood, adolescence and youth, adulthood and old age. The teaching of FLE will apply life skills at different levels to match the different stages of development. LS-based FLE provides adolescents with skills to improve health seeking behaviours that safeguard their sexual and reproductive health. These skills also enable young people to influence their peers, siblings, and friends live a healthy and safe lifestyle.

FLE is designed to start at primary school level, around age 8 years, so that knowledge, attitudes and skills can be taught early. Establishing a positive mindset towards sexuality and reproductive health helps to build healthy and safe lifestyles from an early age. Studies have shown that sexuality education has the potential to delay sexual activity, reduce the number of sexual partners and empower young people to adopt healthy lifestyles and avoid risky behaviour and practices.

It is important to create an enabling environment in schools and communities for sexuality education. Partnerships with groups influential in the lives of young people will be nurtured – teachers, church leaders and administrators, community leaders, service providers and parents. It would be appropriate to establish linkages between schools; peer education and youth-friendly services, including counselling services. The programme will also have the

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22 The AHD Programme was reviewed by two external consultants in May-June 2007
23 Findings of Research brief series in Adolescent Health by Youth InfoNet, Family Health International
option to reach out-of-school youth through youth facilities and community-based settings, in a non-formal approach.

AHD Phase 1 has assisted the development of FLE in Fiji in developing a revised FLE curriculum which reached pilot/introduction stage in 2008. Phase 2 will continue to assist FLE in Fiji to ensure that it rolls out to all levels of secondary school so that it achieves full implementation by 2011. FLE will also be developed in other countries. Situational analysis of FLE in Solomon Islands and Vanuatu has been carried out while preliminary work has begun in Kiribati and Tuvalu. Workshops to introduce the concept of FLE and gauge stakeholder responses were carried out in Tonga and Samoa while the remaining countries are interested to start FLE work. In this regard, an FLE approach is mapped out under as follows:

- Year 1: FLE support to Fiji, Solomon Is, Tuvalu and Vanuatu
- Year 2: FLE support to Samoa, Kiribati, Tonga, Marshall Islands
- Year 3: FLE support to Cook Islands and FSM
- Year 4: FLE programme review in well established programmes for lessons learned.

The main activities under FLE include: creating an enabling environment for FLE, curriculum development, learning and teaching materials and capacity building for FLE teachers. Given the importance accorded to FLE and the large amount of work involved in its development, Phase 2 will recruit a full time FLE Specialist. The FLE Specialist will advise and facilitate curriculum development, local capacity building, teacher training, introduction in schools, monitoring and assessments, and programme evaluation. In some countries it will also be necessary to appoint an FLE focal person to coordinate the development of FLE activities at country level.

(ii) School-based Counselling

Both teachers and students expressed the need for Counselling services in the school environment. Counselling is generally lacking and it is envisaged that the teaching-learning of FLE will create more demands for student counselling. Phase 2 will develop counselling programmes in selected schools in a number of countries who have capacity to train school-based counsellors. Activities will include awareness for counselling services, establishing an environment where counselling services become part of the school activities, build teacher skills in providing counselling long-term and short-term, and supporting schools to furnish a counselling room.

In addition to one-to-one counselling model, another model involves the concept of “student support and care” where support and care is integrated in the classroom environment. It aims to assist the holistic development of adolescents beyond academic achievements. The support package will provide opportunities for teachers to adopt a caring attitude for students, identify students at risk, provide guidance/counselling and support for those who in need, and make referrals to linked youth-friendly services, when necessary. Teachers will need to be trained to adopt changed attitudes and behaviour in expanding their roles from just academic teaching to

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supporting the psycho-social concerns of students. The concept of student support and counselling maximises the delivery of a comprehensive school-based FLE programme.

To introduce this concept and develop an appropriate package for student support and care, consultations with the Ministry of Education and teachers will be necessary. The programme will need interactive teacher-student sessions; this way, teachers will know students better and understand their psycho-social background; identify those that need more help and guidance; and take a more participatory approach into problem-solving by linking students with parents and families and make referrals to other services, if necessary.

In countries where there is interest to establish support and care services for students, a number of schools will be selected to participate in the project. Basic criteria for selecting schools include interest shown by schools, credible leadership in school management, and the presence of a school counsellor.

(iii) Introduction of FLE in Pre-Service Teachers Training Institutions

FLE taught as part of the pre-service teachers training will enable the development of teacher skills in teaching FLE as they graduate. This will increase the number of capable teachers to teach FLE in schools. This approach will be explored in teaching institutions in Fiji and a few other countries in Year 2 of the SDP. In addition training of pre-service teachers in FLE may also consider introducing “care and support programme for students”. The training will include the development of a Support and Care Programme for each school, tasks involved, assessment tools for students, referral and linked youth-friendly services, and monitoring tools.

(iv) Peer Education (PE)

Peer Education has been a major programme in Phase 1 and a number of successful experiences have been derived. The strategy will be further strengthened under Phase 2. Peer Education is a process whereby well trained and motivated young people undertake non-formal educational activities to benefit other young people. The training is aimed at developing their knowledge, attitudes, values and skills, and enabling them to be responsible for protecting their own health.

Peer education involves the use of members of a given group to bring about behaviour change among other members of a similar group by modifying norms, values and attitudes of communities and target groups. PEs are particularly suitable in reaching groups with high risk behaviours (such as sex workers, street children) and vulnerable groups. To be effective, PEs programmes must apply the life skills approach and the BCC model. They must be well planned and developed, and should clearly describe the types of behaviour change to be achieved, including the application of life skills-based Peer Education.

Although a time-consuming and resource-demanding intervention, PE is a cost-effective if focused on selected groups with well-defined specific risk behaviours. It involves reinforcement of BCC with these groups over time. The ultimate aim is to change risky behaviour which can have a significant impact on SRH problems, such as reduction in the
incidence of STIs, teenage pregnancy and substance abuse. Plans will be made to target vulnerable and risk groups. A community mapping of all vulnerable and risk groups will be made and appropriate interventions developed. Such groups might include: unemployed school leavers, adolescent parents, youth engaged in drugs and excessive use of alcohol, sex work, and street dwellers. For unemployed groups, AHD activities and programmes should incorporate livelihood skills training, and securing partnership with ILO to facilitate these activities.

The AHD programme will assist countries in developing school-based PE particularly in schools that have introduced FLE curriculum. School-based PE will reinforce FLE teaching and learning facilitated by FLE teachers. PE in the school setting is easier to manage and coordinate because it takes place within a disciplined institution and Peer Educators can reach their peers easily within the school environment.

Phase 1 developed a number of PE programmes in varying scales with varying effectiveness. PE models developed include MOH-based PE, school-based PE, NGO-based PE, institution-based PE (University of the South Pacific), and community-based PE. Phase 2 will evaluate existing PE projects before plans are made for expansion and up-scaling. It will also work towards completion of the Peer Education guidelines and PE training manual as tools for standardising and strengthening PE in the region.

**Tertiary level Peer Education:** This is a new PE initiative which commenced in 2008 will be expanded in Phase 2 to other tertiary level educational institutions such as nursing and medical schools, technical colleges, etc. It aims to establish a PE programme in an institution setting and to mobilise support for strengthening youth-friendly services. It is envisaged that following establishment in Fiji, other countries will replicate and/or adapt the Fiji models.

**(v) Behaviour Change Communication (BCC)**

BCC is an interactive process whereby tailored messages and approaches are developed to be communicated to promote and sustain individual, community and societal behaviour change, using a variety of communication channels. The aim of BCC is to develop the skills and capabilities of specific audiences of young people to promote and safeguard their own health and development. Its ultimate aim is to develop positive behaviours and to reinforce and maintain appropriate behaviours. Phase 2 will use BCC as a tool to support Outputs 1, 2 and 3.

The programme will ensure that vulnerable and risk groups are priority targets to reach, paying particular attention to the vulnerability of girls. A comprehensive BCC strategy will be developed – ensuring that it is gender-sensitive and culture-appropriate and one that has relevance to the context of young people in their communities. A variety of communication methods and tools will be used including – training, face-to-face discussions, community media, mass media, information and communications technologies (ICT) and counselling.

The BCC model focuses on a number of logical steps which motivate and support behaviour change.

**Stages of Behaviour Change**

1. Not thinking about the behaviour
2. Thinking about it
3. Making a decision to change
4. Acting on the decision
5. Being reinforced on changed behaviour
6. Sustaining the behaviour change
Plans will be made to utilise existing research information to determine youth behaviours and to understand how they put adolescents at risk. This information is essential for planning BCC strategies. The AHD Programme will work in collaboration with the SPC HIV programme on the application of the BCC principles to add value to the various educational activities under Output 2. The Stepping Stone programme is an example of community-based initiative to engage communities in planning and implementing HIV prevention through community mobilisation, media advocacy, and community empowerment.

(vi) Multi Channel Media Campaigns

The ability to formulate the right messages targeted at specific groups using the most appropriate media channel and using persistent and sustained multi-media efforts is critical to facilitate behaviour change and health-seeking behaviours. The mass media is a powerful tool for communicating messages because it can disseminate information to many young people of different ages, backgrounds and locations. Seminars, training for journalists, round-table discussions and press conferences are types of communications channels for advocacy.

Planning media programmes requires effective organisation and coordination so that efforts are effective. A media strategy needs careful planning, researching and reinforcement plans. Phase 2 will work with mass media to support social advertisement and campaigning on specific SRH issues. Some countries (RMI & Tonga) have shown interest to establish media programmes to support AHD advocacy, awareness, information and education. A multi-channel media package may include repeated replay and reprints of the following combination of media activities:

- Weekly radio talks on SRH related issues
- Reinforcement of the same messages with 1-2 public youth events per year
- School-based activities and seminars at Youth Centre to discuss same issues
- Newspaper articles using research information
- Radio spots and TV spots
- IEC-BCC materials for specific messages.

(v) Edutainment

Edutainment is an educational-entertainment tool to reach communities and in particular out-of-school youth. Edutainment can be popular and effective. To be effective, edutainment must be carefully planned. It requires research on audience preferences, community myths, use of research to identify contents for drama, song and music, selecting and preparing entertainers, pre-testing of lyrics and dramas, promotion of edutainment activities, conduct of edutainment at the right time and place, monitoring & evaluation. Phase 2 will review Phase 1 edutainment activities to assess effectiveness before new activities are planned, particularly in FSM, Solomon, Vanuatu, Tonga and Kiribati where edutainment activities were actively undertaken.

Creativity and careful planning must be used to include educational messages within songs, mini plays, TV/radio dramas. Dramas, street theatres and puppet shows are particularly effective because they bring the audience into the intimate thoughts and action of the characters. A well performed drama is persuasive because people can see the consequences of wise versus foolish behaviour. It stirs emotions and therefore people remember and share the stories with family and friends thereby disseminating the messages.
Resources to support Output 2

In order to implement activities under OUTPUT 2 and achieve results, funding support is required. Funds estimated at $1,900,000 over 4 years will be required for the following activities:

a) Develop and deliver FLE programmes
b) Fund a full-time FLE Specialist to assist at least five countries in FLE
c) Develop and deliver School-based Counselling and Support & Care Programmes
d) Develop and deliver Peer Education programmes
e) Develop and deliver Media and Edutainment programmes

The budget estimate to support Output 2 is summarised as follows:

<table>
<thead>
<tr>
<th>Output 2: Improved Life Skills Based AHD Information &amp; Education</th>
<th>2009 Year1</th>
<th>2010 Year2</th>
<th>2011 Year3</th>
<th>2012 Year4</th>
<th>TOTAL Y1 to Yr4</th>
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<tr>
<td>2.1 Family Life Education (FLE)</td>
<td>200,000</td>
<td>200,000</td>
<td>200,000</td>
<td>200,000</td>
<td>800,000</td>
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<tr>
<td>2.2 FLE Specialist</td>
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<td>90,000</td>
<td>90,000</td>
<td>90,000</td>
<td>360,000</td>
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<tr>
<td>2.3 School-based Counseling</td>
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<td>30,000</td>
<td>30,000</td>
<td>30,000</td>
<td>120,000</td>
</tr>
<tr>
<td>2.4 Peer Education</td>
<td>100,000</td>
<td>100,000</td>
<td>100,000</td>
<td>100,000</td>
<td>400,000</td>
</tr>
<tr>
<td>2.5 Edutainment &amp; Multi-media</td>
<td>30,000</td>
<td>50,000</td>
<td>50,000</td>
<td>50,000</td>
<td>180,000</td>
</tr>
<tr>
<td><strong>Subtotal 2</strong></td>
<td><strong>450,000</strong></td>
<td><strong>470,000</strong></td>
<td><strong>470,000</strong></td>
<td><strong>470,000</strong></td>
<td><strong>1,860,000</strong></td>
</tr>
</tbody>
</table>
Output 3: Strengthened Youth-friendly Services (YFS)

Strengthening, expanding and up-scaling Adolescent Sexual and Reproductive Health (ASRH) services for young people constitute a core component of the strategic plan. It aims to build and further progress initiatives developed during Phase 1. An AHD programme must have an effective youth-friendly services component to complement other programme areas.

3.1 Rationale for Youth-friendly Services

Youth-friendly Services (YFS) aims to safeguard the health of young people and to avoid unplanned pregnancies, prevent STIs and HIV and other related youth issues. Young women are at higher risks for complications during pregnancy and childbirth while babies born to these young mothers are likely to have poorer outcomes early in life – such as low birth weight, early infections and nutritional problems.

The need for information and access to youth-friendly services is crucial, particularly during this current era of increasing STI infection rates and teenage pregnancy. Community perception that easy access to SRH services may encourage early sexual activity still prevails. Efforts will be made to collect data and evidence to allay these concerns. In the region, the availability, access and utilisation of services for young people are still limited. Many factors are attributed to these circumstances and some have been documented. Plans will be made to address these factors in Phase 2, in order to improve access and use of services. Barriers to SRH services might occur at individual, community and institutional levels. Efforts will be made to strengthen programme design of youth-friendly ASRH services – to enhance accessibility and utilisation. A review of key factors affecting the youth-friendliness of youth facilities should consider the following factors:

- Programme factors to support AHD Services
- Facility factors, SRH commodities and Guidelines for Youth-friendly services
- Service Provider competency and skills
- Youth perception of the services provided

Because of differing ages, social background and lifestyles, there is a need to package services that meet the different needs of adolescents at different stages.

3.2 Policy Direction

Access to services helps to prevent unplanned pregnancy, STIs and HIV and contributes positively to improved quality of life and poverty reduction. There is a need to include the
discussion of YFS and its role in safeguarding adolescent health in policy dialogue. ASRH should be linked to the national HIV and RH policies and programmes.

Creating a supportive environment through sensitisation of media, policy-makers, parliamentarians, and other interest groups is useful for providing necessary policy support. Laws, regulations and practices that constrain youth from using SRH services should be addressed in the policy dialogue process. To enhance this process, there needs to be sound knowledge base and data to support the policy dialogue and advocacy. This includes information to demonstrate that SRH programming for young people will lead to more responsible behaviour. Some of this information already exist, such as in Situational Analysis reports, operational research (conducted in phase 1), youth mapping reports, and other forms of research. Documentation of lessons learned and success stories from Phase 1 will be compiled and shared with governments, NGOs and partner organisations so that there is common vision for adopting and replicating successful YFS and programmes on a larger scale.

### 3.3 Programming Direction

Phase 2 aims to build on Phase 1 modalities for delivering youth-friendly ASRH services and work towards strengthening service delivery facilities by expansion and scaling-up of programmes and services. The latter should be carried out through consultation and forming coalition among key partners at regional, national and provincial levels and partner organisations. To complement access of services, a plan will be developed in each country to promote and generate demands for service utilisation. The health-seeking behaviour of youth and adolescents will be explored (through community-based research or rapid assessments using focus groups discussions) to determine appropriate interventions.

ASRH services can be effectively delivered through existing primary health care system and should be programmed as key component of the national reproductive health programme with close integration with STI-HIV programmes and services. To strengthen ASRH services, a review of existing YFS modalities will be made in terms of coverage, utilisation of clinics, and patterns of use. The review will also identify the most effective modalities of YFS delivery from those currently implemented and ways to strengthen service utilisation and coverage.

### 3.4 Key Interventions and Activities under Output 3

A number of interventions and activities to support and strengthen provision of ASRH services described below will be implemented in Phase 2 building on the initiatives made in Phase 1.

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**ASRH Services Package**

**A minimum package includes**

- SRH core elements – information, counselling and services for prevention of early pregnancy, contraception and family planning, prevention of abortion
- STIs/HIV-AIDS: information, education and counselling
- Screening, treatment and prevention of STIs/HIV
- Condoms for STI prevention
- VCT and ART
- Gender-based violence counselling and referral
- Sexual assault – counselling and referral
- General consultation – general check up, nutrition, risk factors for NCD, counselling for smoking, alcohol and substance abuse
- Referral linkages
(1) **Guidelines for Youth-Friendly Services**

A generic guideline for delivering an essential package of youth-friendly ASRH services will be developed to be adapted by countries. A basic ASRH services package includes: counselling; contraceptives and family planning; pregnancy testing; screening, prevention and treatment of STIs; HIV screening and prevention services; and links to a referral network. Some facilities, depending on resources, will be able to provide additional services such as Pap smear testing, pregnancy care for adolescent mothers and management of sexually abused young people.

Linkages among service delivery facilities will be harnessed so that they are complementary and facilitate referrals. Special efforts will be made to integrate STI/HIV services with core SRH services package. Establishing a youth centre beside or adjacent to the youth clinic has been a successful model during Phase 1 (Vanuatu, Solomons, Tonga, Kiribati, Fiji, FSM, Marshall’s) and will be extended to other countries in Phase 2. A range of youth activities such as youth training, entertainment, drama, outreach and awareness will be strengthened in these non-clinic youth facilities.

(2) **Support for Clinic Facilities and Service Delivery Outlets for YFS**

A range of YFS models implemented in Phase 1 will be reviewed to select the most supported to deliver ASRH services. Each country will select the modalities work best in their circumstances. The types of service delivery points (SDPs) established in Phase 1 include:

- Government-based AHD Centres
- NGO-based youth facilities (centre or clinic)
- School-based clinics
- Community-based multipurpose youth centres
- Church-based clinics
- Integrated youth clinics with primary health services

Other options that will be explored in Phase 2 include:

- Mobile youth clinics
- Private clinics and pharmacies
- Hotlines & Help lines for information, counselling and/or referrals.

In order to expand accessibility of SRH commodities and services beyond the conventional clinic set up, Phase 2 will also explore the use of non-clinic settings as additional SDPs. This includes places where young people congregate such as sports field, indoor game sites, youth clubs, night clubs, and tertiary institutions. Some of these sites are particularly conducive for vulnerable and risk groups whose need for services are more apparent than other groups.

To improve the **youth-friendliness** of facilities for providing SRH for young people, efforts will be made to re-orient existing services to meet the requirements and criteria of YFS. The key features of YFS are categorised under four service aspects including programme characteristics, service provider characteristics, health facility characteristics, and youth perceptions of the services.
Government-run health centres and clinics have the potential to increase access to Youth YFS in both urban and rural settings using the primary health care approach. Some work has been conducted during Phase 1 to integrate ASRH-YFS in these facilities through training of service providers, improvement of health facilities and re-orienting existing primary health care services. More work will be undertaken to build on these initiatives during Phase 2.

Phase 2 of the AHD programme will build the capacity of PHC clinics, school-based clinics, NGOs, community-based clinics and other youth facilities to deliver YFS. It will include the development of standard guidelines for diagnosis and management of SRH conditions, staff training, commodities security and clinic facility improvements.

The AHD programme will continue to support the model of YFS delivered by NGO youth centers and clinics under the concept of “one-stop-shop”. Youth facilities will be developed to be able to provide a range of programmes and services – to include ASRH services, counseling, information sources, educational activities, general consultation and referrals. There will be mechanisms for facilitating exchange of experiences among service providers of YFS facilities. Facilities that are found to comply with established standards of YFS will qualify to receive the title of ‘YFS’ from Ministry of Health. Criteria for defining achievement of YFS status will be developed.

(4) Multi-purpose Youth Centres (MYC)

The concept establishing multi-purpose youth centres aims to put in place a central meeting place that provides a range of programmes and services for young people including: youth-friendly services, SRH life skills-based training, livelihoods training, healthy lifestyles activities, educational and communication activities and other youth-related development programmes. The AHD phase 2 should provide adequate resources to invest in such facilities that have the potential to pull together a number of youth programmes and services in one location. It also has the potential to mobilise existing human resources from various organisations and agencies (e.g., Health promotion staff, public health sections, Min of Education and NGOs) to participate in the planning and implementation of centre-based activities. MYC models established in FSM, Kiribati, Tonga, RMI and Fiji will be strengthened and replicated.

(5) Training of Service Providers in Youth-friendly Services

Service providers of ASRH services (doctors, nurses, peer educators, para-medical) should be well trained to acquire the competencies in delivering services, including counselling and “youth-friendly” approach. Positive staff attitudes and behaviours in providing YFS are crucial to the quality of service delivery. Appropriate health care is not just concerned with achieving coverage with provision of services; it is also about the quality of these interventions and services. The importance of having suitably trained staff cannot be overstated. In the absence of trained and competent service providers, quality of services is likely to be compromised.

A rights-based approach for youth services should be included in the training of service providers. A training package for service providers will be developed to include the concept of YFS with particular attention to ensuring confidentiality and privacy, quality of services, technical updates in ASRH services, counselling, management of gender-based violence, and simple methods for undertaking operational research. Service providers need greater education about the nature of sexual abuse, its devastating consequences and their role in
addressing, reporting and preventing such abuse from recurring. YFS should be strategically positioned to detect sexual and physical abuse of young people.

**Other types of AHD Training**

- **AHD pre-service training:** The programme will work with nursing, medical and paramedical programmes to incorporate ASRH into the curricula of health training courses. Incorporating a well developed AHD module into the UNFPA-funded certificate course on Reproductive Health Training Programme (RHTP)\(^{25}\) at the Fiji School of Medicine will be explored. The training of trainers concept will be applied so that a critical mass of trainers will be developed within each country over a period of time. Existing guidelines and protocols, procedures and training manuals will be reviewed and strengthened to facilitate national capacity development and provision of quality services.

- **Management of YFS Facilities:** To maintain the quality of clinic services, management and coordination of clinic facilities and functions are important. Increasing demands for utilisation of services will require plans on how to inform and create awareness about the availability of ASRH services in a community. YFS facilities should have established links to other youth programmes such as – Peer Education, FLE, Community-based programmes and other health services.

- **Monitoring and Evaluation of YFS:** Training activities will also include strengthening the monitoring system to include key indicators which will require data collection and analysis on an ongoing basis. The clinic team will gauge the performance of the YFS facility by conducting a regular review of the services it provides through analysis of services data and clinic operations. This will determine patterns of clinic utilisation, clinic load, and resources required. It also establishes a profile of clinic users. Based on this regular review of information and identifying lessons learned in the process, mechanisms for strengthening and improving clinic operations and service delivery can be planned and implemented by the clinic team.

- **Documentation of Best Practices in YFS:** Country teams will be encouraged to document experiences, lessons learned and best practices for sharing with stakeholders, partners and with other countries. Such information can be appropriately packaged and used as advocacy tools to support the AHD Programme.

To ensure that the AHD is well managed and implemented at all levels and move towards sustainability, mechanisms for on-going capacity development must be put in place to support programme managers and service providers. The process of identifying priorities for country action must include a close look at the existing systems and capacities at national level. The AHD regional team will adapt and develop training curricula, manuals, teaching materials, learners’ assessment tools, and criteria for selecting core trainers. Capacity building will include training of trainers in developing a policy dialogue, packaging Youth-friendly Services, Life Skills training, family life education, multi-media development, edutainment and

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\(^{25}\) *The RHTP is a 3-month certificate course in Reproductive Health funded by UNFPA and run by the Fiji School of Medicine.*
operational research. Some of these elements will be covered at the one-week annual Review and Planning workshop which is attended by country coordinators, UNFPA, UNICEF and SPC.

**Resources to support Output 3**

In order to implement activities under OUTPUT 3 and achieve results, funding support is required. Funds estimated at $1,265,000 over 4 years will be required for the following activities:

- Support youth facilities for youth-friendly services
- Support training and capacity building for service providers
- Develop youth-friendly services package

<table>
<thead>
<tr>
<th>OUTPUT 3: STRENGTHENED YOUTH FRIENDLY SERVICES</th>
<th>2009 YEAR1</th>
<th>2010 YEAR2</th>
<th>2011 YEAR3</th>
<th>2012 YEAR4</th>
<th>TOTAL Y1 to Yr4</th>
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<td>250,000</td>
<td>250,000</td>
<td>250,000</td>
<td>950,000</td>
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<td>80,000</td>
<td>100,000</td>
<td>100,000</td>
<td>100,000</td>
<td>380,000</td>
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<td>3.3 Development of Youth-friendly Services Package</td>
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<td>15,000</td>
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<td>10,000</td>
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<td>3.4 Operational Research</td>
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<td><strong>530,000</strong></td>
<td><strong>530,000</strong></td>
<td><strong>2,025,000</strong></td>
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</table>
Output 4: Strengthened Programme Management

To strengthen the management and delivery of the AHD programme at both regional and national levels, a number of areas will be supported. These include capacity building of project staffing, strengthening monitoring and evaluation mechanisms, operational research for evidence-based programming, documentation of best practices and experiences, and communications development. Experiences and lessons learned in Phase 1 will be taken into account to support and strengthen programme management in Phase 2.

4.1 Human Resources

Adequate staffing to manage, coordinate and implement the AHD programme is required if the programme is to adequately achieve its intended results. Lessons learned from Phase 1 illustrated the challenges and compromises that have to be made because of inadequate staffing to deliver the programme. Therefore, support for adequate staffing is required at both regional and national level if the joint initiative is to gain programme expansion, up-scaling, institutionalisation, and sustainability.

(a) Regional Project Personnel
The AHD team at SPC will require seven (7) full-time officers to undertake regional implementation functions. They comprise the following:

1) The AHD Advisor (Team Leader) is responsible for the overall programme management and coordinates the implementation of interventions and activities.
2) Two Programme Development Officers (PDOs) are responsible for the development, implementation, monitoring and evaluation of programmes applying a rights-based, gender-sensitive and life skills-based approach.
3) A Family Life Education Specialist (FLE) is responsible for the development of FLE including needs assessment, planning, curriculum development, resources development, teachers training and orientation to teaching and monitoring FLE in the school.
4) An Operations Research Specialist is responsible for gathering information/research findings and for planning, implementing and coordination of operational research to support evidence-based programming, and to build regional AHD research capacity.
5) A Communications Officer is responsible for developing communications packages to enhance advocacy and information sharing.
6) A Project Assistant is responsible for the ongoing administrative and communication functions of delivering the regional programme.

Positions under items (3), (4), (5) are new positions that are needed to support Phase 2. The AHD project will seek personnel support from the Australian Youth Ambassador Development (AYAD), Volunteer International Development Assistance (VIDA) and UNV programme. In addition short-term consultants will be recruited on short term to provide assistance in specific areas, when and where appropriate.
(b) National Project Personnel

Each country will continue to have in place a national AHD Coordinator whose role is to coordinate the implementation of the AHD programme at country level. She/he formulates a local AHD team made up of relevant public health staff (HIV/STI Coordinator, RH Manager, IPPF-Member Association representative, and other relevant officers), a project assistant and a team of peer educators. It will be desirable to identify counterparts or focal points for YFS, FLE and research depending on the size of the country and the level of activities at country level. The country team will also strengthen the AHD stakeholders’ network formulated in Phase 1. The AHD project coordinating committee (PCC) will also review its terms of reference and membership to strengthen its roles in supporting, monitoring and guiding the implementation at country level. Key discussion areas from PCC will feed into programme monitoring meetings at regional level.

4.2 Monitoring and Evaluation

The AHD programme applies a “results-based approach” therefore monitoring and evaluation tools are crucial to guide implementation, facilitate on-going assessment of implementation and to measure results at different levels. This includes an assessment of how inputs and activities are being processed to produce outputs (process monitoring), how outputs are being translated to produce outcomes and impact at later stages of implementation to assess programme impact. The tools will build on those developed during Phase 1. In the development of regional and country annual workplans, description of linkages between inputs and activities to outputs, and then from outputs to behavioural outcomes, and finally to programme impact will be documented.

The logframe matrix is being developed to facilitate project monitoring and evaluation. The AHD Logical Framework applies the results-based management (RBM) approach for measuring programme results using performance indicators. The logframe establishes a set of performance indicators to measure programme results at different levels from activity level to outputs to impact level.

Monitoring Mechanisms

To monitor implementation, a number of mechanisms introduced in Phase 1 will continue in Phase 2. Monitoring activities will be implemented at both regional and national levels.

Monitoring at Regional level:

1) The project advisory committee (PAC) made up of heads of agencies, meets once a year to discuss strategic programme direction and provide advice on other issues related to AHD.

2) The project management committee (PMC) made up of management personnel from the three agencies, meets every one to two months to discuss programme progress and related issues.

26 The AHD Stakeholder Network in each country comprises government and NGO partners whose work is related to the delivery of AHD initiatives.

27 The key members of the PCC include the AHD Coordinator, RH Manager/Director, STI/HIV Coordinator, and a representative from the NGO Family Health organization. Other officers can be co-opted to attend meetings.
3) **Country missions:** The regional AHD Team will visit each country to provide technical assistance in the implementation of their workplans and to monitor country programmes.

4) A five-day **Annual Review and Planning meeting** is conducted in Fiji around November each year to review the implementation of AHD programme and to develop the annual workplans for the following year.

5) **Mid-Term Review:** A mid-term review will be undertaken by an independent consultant at end of year 2 or early year 3 of implementation, guided by a clear terms of reference. The results of the evaluation will guide the implementation in the latter of the strategic phase.

6) **Teleconference:** Once a quarter the regional AHD team holds a meeting with country AHD teams via telephone conference.

**At country level:**
- The **project coordinating committee** (PCC) meets quarterly, or more often as required.
- The **AHD stakeholders** group meets 1-2 times a year to undertake an internal programme review.

**A summary of the monitoring meetings are tabulated below:**

<table>
<thead>
<tr>
<th>Operational level</th>
<th>Monitoring Mechanisms</th>
<th>Schedules</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At country level</strong></td>
<td>□ AHD Team meeting&lt;br&gt;□ Project coordinating committee (PCC)&lt;br&gt;□ AHD stakeholders internal review meeting</td>
<td>Every 2-3 months&lt;br&gt;1-2 times per year</td>
</tr>
<tr>
<td><strong>At regional level</strong></td>
<td>□ Project management committee (PMC) meeting&lt;br&gt;□ Project advisory committee (PAC) meeting&lt;br&gt;□ Annual Review and Planning meeting&lt;br&gt;□ Mid-Term Review – an independent consultant&lt;br&gt;□ Country missions: at least once per country per year – to provide technical assistance and monitor country programmes.&lt;br&gt;□ Teleconference between regional team and country AHD teams</td>
<td>Every 2-3 months&lt;br&gt;PAC – once a year&lt;br&gt;Annual review meetings&lt;br&gt;Yr 2-3 of the project&lt;br&gt;At least once per country per year&lt;br&gt;Quarterly</td>
</tr>
</tbody>
</table>

4.3 **Operations Research**

It is important that on-going operations research is carried out so that research data can be used to support evidence-based programming. The long-term benefit of incorporating operational research activities is consistent improvement and strengthening of programmes and services that meet the needs of young people.

A number of early research initiatives were conducted in Phase 1, and efforts will be made to build on these during phase 2. Experiences show that in order to build research as part of the overall AHD programme, adequate resources are required, in particular human resources.
Given the large amount of work involved in building research capacity, a full time Researcher will join the regional AHD project management team. A Research Specialist is required to coordinate all steps of the research process, from identifying research needs, to development of research plans, to supervising data collection, to analysing data, and producing the findings and finally to utilise findings to strengthen programme planning and to solicit better appreciation of research as a tool for strengthening programmes and systems. The Researcher will work closely with UNFPA and UNICEF researchers in this field as well as contribute towards the M & E component of the regional programme.

It will also be desirable to identify a national researcher in each of the participating countries to act as a local counterpart for the regional researcher. The national researcher will develop knowledge and skills to be able to conduct ASRH research. The research team will closely work with the AHD coordinators who will assist in identifying and designing research studies that can strengthen the delivery and implementation of AHD programmes.

**Resources to support Output 4**

In order to implement activities under OUTPUT 4 and achieve results, funding support is required. Funds estimated at $4,583,000 over 4yrs will be required for the following activities:

<table>
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<th>Output 4: Strengthened Programme Management and Delivery</th>
<th>2009 YEAR1</th>
<th>2010 YEAR2</th>
<th>2011 YEAR3</th>
<th>2012 YEAR4</th>
<th>TOTAL Y1 to Yr4</th>
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<tr>
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<td>170,000</td>
<td>200,000</td>
<td>180,000</td>
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<td>100,000</td>
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<td>80,000</td>
<td>90,000</td>
<td>90,000</td>
<td>340,000</td>
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<td>80,000</td>
<td>80,000</td>
<td>320,000</td>
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<tr>
<td>4.5 FLE Coordinator (Fiji)</td>
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<td>40,000</td>
<td>40,000</td>
<td>40,000</td>
<td>160,000</td>
</tr>
<tr>
<td>4.6 AHD Project Assistant (SPC)</td>
<td>30,000</td>
<td>30,000</td>
<td>30,000</td>
<td>30,000</td>
<td>120,000</td>
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<tr>
<td>4.7 Country AHD Coordinators - 10 countries</td>
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<td>150,000</td>
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<td>15,000</td>
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<td>4.9 Project Travel (5 technical officers at SPC)</td>
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<td>120,000</td>
<td>130,000</td>
<td>130,000</td>
<td>480,000</td>
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<td>30,000</td>
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<td>4.11 Office Equipment (3 new technical staff)</td>
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### ADOLESCENT HEALTH AND DEVELOPMENT (AHD): 2009-2012 Estimated Budget

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<tr>
<td>4.12</td>
<td>Project Vehicle - 25,000 per country x 7 countries</td>
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<td>-</td>
<td>175,000</td>
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<td>2,083,000</td>
<td>2,024,500</td>
<td>1,963,000</td>
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5. MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

The regional AHD programme is a multi-country initiative jointly supported by UNFPA, UNICEF and SPC, implemented at regional and country level and engaging active participation of partners and ten Pacific island countries.

While SPC is the main implementing agency, ongoing consultation and dialogue takes place with both UNFPA and UNICEF for technical support and guidance. Mechanisms are in place both at regional and national levels to monitor the project on an on-going basis and to facilitate the monitoring of project outputs and results. SPC takes lead role in coordinating the regional programme and provides technical assistance for the country teams.

5.1 PARTNERSHIP AND COLLABORATION

The joint initiative demonstrates a partnership programme to support AHD in the region, working with both governments and NGOs. Beyond these core partners, the programme will extend the partnership to engage other development partners so that other aspects of youth development can be addressed alongside adolescent sexual and reproductive health. For example, some early discussions have taken place with ILO and WHO regarding possible collaboration on a healthy lifestyle programme for youth.

Linking with other UNFPA programmes, the AHD will collaborate with programmes focusing on reproductive health and rights, gender, and the PPAPD project. With UNICEF, collaboration will be made with the HIV programme and the Policy, Advocacy Planning and Evaluation programme. The AHD will also collaborate with other SPC programmes to share resources and expertise, including public health programme, STI-HIV, Pacific Healthy Lifestyles, Demography & Statistics, Community Education Training Centre (CETC), and Youth Section under the Human Development Programme (HDP). The regional team will continue to support and build in-country capacity to ensure effective implementation of the AHD programme.

Joint fund-raising proposals will be made to donors to support new initiatives in two areas: FLE Expansion and Operational Research. The expansion of these initiatives will require two new technical staff at the regional level – an FLE Specialist and a Research Specialist. Both positions are crucial if we are to progress AHD programme to a new level of operation.

The AHD Programme will maintain dialogue with other relevant agencies and partners at both regional and national levels. It will also explore opportunities for strengthening partnership, joint innovations, mobilise additional resources and expertise, and facilitate improved coordination for better use of resources for greater impact.
5.2 THE ROLE OF PARTNER AGENCIES

UNFPA, UNICEF and SPC will continue to support the implementation of the multi-country regional programme through provision of both funding and technical assistance. SPC remains the implementing agency and therefore will be responsible for both direct involvement with participating countries at all stages of programme planning and implementation.

SPC is a regional intergovernmental organization based in Noumea, New Caledonia with a sub-regional office in Fiji and a number of country offices. Its mission is to help Pacific island countries position themselves to respond effectively to the challenges they face and to make informed decisions about their future. Its membership extends to 22 Pacific island countries and territories (PICTs). SPC has demonstrated technical and programme management capacity with well-structured monitoring and evaluation mechanisms, including a sound financial management system. SPC will ensure that the regional AHD programme is well managed and coordinated, that annual workplans are developed and aligned with the SPD and in consultation with UNFPA and UNICEF, and that regular reporting is undertaken and circulated as required. SPC will also ensure that decisions taken at the level of Project Management Committee (PMC) and Project Advisory Committee (PAC) are implemented and reported upon.

UNICEF Pacific implements a multi-country programme in 14 Pacific island countries with a special focus on three countries – Kiribati, Solomon Is and Vanuatu. The overall goal of UNICEF Pacific is support the child health and development in the governments of the 14 PICs through progressively realising child rights. The joint AHD programme will be supported under its HIV and AIDS programme which implements a range of activities to reduce vulnerability to and impact of HIV and AIDS among at risk populations. The programme focuses in three priority countries in addition to Fiji and Tuvalu.

UNFPA for the Pacific has four key programme areas in 14 Pacific island countries including Reproductive Health, Population and Development, Reproductive Health Commodities and Gender. The overall goal of UNFPA in the Pacific is to support gender appropriate reproductive health and population and development programme in the context of ICPD and MDGs. The joint AHD Programme will be supported under its regional reproductive health programme.

5.3 COORDINATION AT REGIONAL LEVEL

The aim of coordination is to identify areas of complementarity and synergy while avoiding duplication of work. Programme gaps will be identified and addressed. Given the need for inter-sectoral interventions, the AHD management team will support the pivotal role of the MOH in mobilising other sectors. It will be necessary at country level to develop mechanisms to facilitate inter-sectoral collaboration and networking.

A second level of coordination will be extended to involve members of other regional programmes or agencies that address AHD and ASRH. It will be particularly important to work in partnership with organizations whose work links to AHD issues, such as WHO, IPPF, ILO and programmes within SPC such as the youth section of HDP, HIV programme, and Demography
and Statistics. The SPC has undertaken a youth mapping to capture existing and potential collaborations and this inventory will be used by the AHD programme.

The AHD project will be managed and coordinated by the AHD Regional Management Team based at SPC in Suva, Fiji. As in phase 1 the regional team will be assisted and guided by the interagency Project Management Committee (PMC) which consists of senior level management from UNFPA, UNICEF and SPC, and by the Project Advisory Committee (PAC) made up of heads of partner agencies. While PMC meets more regularly every 2-3 months, PAC will continue to meet once a year to review project accomplishments, implementation issues and constraints, and to set the direction for future programme design and the way forward.

### 5.4 COORDINATION AT COUNTRY LEVEL

Implementation at the country level is coordinated and managed by locally recruited AHD Coordinators. While most of them are based with public health units at ministries of health, AHD Coordinators in Tonga and Marshall Islands are NGO-based on the recommendation of the ministry of health. This is based on NGO credibility and capacity to deliver community-based programmes. MOH-based AHD coordinators inherit the advantage of having a stronger catalytic role in mobilising support within MOH. They are accountable to the Directors or Managers of the national RH programme or to the Director of Public Health in each country. They also report to the SPC-based AHD Team on a regular basis. A number of AHD coordinators also have other duties within MOH or NGO where they are located. The capacity of the AHD Coordinator to undertake the prescribed roles is a determining factor in the extent and quality of programme implementation at country level.

Under Phase 1, AHD Coordinators or their assistants in Kiribati, Marshall Islands, Samoa, Solomon Is, Tonga, Samoa, Vanuatu; were costed under the joint AHD budget while in Cook Is, Fiji and Tuvalu were paid by their respective governments. For recruitment under Phase 2, the process will engage a joint SPC-MOH process particularly if the salary of the position is paid by the AHD programme. The process will be based on the recruitment standards in the respective countries. When an AHD Coordinator changes, SPC and MOH will recruit the new coordinator jointly and ensure a smooth hand over to the new officer is conducted. This will avoid loss of programme continuity, as happened in some instances in Phase 1.

AHD Coordinators are managers and coordinators at country level and depending on the mix of skills, they can also undertake implementation as well. In countries where implementation has increased in size and depth extending from advocacy to planning, supervision and evaluation, the programme will be supported to have a full-time Assistant Coordinator.

Each country has a Project Coordinating Committee (PCC) of key stakeholders, partner agencies and AHD staff to monitor and review project implementation and address issues on a quarterly basis. There is also a Stakeholders Group who represents other agencies and sectors and meet once or twice a year to undertake multi-sectoral consultation.
### AHD LOGFRAME MATRIX: 2009-2012

<table>
<thead>
<tr>
<th>Hierarchy of Results</th>
<th>OVI</th>
<th>MOV</th>
<th>Risks and Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. GOAL</strong>&lt;br&gt;IMPROVED HEALTH AND DEVELOPMENT OF YOUNG PEOPLE, ESPECIALLY SEXUAL AND REPRODUCTIVE HEALTH (results at impact level)</td>
<td>1) Adolescent fertility rate (15-19 ASFR) 2) Percentage of all births to teenage mothers 3) Percentage of male and females (15-24yrs) who are HIV infected 4) Prevalence of any STI in Males and females aged 15-24 yrs</td>
<td>□ Demographic health surveys (DHS) □ Population Census Reports □ Health Statistics &amp; Records □ Second generation surveillance on STIs (SGS)</td>
<td>National and regional political stability Governments maintain support for integrated youth and adolescent programme and services. Funding available to support DHS, surveys and census.</td>
</tr>
<tr>
<td><strong>2. OUTCOME</strong>&lt;br&gt;IMPROVED KNOWLEDGE, ATTITUDES, PRACTICES AND BEHAVIOUR (KAPB) REGARDING SEXUAL HEALTH AMONG YOUNG PEOPLE (results at behaviour level)</td>
<td>1) Percentage of females &amp; males 15-24 yrs who can identify risk taking behaviour (ie. who both correctly identify main modes of HIV transmission and reject major misconceptions about transmission) 2) Contraceptive prevalence rate by method and age 3) Unmet need for contraception (15-24 yrs) 4) Condom use at last sex among males and females, 15-24 yrs 5) Number and percentage of 15-24 year olds receiving HIV test in last 12months and know their results. 6) Number of Adolescents and young people utilizing ASRH services 7) Number and percentage of 15-24 year olds who have had sex before age 15 and 18 8) Proportion of young people who do not have concurrent and/or multiple sexual partners 9) Clinic Utilization records by age, sex and type of services provided.</td>
<td>□ Demographic health surveys (DHS) □ KAPB Studies on sexual and reproductive behaviour □ Community-based Youth Studies □ Clinic Reports and utilization data</td>
<td>A supportive socio-cultural environment for adolescent programme continues to exist in each country. Resources are available to support studies</td>
</tr>
<tr>
<td>Hierarchy of Results</td>
<td>OVI</td>
<td>MOV</td>
<td>Risks and Assumptions</td>
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<tr>
<td><strong>3. OUTPUTS</strong></td>
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<tr>
<td><strong>Output 1</strong></td>
<td><strong>STRENGTHENED POLICY ENVIRONMENT AND ENHANCED ENABLING COMMUNITY ENVIRONMENT</strong></td>
<td>Number of countries that have integrated AHD into national youth policy, RH policy and HIV policy.</td>
<td>□ Youth Policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ RH policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ HIV Policy or strategy</td>
</tr>
<tr>
<td><strong>Activities under Output 1</strong></td>
<td>(1) AHD Advocacy packages and Information-communication tools developed to facilitate policy dialogue.</td>
<td>□ AHD Advocacy and information communication packages in place</td>
<td>A supportive socio-cultural environment for adolescent programme continues to exist in each country.</td>
</tr>
<tr>
<td></td>
<td>(2) Number of meetings to facilitate policy dialogue at regional and country level.</td>
<td>□ List of advocacy tools</td>
<td>Resources are available</td>
</tr>
<tr>
<td></td>
<td>(3) Number of partner agencies at different levels that work with AHD programme.</td>
<td>□ List of partners &amp; stakeholders mobilized to support AHD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) Number of communities participating in social mobilisation for AHD, in each country</td>
<td>□ Reports of meeting and events to support advocacy and social mobilization – eg PPAPD meetings.</td>
<td></td>
</tr>
<tr>
<td><strong>Output 2</strong></td>
<td><strong>STRENGTHENED GENDER-SENSITIVE AND LIFE SKILLS BASED INFORMATION AND EDUCATION FOR YOUNG PEOPLE</strong></td>
<td>Number of countries approving FLE policy</td>
<td>Min of Health supports and endorses Family Life Education.</td>
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<tr>
<td></td>
<td></td>
<td>Number of situation analysis in FLE conducted</td>
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<tr>
<td></td>
<td></td>
<td>Number of countries establishing FLE</td>
<td></td>
</tr>
<tr>
<td><strong>Activities under Output 2</strong></td>
<td>(1) Number of countries developing and introducing FLE syllabus in schools</td>
<td>FLE curriculum in place</td>
<td>Ministry of Education is supportive of introduction and integration of AHD programme and FLE syllabus in schools</td>
</tr>
<tr>
<td></td>
<td>(2) Number and % of schools teaching FLE by countries</td>
<td>FLE reports in place about FLE status in each country</td>
<td>Teachers are available to teach FLE.</td>
</tr>
<tr>
<td></td>
<td>(3) Number and % of Teachers trained to deliver FLE curriculum in each country</td>
<td>FLE resources and materials</td>
<td>Resources are available</td>
</tr>
<tr>
<td></td>
<td>(4) % of students receiving FLE classes by country/year</td>
<td>Pre-FLE implementation KAPB Survey Report</td>
<td>Parents &amp; church are supportive of sexuality education in schools</td>
</tr>
<tr>
<td></td>
<td>(5) List of FLE resources developed and distributed to support FLE delivery by country.</td>
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<td></td>
<td>(6) KAPB Baseline study conducted as pre-intervention assessment tool, by country</td>
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<tr>
<td><strong>Hierarchy of Results</strong></td>
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<tr>
<td><strong>2.2 School-based Counselling</strong></td>
<td>1) Number of schools introducing counselling services 2) Number of teachers trained in basic counselling 3) Number of certified trained counsellors in schools 4) Training guideline/manual in counselling developed</td>
<td>□ Reports on school-based counselling □ Counselling guideline in place □ List of trained counsellors</td>
<td>Teachers are available and are interested to be trained in counseling.</td>
</tr>
<tr>
<td><strong>2.3 FLE for Pre-Service Teachers Training institutions</strong></td>
<td>1) Number of teacher institutions teaching FLE 2) Number of teacher students taking FLE classes</td>
<td>Reports of Teacher training institutions FLE curriculum in teacher syllabus</td>
<td>Teacher institutions are agreeable to incorporating FLE.</td>
</tr>
<tr>
<td><strong>2.4 Peer Education Programme (Youth)</strong></td>
<td>1) A Standardised skills-based PE manual developed 2) Number of countries with Peer Ed programmes 3) Number of Peer Educators recruited and trained in each country 4) Number of Peer Education models developed 5) Percentage of PE trainers that actively conduct Peer Education activities 6) Number of activities per country that engage “youth participation”</td>
<td>□ PE manual in place □ Peer education country reports. □ List of PEs in each country □ Models for Peer education □ Youth participation list</td>
<td>Peer education is accepted by communities Funding available</td>
</tr>
<tr>
<td><strong>2.5 Behaviour Change Communication (BCC)</strong></td>
<td>1) A standard BCC package developed to support AHD information and education strategies 2) Number of countries actively integrating BCC approaches into FLE, PE and other educational activities</td>
<td>□ BCC package in place □ BCC reports</td>
<td>Expertise and funding to support BCC available</td>
</tr>
<tr>
<td><strong>2.6 Edutainment and Media</strong></td>
<td>1) Number of Reviews of Edutainment Activities conducted in selected countries 2) Number &amp; % of young people reached by edutainment and media in each country 3) List of AHD messages developed for medial and edutainment 4) Catalogue of media &amp; edutainment activities developed.</td>
<td>□ Reports of review of Edutainment Activities □ Edutainment Plans in place □ List of AHD messages □ Catalogue of Media packages and Edutainment Activities in place</td>
<td>Edutainment and Media are accepted by communities.</td>
</tr>
<tr>
<td><strong>Hierarchy of Results</strong></td>
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<td><strong>MOV</strong></td>
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<td><strong>Output 3</strong></td>
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</table>
| IMPROVED YOUTH FRIENDLY SERVICES | Number of facilities providing youth friendly services, by type of facility in each country | □ List of centres and clinics providing YFS  
□ Facility reports. | Religious, community and parents support access to youth-friendly services |
| **Activities under Output 3** |         |         |                          |
| 3.1 Youth Facilities for youth-friendly services (YFS) established | 1) Criteria for Youth-friendly Services developed and applied  
2) Number of youth facilities by countries that meet the standard criteria of YFS  
3) Number of countries implementing Standard YFS package  
4) Number of govt PHC facilities providing YFS  
5) Number of NGO, private and community-based facility providing YFS in each country  
6) List of service delivery outlets delivering YFS | □ Standard criteria for YFS established  
□ Standard YFS package available  
□ YFS Reports in place for each country  
□ Site Visits and monitoring missions.  
□ Catalogue of YFS models in place | MOH and NGO facilities are supportive of integrating AHD youth-friendly services.  
Funds and resources are available to support YFS |
|                          | 3.2 Training of Service Providers | 1) Training package and guidelines for YFS developed  
2) Number of service providers (nurses and doctors) trained in youth-friendly services  
3) Number of PEs trained in youth-friendly services  
4) Percentage facilities that have a PE programme  
5) Number of activities that involve participation of young people in service delivery | YFS Training Package and Guidelines in place  
Training reports  
Training institute report | Youths are motivated to access and use available services |
|                          | 3.3 Management of YFS facility | 1) Recording and Reporting system of health services data established in each YFS facility  
2) Monitoring and Evaluation plans established  
3) List of clinic equipment  
4) Treatment Guidelines  
5) Number of staff meetings held for clinic management | □ Clinic reports  
□ Clinic Logbook  
□ Consolidated monthly clinic utilization and clinic load  
□ M&E system in place  
□ Clinic inventory in place  
□ Reports of meetings in place | Resources for supporting YFS are available |
### Hierarchy of Results

#### Output 4
**IMPROVED PROGRAMME DEVELOPMENT, MANAGEMENT, MONITORING AND EVALUATION**

<table>
<thead>
<tr>
<th>Activities under Output 4</th>
<th>OV1</th>
<th>MOV</th>
<th>Risks and Assumptions</th>
</tr>
</thead>
</table>
| 4.1 Recruitment of Programme staffing | 1) Strategic Plan developed  
2) Annual Workplans and budget developed  
3) Implementation plans developed  
4) Monitoring and Evaluation plans developed  
5) List of Research Activities | □ Strategic Plan in place  
□ Annual workplan and budgets are updated  
□ Implementation plans in place  
□ M & E plans in place  
□ Research reports | Funds made available by UNFPA and UNICEF to support activities proposed under the project. |
| 4.2 Development of AHD programme management documents | 1) Percentage of staffing positions filled  
2) Positions filled at regional level  
3) Positions filled at country level | Recruitment notices  
Recruitment reports  
List of programme staffing | Staffing personnel available |
| 4.3 Development of Monitoring and Evaluation Framework | 1) AHD Strategic Plan 2008-2012 finalized  
2) Annual Workplans and budgets developed each year – regional and country  
3) Monitoring and Evaluation framework developed | □ AHD ME framework established  
□ Annual programme reviews conducted  
□ Number of PMC & PAC meetings conducted  
□ Number of PCC meetings held – regional and country level  
□ Number of teleconferences held between regional team and AHD country teams | Country participation secured |
| 4.4 Country missions | 1) Number of missions undertaken per country per year  
2) Check-list for country missions developed | □ Country Mission Reports  
□ Check-list in place  
□ One page Summary of AHD Status in each country | Staff are committed to undertake country missions |
### List of Key Stakeholders Met/Interviewed

#### UNFPA Pacific Sub Regional Office, Suva, Fiji

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Dirk Jena</td>
<td>UNFPA Representative/Director</td>
</tr>
<tr>
<td>Dr Annette Robertson</td>
<td>UNFPA Deputy Rep/Deputy Director</td>
</tr>
<tr>
<td>Dr Wame Baravilala</td>
<td>RH Adviser</td>
</tr>
<tr>
<td>Ms Virisila Raitamata</td>
<td>Assistant Representative</td>
</tr>
<tr>
<td>Ms Lorna Rolls</td>
<td>Assistant Representative / Polynesia focal point</td>
</tr>
<tr>
<td>Mr. Jone Navakamocea</td>
<td>Population &amp; Development Planning Specialist</td>
</tr>
<tr>
<td>Dr Adriu Naduva</td>
<td>Programme Analyst/Youth &amp; AHD Focal Point</td>
</tr>
<tr>
<td>Ms. Maha Muna</td>
<td>Gender Adviser</td>
</tr>
<tr>
<td>Ms. Ariela Zibiah</td>
<td>Communications Officer</td>
</tr>
</tbody>
</table>

#### AusAID, Suva, Fiji

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Department</th>
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<tbody>
<tr>
<td>Ms. Rebecca McLean</td>
<td>Second Secretary, Development Cooperation</td>
</tr>
<tr>
<td></td>
<td>Australian High Commission</td>
</tr>
<tr>
<td>Ms. Melinia Nawadra</td>
<td>Australian High Commission, Suva, Fiji</td>
</tr>
</tbody>
</table>

#### NZAID, Wellington, New Zealand (via teleconference)

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Salili</td>
<td>Wellington, New Zealand</td>
</tr>
<tr>
<td>Ms. Lavea’i</td>
<td>Wellington, New Zealand</td>
</tr>
</tbody>
</table>

#### Secretariat of the Pacific Community, Public Health Division, Suva, Fiji

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Dr. Josaia Samuela</td>
<td>Manager, Health Advance Unit</td>
</tr>
<tr>
<td></td>
<td>(Former Family Health Advisor, MOH)</td>
</tr>
<tr>
<td>Dr. George Malefoasi</td>
<td>AHD Adviser, Adolescent Health &amp; Development Program</td>
</tr>
<tr>
<td>Mr. Penisoni Naupoto</td>
<td>FLE Programme Development Officer</td>
</tr>
</tbody>
</table>

#### UNICEF Pacific, Suva, Fiji

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Dr. Isiye Ndombi</td>
<td>UNICEF Representative to the Pacific Islands</td>
</tr>
<tr>
<td>Ms. Isabelle Austin</td>
<td>Deputy Representative</td>
</tr>
<tr>
<td>Dr. Annefrida Kisesa- Mkusa</td>
<td>Chief, HIV &amp; AIDS</td>
</tr>
<tr>
<td>Mr. Simon Molenijk</td>
<td>Education Officer (OIC)</td>
</tr>
<tr>
<td>Ms. Vika Waradi</td>
<td>Communications Officer (Behaviour Change)</td>
</tr>
<tr>
<td>Dr. Ider Dungerdorj</td>
<td>PMTCT Specialist</td>
</tr>
<tr>
<td>Ms. Sharana Ali</td>
<td>HIV/AIDS Officer</td>
</tr>
<tr>
<td>Ms. Sdote Kaimacuata</td>
<td>Child Protection Officer</td>
</tr>
<tr>
<td>Ms. Silva Pina</td>
<td>Child Protection Officer</td>
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#### IPPF-ESEAOR Sub Regional Office for the Pacific, Suva, Fiji

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Ms. Archana Mani</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>Mr. Timoci Vatuloka</td>
<td>Programme Officer (Youth Focal Point)</td>
</tr>
<tr>
<td>Mr. William Fuata</td>
<td>Programme Officer</td>
</tr>
</tbody>
</table>
**Country AHD Teams**

**Fiji**

- Dr. Josefa V. Koroivueta, Deputy Secretary, Public Health, MOH
- Dr Francis Bingwor, National Advisor Family Health, MOH
- Ms. Manaini Rokovunisei, National AHD/HIV Coordinator, MOH
- Sr. Sulueti Duvaqa, Lecturer (former AHD Coordinator)
  - College of Medicine and Nursing, Fiji National University
- Sr. Lauhitu Balawanilotu, “Our Place” YFS Clinic, Suva
- Ms. Elenoa Seruvatu, Peer Educators Development Team
  - University of South Pacific
- Ms. Laisiasa Wainivesa, Peer Educators Development Team
- Mr. Asianate Korocawiri, Peer Educator, Korovisilou Health Center
- Sr. Laufitu Balawanilotu, Peer Educator, Korovisilou Health Center
- Ms. Laisiasa Wainivesa, Peer Educators Development Team
- Mr. Asianate Korocawiri, Peer Educator, Korovisilou Health Center
- Ms. Elenoa Seruvatu, Peer Educators Development Team
- Mr. Asianate Korocawiri, Peer Educator, Korovisilou Health Center
- Mr. Jone Ratulevu, Peer Educator, Korovisilou Health Center
- Two student Peer Educators, Department of Youth & Sports

**Solomon Islands**

- Dr. Tenneth Dalipanda, Director, Public Health, MOH
- Dr. Nemia Bainivalu, Director, HIV/AIDS Department, MOH
- Mr. Gideon Sukumana, FLE Curriculum Development Officer, MoE
- Ms. Judith Seke, RH/AHD Coordinator, MOH
- Ms. Nancy Pego, National AHD Coordinator, MOH
- Ms. Sarah Ben, Former National AHD Coordinator
- Mr. Crispin Siama, Former AHD Project Assistant and SIPPA Volunteer
- Mr. Kang Yun Jong, Chief of Field Office, UNICEF Pacific – Solomon Islands
- Mr Mike Salini, Executive Director
  - Solomon Islands Planned Parenthood Association (SIPPA)
- Ms. Sarah Ben, Former National AHD Coordinator
- Mr. Crispin Siama, Former AHD Project Assistant and SIPPA Volunteer
- Mr. Kang Yun Jong, Chief of Field Office, UNICEF Pacific – Solomon Islands
- Mr. Mike Salini, Executive Director
  - Solomon Islands Planned Parenthood Association (SIPPA)
- Sister Leena, Midwife, Kukum Govt. Clinic, Honiara
- Sister June & Sister Rose, Nurse/Midwife, Rove Govt. Clinic, Honiara
- Mr. Alfred Ngire, Youth Nurse, SIPPA Clinic, Honiara
- Ms. Doris, Coordinator, SISTA SAVE project, SIPPA, Honiara
- Mr. Humphry and Ms. Hendrittka, SISTA SAVE project staff, SIPPA, Honiara
- Ms. Mary and 8 female YP, Young Girls for Change, Honiara
- 7 YP (volunteers & students 4M/4F), Young people in the SIPPA Youth Centre, Honiara

**Kiribati**

- Mr. Riwata, Deputy Secretary for Health (OIC, MOH)
- Dr. Kenneth, Deputy Director of Public Health, MOH
- Ms. Maere Anterea, RH Coordinator, MOH
- Ms. Maeto Uriam, AHD Coordinator, MOH
- Mr. Takamwe Ioata, AHD Project Assistant, MOH
- Mr. Taniera Taibuako, HIV Coordinator, MOH
- Ms. Meweritomga, Health Promotion Unit, MOH
- Ms. Emaima, HIV Secretariat Field Officer, MOH
- Ms. Teburantake Kaei, Curriculum Development Officer, CDRU, MoE
- Ms. Mauea Wilson, Youth & Development Section, Min of Internal & Soc. Affairs (MISA)
- Mr. Tenea Atera, Betios Town Council Sports & Youth Section
- Mr. Harry Langley, TUC Sports & Youth Section
- Ms. Norma Yee Ting, Executive Director, Kiribati Family Health Association
Mr. Amota    Youth Nurse, Kiribati Family Health Association
Mr. Abitara    Youth Officer, Kiribati Family Health Association
Ms. Ueraoi Taniera   HIV/AIDS Prog. Officer, UNICEF Kiribati
Sister Tpwataua    Nurse/Counselor, Temikin Clinic, Betio Town
Ms. Naatia    Youth for Christian Living (YCL), Public Relations Officer
Mr. Teraoi    Programme Officer, YCL
Mr. Rubo    HR Officer, YCL
9 Youth Volunteers   AHD Project

Tonga

Dr. Siale ‘Akau’ola   Director for Health, Ministry of Health
Dr. Malakai Ake    Chief Medical Officer (Public Health)/President TFHA
Mr Siale Puloka    Executive Director, Tonga Family Health Association
Ms Katherine Mafi   AHD Project Coordinator, Tonga Family Health Association
Ms. Faleata Leha    Programme Officer, Tonga Family Health Association
Ms. Amelia Hoponoa   Programme Coordinator, Tonga Family Health Association
Ms. Helen Teu    Peer Educator/Youth Volunteer, TFHA
Mr. Nonga Pulu    Peer Educator/Youth Volunteer, TFHA
Ms. Amelia Hoponoa   Programme Coordinator, TFHA
Mr. Savelio Lavelua    President, Tongatapu Youth Congress, and
Team Leader, The Salvation Army, Tonga
Ms. MilikaTuita    Programme Analyst, UNDP, Tonga
Bibliography

19. Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth in Karibiti (2008);
30. TONGA. Science Syllabus for Class 7 & 8. Curriculum Development Unit, MEWAC, The Kingdom of Tonga
32. UNFPA (2011). AHD Evaluation TOR
Questionnaire sent out to AHD Coordinators in the 10 AHD project Countries

General Demographics

1. I live and work in (select-circle as appropriate):
   - Cook Islands
   - Federated States of Micronesia
   - Fiji
   - Kiribati
   - Republic of the Marshall Islands
   - Samoa
   - Solomon Islands
   - Tonga
   - Tuvalu, and
   - Vanuatu

2. I am a male/female

3. My age is:

4. My educational level is up to:
   - primary school
   - secondary school
   - bachelor degree
   - master degree

5. I have professional training/experience in (check all and fill in as appropriate):
   - nursing
   - teaching
   - counseling
   - training
   - other (please specify) ______________________________________

6. How long have you been working as the ARH/AHD Coordinator?

Questions related to Output 1: Enhanced Supportive Policy Environment and Enabling Community Environment:

7. Are there any specific policies and/or strategies on AHD/ASRH in your country’s national development plans? Yes/No
8. If “yes”, was it due to the efforts or result of the AHD project? Yes/No
9. Are there any specific policies and/or strategies on AHD/ASRH in your country’s national health sector plans? Yes/No
10. If “yes”, was it due to the efforts or result of the AHD project? Yes/No
11. Are there any specific policies and/or strategies on AHD/SRH in your country’s national education sector plans? Yes/No
12. If “yes”, was it due to the efforts or result of the AHD project? Yes/No
13. Are there any specific policies and/or strategies on AHD/ASRH in your country’s national youth sector plans? Yes/No
14. If “yes”, was it due to the efforts or result of the AHD project? Yes/No
15. Does the government allocate any resources/budgets for implementation of AHD and SRH activities? Yes/No
16. If the above answer is “yes” what percentage of the national budget? ___ %
17. Is FLE/Life skills incorporated in the regular school curriculum in your country? Yes/No
18. If the above answer is “No”, please explain _________________________________
19. If the answer is “Yes”, how many schools are offering FLE in your country?
20. What kind of assistance would your country require to facilitate incorporating ASRH / FLE and Life Skills into the regular school curriculum?

Questions related to Outputs 2: Strengthened SRH Information and Education for Young People:

21. How accessible are IEC/BCC and advocacy materials to young people? Easily/not easily/difficult
22. How many additional FLE and Peer Educators have been trained since 2008? _____
23. What is the total number and gender representation of FLE and Peer Educators?
   M___ F___
24. In your view, what are the main achievements of this component of the AHD project?
25. Do you think peer educators conduct sufficient community outreach to cover large populations of young people in your country? Yes/No
26. How many young people were reached with SRH information both in school and out of school in the following years? In 2008 - ____; 2009 - ____; 2010 - ____; 2011 -

Questions related to Outputs 3: Strengthened Youth Friendly Services:

27. How many YFS centres/clinics have been established since 2008? __________
28. Where are the YFS centres/clinics generally established? In hospitals, clinics, schools, clubs. Please elaborate
29. What kind of services/activities is carried out in the youth centres? (tick all as appropriate)
   - voluntary counseling on STI / HIV
   - distribution of contraceptives including condoms
   - demonstration on use of contraceptives including condoms
   - distribution of IEC materials on ASRH
   - opportunity to discuss ASRH with other young people
30. On average, how many youths use the ARH centres or Youth Clinics every month?
31. Please provide data about their age, gender, marital status and reasons for visit?
32. Were there any school based peer education programme carried out recently?
33. If school based peer education was carried out, what is the total number of students who were reached
34. For school based peer education, what were the challenges faced by the peer educators and what are possible solutions to them? __________
35. How many community based peer education activities have been carried out by peer educators in the past two years? __________
36. How many youths in total would have been involved in the community outreach programme? __________
Questions related to **Output 4: Enhanced Programme Management and Deliver:**

37. How many staff are employed/funded under the AHD project? __________
38. How many other staff (govt/NGO) are involved in the AHD project?
39. List the type/category of staff involved in the AHD project:

40. What are the mechanisms for supervision? Please explain:
41. Do you keep a record book of activities carried out by peer educators?
42. Have you attended any PE activities? If yes, please elaborate
43. How do you determine the quality of the peer educator’s sessions?
44. What are the main challenges of the joint AHD project? Please explain
45. How would you improve the integration of ASRH in life skills and FLE training?
46. What are some of the challenges in operating a school-based clinic (if in operation)?
47. Do you know if ARH is integrated into existing health service? If so, in what forms or ways?
48. Are the staffs trained in ASRH services including counseling?

Questions relating to **Lessons Learnt:**

49. What are the main lessons learned in coordinating AHD project in your country?
50. What would you recommend to improve results of AHD project in your country (programme and management changes)?
51. Has internal/national capacity been adequately developed?
52. What are some of your observations and comments on the preparation of country work plans?
53. What are some of your observations regarding the integration of project activities and their implementation at country levels?
54. What are some of your observations with regards to general management, monitoring and supervision of the AHD project by SPC / UNFPA / UNICEF?
55. Do you think the current structure within the project, including staffing, is adequate and able to deliver the activities needed to be undertaken?
56. With regards to capacity building, what suggestions would like to make with regards to in country capacity?
57. What suggestions, if any, do you have towards further integration of ARH in the health service?
58. How can we maximise the utilisation of youth clinics by young people?
<table>
<thead>
<tr>
<th>Time</th>
<th>Day</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.00am</td>
<td>16/1/2012</td>
<td>Desk Review</td>
<td>Meeting with Curriculum Development Ministry of Education</td>
</tr>
<tr>
<td></td>
<td>17/1/2012</td>
<td>Desk Review</td>
<td>Mr. Siale ‘Ataongo Puloka Executive Director Tonga Family Health Association</td>
</tr>
<tr>
<td></td>
<td>18/1/2012</td>
<td>Desk Review</td>
<td>Ms. Vika ‘Aonga TFHA STI Clinic Coordinator Youth Friendly Services</td>
</tr>
<tr>
<td></td>
<td>19/1/2012</td>
<td>Field visit to clinics</td>
<td>Mr. Savelio Lavelua Team Leader The Salvation Army/ President of the Tongatapu Youth Congress</td>
</tr>
<tr>
<td></td>
<td>20/1/2012</td>
<td>Desk Review</td>
<td>Meeting with parlimentarian committee [discuss with Milika UNDP]</td>
</tr>
<tr>
<td>11.30am</td>
<td>16/1/2012</td>
<td>Desk Review</td>
<td>Desk Review</td>
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<td>17/1/2012</td>
<td>Desk Review</td>
<td>Desk Review</td>
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<td>18/1/2012</td>
<td>Desk Review</td>
<td>Field visit to clinics</td>
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<td>19/1/2012</td>
<td>Desk Review</td>
<td>Meeting with parlimentarian committee [discuss with Milika UNDP]</td>
</tr>
<tr>
<td>2.00pm</td>
<td>16/1/2012</td>
<td>Desk Review</td>
<td>Desk Review</td>
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<td>17/1/2012</td>
<td>Desk Review</td>
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<td>Desk Review</td>
<td>Field visit to clinics</td>
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<td></td>
<td>19/1/2012</td>
<td>Desk Review</td>
<td>Meeting with parlimentarian committee [discuss with Milika UNDP]</td>
</tr>
<tr>
<td>3.30pm</td>
<td>16/1/2012</td>
<td>Meeting with Director of Youth Ministry of Youth</td>
<td>Meeting with Milika UNDP Officer</td>
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<tr>
<td></td>
<td>17/1/2012</td>
<td>Meeting with Director of Youth Ministry of Youth</td>
<td>Meet with Milika UNDP Officer</td>
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<tr>
<td></td>
<td>18/1/2012</td>
<td>Meeting with Director of Youth Ministry of Youth</td>
<td>Ms. Helen Teu National Peer Educator/Youth Volunteer for TFHA</td>
</tr>
<tr>
<td></td>
<td>19/1/2012</td>
<td>Meeting with Director of Youth Ministry of Youth</td>
<td>Mr. Nonga Pulu National Peer Educator/ Officer in Charge of the Filitonu Drama Group / Youth Volunteer / Youth Dropped in Center</td>
</tr>
<tr>
<td></td>
<td>20/1/2012</td>
<td>Desk Review</td>
<td>Desk Review</td>
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### TRAVEL & CONSULTATION SCHEDULES FOR AHD EVALUATOR – in Solomon Islands

<table>
<thead>
<tr>
<th>Time</th>
<th>23/1/2012</th>
<th>22/1/2012</th>
<th>24/1/2012</th>
<th>25/1/2012</th>
<th>26/1</th>
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</thead>
<tbody>
<tr>
<td>9am-9.30am</td>
<td>Sr Judith Seke, Reproductive Health Manager MOH</td>
<td>Field Visit to Youth Nurse at Kukum Clinic Honiara City Council</td>
<td>Meet with UNICEF Officer Stake Holders</td>
<td>Meet with Mr. E Anisitolo Youth Director (MWYCF)</td>
<td>Desk Review / Report Writing</td>
</tr>
<tr>
<td>9.45am-10.15am</td>
<td>Nancy Pego, Adolescent Health Coordinator MOH</td>
<td>Desk Review</td>
<td>Meet with SCA Stake Holders</td>
<td>Meet with Mr. Gideon Sukumana FLE Officer Ministry of Education</td>
<td>Desk Review / Report Writing</td>
</tr>
<tr>
<td>10.20am-10.50am</td>
<td>Dr Tenneth Dalipanda, Director of Public Health MOH</td>
<td>Field Visit to Youth Nurse at Rove Clinic Honiara City Council</td>
<td>Meet with Young Girls for Change Group HCC</td>
<td>Meet with Philma Zaku Youth Coordinator COM (FBO)</td>
<td>Desk Review / Report Writing</td>
</tr>
<tr>
<td>11am-11.30am</td>
<td>Dr Lester Ross, Permanent Secretary MOH</td>
<td>Desk Review</td>
<td>Meet with OXPAM young Ambassador Stake Holders</td>
<td>Meet with rep from Church of Melanesia</td>
<td>Desk Review / Report Writing</td>
</tr>
<tr>
<td>1.30pm-2pm</td>
<td>Dr Nemia Bainivalu, Director of HIV &amp; AIDS Department MOH</td>
<td>Visit SISTA Save group at SIPPA NGO</td>
<td>Desk Review / Report Writing</td>
<td>Desk Review / Report Writing</td>
<td>Desk Review / Report Writing</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Activities</td>
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<tr>
<td>30/1/2012</td>
<td>10.30am</td>
<td>Desk Review / Report Writing&lt;br&gt;Focus Group: The Government organizations include: Ministry of Health – HP Unit, RH and PPTCT; Youth &amp; Development Section, MISA; Community Policing; HIV Secretariat Field Officer and HIV Coordinator</td>
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<tr>
<td>31/1/2012</td>
<td>10.30am</td>
<td>Field visits to YFS &amp; VCCT clinics – with MHMS (2) and KFHA</td>
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<tr>
<td>1/2/2012</td>
<td>10.30am</td>
<td>Meeting with RH Coordinator and PPTCT Coordinators</td>
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<tr>
<td>2/2/2012</td>
<td>10.30am</td>
<td>Meeting with HIV Secretariat Field Officer and HIV Coordinator</td>
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<tr>
<td>3/2/2012</td>
<td>10.30am</td>
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<tr>
<td>30/1/2012</td>
<td>12.30pm</td>
<td>Focus group: The NGOs include: KFHA; KRCS; BTC Sports and Youth Section; TUC Sports and Youth Section; Marine Training College; YCL; KPC; KCY</td>
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<tr>
<td>31/1/2012</td>
<td>12.30pm</td>
<td>Meeting with KFHA</td>
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<tr>
<td>1/2/2012</td>
<td>12.30pm</td>
<td>Meeting with Youth &amp; Development Section, MISA</td>
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<tr>
<td>2/2/2012</td>
<td>12.30pm</td>
<td>Debrief with AHD Coordinator</td>
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<td>3/2/2012</td>
<td>12.30pm</td>
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<tr>
<td>30/1/2012</td>
<td>2.00-2.30pm</td>
<td>Permanent Secretary for Ministry of Health &amp; Medical Services</td>
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<tr>
<td>31/1/2012</td>
<td>2.00-2.30pm</td>
<td>Meeting with FBOS Kiribati Protestant Church</td>
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<tr>
<td>1/2/2012</td>
<td>2.00-2.30pm</td>
<td>Field visits</td>
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<tr>
<td>2/2/2012</td>
<td>2.00-2.30pm</td>
<td>Debrief with Director of Public Health</td>
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<tr>
<td>3/2/2012</td>
<td>2.00-2.30pm</td>
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<tr>
<td>30/1/2012</td>
<td>3.15-4.00pm</td>
<td>Director CDU &amp; CDU staff</td>
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<tr>
<td>31/1/2012</td>
<td>3.15-4.00pm</td>
<td>Focus Group with AHD Team</td>
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<tr>
<td>1/2/2012</td>
<td>3.15-4.00pm</td>
<td>Field visits</td>
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<tr>
<td>2/2/2012</td>
<td>3.15-4.00pm</td>
<td>Field visits</td>
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<tr>
<td>3/2/2012</td>
<td>3.15-4.00pm</td>
<td>Desk Review / Report Writing</td>
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<tr>
<td>Time</td>
<td>6/2/2012</td>
<td>7/2/2012</td>
<td>8/2/2012</td>
<td>9/2/2012</td>
<td>10/2/2012</td>
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<tr>
<td>10.00am</td>
<td>Travel from Kiribati</td>
<td>Meeting at OUR PLACE with AHD Suva team</td>
<td>Meeting at Nausori Health Cneter with AHD team</td>
<td>Report Writing</td>
<td>Report Writing</td>
</tr>
<tr>
<td>11.30am</td>
<td>Travel from Kiribati</td>
<td>Sister Sulueti Duvaga, Fiji National University</td>
<td>Desk Review / Report Writing</td>
<td>Report Writing</td>
<td>Debrief Meeting</td>
</tr>
<tr>
<td>2.00pm</td>
<td>Travel from Kiribati</td>
<td>Meeting Dr Josaia Samuela, SPC</td>
<td>Meeting with USP Peer Educators team</td>
<td>Report Writing</td>
<td>Report Writing</td>
</tr>
<tr>
<td>3.30pm</td>
<td>Travel from Kiribati</td>
<td>END</td>
<td>Meeting with Director for Youth and Sports</td>
<td>Report Writing</td>
<td>Depart Fiji</td>
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</table>