COMPOSITE REVIEW
OF UNFPA'S THIRD COUNTRY PROGRAMME
OF ASSISTANCE TO THE PACIFIC
2003-2007
UNFPA’s Third Country Programme of Assistance to the Pacific

UNFPA, United Nations Population Fund has been in the Pacific for more than thirty years now. During this time UNFPA’s commitment and support to the Pacific has also grown; together with the partnerships and friendship we enjoy today. This document is a review of the UNFPA Pacific Sub-Regional Office’s third country programme in the Pacific. The review of the programme of the 2003-2007 cycle will also provide a platform for the work that will be achieved in the next programme cycle 2008-2012.

I would like to thank all UNFPA Pacific SRO staff, UN family colleagues, our country partners and friends - who have worked tirelessly to make the 2003-2007 UNFPA Programme cycle a success. Special thanks also to all who assisted in the compilation of this report; especially UNFPA consultant, Ms. Margaret O’Callaghan, for all your efforts to research and collate the work and efforts of the Pacific SRO in this document.

UNFPA’s Programme of Assistance is guided by the International Conference on Population and Development Goals and the Millennium Development Goals. UNFPA is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity.

Najib M. Assifi
Director Pacific Sub-Regional Office &
UNFPA Representative
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AHD</td>
<td>Adolescent Health and Development</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>CCA</td>
<td>Common Country Assessment</td>
</tr>
<tr>
<td>CP2/CP3</td>
<td>Country Programme (second or third)</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>Country Technical Services Team</td>
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<td>Demographic Health Survey</td>
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<td>FBOs</td>
<td>Faith Based Organizations</td>
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<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FSMic</td>
<td>Federated States of Micronesia</td>
</tr>
<tr>
<td>FSM</td>
<td>Fiji School of Medicine</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund Against AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>HIES</td>
<td>Household Income and Employment Survey</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>HOPS</td>
<td>Heads of Planning and Statistics</td>
</tr>
<tr>
<td>HQ</td>
<td>Headquarters (UNFPA)</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<td>LDCs</td>
<td>Least Developed Countries</td>
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<tr>
<td>LSMS</td>
<td>Living Standards Measurement Survey</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MICs</td>
<td>Multi-Indicator Cluster Surveys</td>
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<tr>
<td>MIRH</td>
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<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MYFF</td>
<td>Multi-Year Funding Framework</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
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<td>NSO</td>
<td>National Statistical Office</td>
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<td>NZAID</td>
<td>New Zealand Agency for International Development</td>
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<tr>
<td>OHCHR</td>
<td>Office of the United Nations Commissioner for Human Rights</td>
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<tr>
<td>OHCA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>OR</td>
<td>Operations Research</td>
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<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>PAOR</td>
<td>Programme Assessment and Operations Research</td>
</tr>
<tr>
<td>PC</td>
<td>Pacific Centre</td>
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<tr>
<td>PoA</td>
<td>Plan of Action</td>
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<tr>
<td>PD</td>
<td>Population and Development</td>
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<tr>
<td>PICs</td>
<td>Pacific Island Countries</td>
</tr>
<tr>
<td>PopGIS</td>
<td>Population Geographical Information Systems</td>
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<tr>
<td>PPAPD</td>
<td>Pacific Parliamentarians Assembly on Population and Development</td>
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<tr>
<td>RBM</td>
<td>Results Based Management</td>
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<tr>
<td>RCM</td>
<td>Regional Consultation Meeting</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<td>RHTP</td>
<td>Reproductive Health Training Programme</td>
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<tr>
<td>RMI</td>
<td>Republic of the Marshall Islands</td>
</tr>
<tr>
<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
</tr>
<tr>
<td>SPC</td>
<td>Secretariat for the Pacific Community</td>
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</tbody>
</table>
SPP  Strategic Partnership Programme
SRH  Sexual and Reproductive Health
STIs  Sexually Transmitted Infections
TA   Technical Assistance
UN   United Nations
UNDAF United Nations Development Assistance Framework
UNDP United Nations Development Programme
UNIFEM United Nations Women’s Development Programme
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
UNSD United Nations Statistical Division
USCB University of Southern California at Berkley
WB   World Bank
WHO  World Health Organization
EXECUTIVE SUMMARY

The UNFPA Office for the Pacific (which is a sub-regional office of the Asia Pacific Division) provided financial and technical support to fourteen Pacific Island countries through its third Multi-Country programme covering the years 2003-2007 (CP3). The work was coordinated by a Suva based team supported by a small group of technical advisors, who provided assistance to the same fourteen countries, as well as to the Papua New Guinea UNFPA programme.

The Pacific is a diverse region of small island countries with immense distances between them and varied cultures and needs. They do share in common a need to strengthen their Reproductive Health education and services, especially for the very large cohort of young people and for preventing maternal mortality and increasing family planning. Accurate and recent data, analysis and use in planning are limited and also much needed in order for governments to know how to cope with the increasing social, economic and environmental challenges of the region. The nature of the Pacific presents significant logistical challenges and makes it a very expensive region in which to work.

In line with current international development practices, a results-based management approach was developed during the programme cycle. This approach emphasized the achievement of outcomes and within this context, a comprehensive planning, monitoring and evaluation programme was developed. As part of this system, an
end-of-cycle evaluation is normally required. However, it was not practical to conduct a holistic programme evaluation - because of the nature of the region covered, the diversity of the programme components, the small size of many project budgets and their different starting dates, as well as the relative cost of undertaking evaluations. Another factor was whether sufficient quality data was available against which to assess performance. The increasing availability of detailed project monitoring information to inform decision making also reduced the need for formal evaluations for some projects.

Therefore, external evaluations were confined to the two relatively large, thematic projects which had been implemented for some years i.e. the Regional Reproductive Health Training Programme and the Adolescent Health and Development project, and a pilot, the Male Involvement in Reproductive Health project. Other projects were reviewed through an assessment of office in-country mission reports, annual reviews, studies, surveys and situation analyses, country Reproductive Health (RH) and Population and Development (PD) analyses and reports of joint programme partner consultations. The latter included annual regional management and Reproductive Health technical meetings, as well as the recent regional consultations for managers of RH and PD programmes held in August and September 2007, respectively.

Together, this information provided the basis for this composite review of the achievements and lessons learnt from the Third Multi-Country Programme of UNFPA assistance to Pacific Island countries. The report, prepared by a consultant, provides a comprehensive overview of programme implementation and the levels of effectiveness at meeting the programme’s objectives.

Two sub-programmes were supported, Reproductive Health and Population and Development, with the following planned outputs:

The Reproductive Health sub-programme was designed to achieve the following outputs:

- Improved quality of and access to reproductive health services, especially in rural and remote areas.
- Improved management of reproductive health programmes.

The Population and Development sub-programme aimed to achieve the following outputs:

- Strengthened country and regional capacity to monitor and report on progress toward the achievement of the ICPD goals and the MDGs.
- Enhanced awareness and understanding among policy makers and key stakeholders of population trends and their implications for sectoral planning and policy formulation.
- Strengthened partnerships with key groups - parliamentarians, policy makers, religious and community leaders, civil society organizations and the media - to broaden the network of population and development advocates.

The third Country Programme (CP3) for the Pacific occurred during a period of considerable change for the regional office, including leadership, office capacity, financial systems and technical services arrangements, as well as the initiation of UN Reform. Partly as a result of the changes, not all projects commenced at the beginning of CP3, some starting as late as 2005. However, by the end of 2007, the Sub-Regional Office had put in place much strengthened management and technical systems to support and manage the CP. As a result of these changes it was able to achieve a high implementation rate and also fund-raise very successfully additional resources to those provided from UNFPA’s core budget for the Pacific.

A very impressive set of high quality technical activities were undertaken in the areas of Reproductive Health. These activities were implemented at both the regional, sub-regional and country specific level. The areas of work were a very appropriate “niche” for the organization (maternal health services, including family planning, adolescent sexual and reproductive health, reproductive health commodity security, gender and data), focused on capacity building and were much appreciated by the Pacific countries.

Of particular note was the initiation of an improved monitoring and evaluation strategy and the undertaking of a range of operationally oriented research and the publishing and dissemination of the results. This emerging data base is beginning to greatly improve UNFPA’s capacity for results based management. Also an impressive achievement was
the strengthening of RH Commodity Security in fourteen countries, including provision of a regional warehouse in Suva, a first for the region. In terms of capacity building, over four thousand mid-level and senior health workers from ten countries had their knowledge and skills upgraded and a number of nationally oriented updated protocols were produced. Tools were introduced and medical supplies and equipment distributed to health facilities, as well as contraceptives, including male and female condoms. The Adolescent Health and Development and the Male Involvement projects met important and growing needs and the need to revitalize Family Planning was increasingly recognized. All projects linked together in various ways. UNFPA increased its partnerships with a range of agencies, including UN, government and regional agencies and NGOs.

However, human resource shortages continue to constrain improvements in reproductive health services, as does the prevailing negative economic situation in almost all countries. Transfer of knowledge and skills to staff in outlying areas of each country also continues to remain a challenge. While national execution of reproductive health services projects continued in CP3 so too did financial accountability issues. Reporting requirements also continued to present problems for some project directors, indicating a need to modify the system.

Overall, while the Reproductive Health sub-programme for 2003-2007 was very appropriate in its scope, some projects appear ambitious. The annual regional technical training of training workshops, while rich in content, did not always result in national and subnational transfer of knowledge. Because of the lack of evidence that the health worker training has had an impact in improved services a major lesson learnt is that there is a need to concentrate more on in-country follow-up, although that is really the responsibility of governments. There is also a need for more comprehensive assistance ie partnering for support for items such as for water and facility renovation.
which are outside UNFPA’s mandate. As well, more community involvement and socio-cultural approaches, especially gender analysis, should enable inputs to be more effective.

While the amount and type of activities and the outputs have been very impressive, there is a continuing inability to see definitive cause and effect, to prove that UNFPA funded activities have made a significant difference to the quality and availability of reproductive health in the Pacific. Evidence of outputs (which have been extensive) is clear but it is still difficult to demonstrate direct impact (outcomes).

No evaluation was undertaken of the Population and Development projects, instead information was obtained from UNFPA and SPC project reports because of the late start of most projects and the lack of baseline data. Globally, UNFPA has traditionally played a very active and effective role in building capacity in data collection over the past three decades. However, in recent years, because of the increased level of capacity and high costs of censuses (and availability of other funds) the organization has reduced its support to this area and concentrated more on building capacity in analysis and use of the results in planning, as well as advocacy to increase awareness of the issues.

A modest contribution to this end was made during CP3 with assistance being provided to countries both regionally, sub-regionally and in-country in the areas of data analysis and its use in policies and planning. This is a useful niche area for UNFPA and one which could well be increased in CP4. CP3 inputs to data collection were relatively small and mostly consisted of technical advice, especially relating to the MDG indicators, as part of the UN mandate. Given that other better resourced agencies are making heavy inputs into data collection a reduced role in this area would seem appropriate. However, the exception would be the DHS’s to which UNFPA expertise could and should play a very useful role. A more significant financial contribution than was available in CP3 would help to maintain a higher profile in this area.

The Parliamentary project (PPAPD) has the potential to play a very useful role in educating decision makers on Pacific population issues. Some gains were made during CP3, especially through the regional meetings and the production of the advocacy kit. However, a number of refinements are required in the approach to make the project more effective and sustainable. A revised relationship with other agencies working on Population and Development, and a focus on its particular niche area of expertise would seem to be appropriate.

The Indicator project is helping to fill a significant data gap for UNFPA’s priority countries and will provide essential baseline data for assessing CP4 achievements. The Gender Based Violence (GBV) research is helping to place the subject on national agendas which is crucial if their rights are to be met and women’s reproductive health improved. Such research is a useful example of how data can define a problem and be used for advocating for attention to be paid to the subject and providing guidance on how the issues should be addressed.

General recommendations focus on management, programming, technical and capacity building issues, with responsibilities for addressing the issues mostly the responsibility of UNFPA and the implementing agencies (which include governments). Project specific issues are described under each project section and in the various project evaluations.

Overall, the Third Country Programme, through both the Reproductive Health and the Population and Development sub-programmes, made many valuable contributions to addressing reproductive health and population issues in the Pacific, and, to varying extents, contributed to achieving the outcomes. The various projects provided an appropriately inter-related programme of assistance and received high quality technical assistance to do so. There were a number of significant specific achievements, including the development of a comprehensive monitoring and evaluation data base which will greatly enhance results based management in the future.

It is apparent that both sub-programmes were somewhat constrained by various issues inherent in Pacific island countries as well as some design and implementation weaknesses and workload issues. The latter needs to be rectified in CP4, including being less ambitious and more focused, with increased focus on socio-cultural issues, including gender.

It is notable that the Sub-Regional Office is now in a much better position than it was at the beginning of CP3 to oversee the addressing of such issues in the future. It does, however, still require some additional types of technical expertise to be able to effectively address the reproductive health needs of the region.
The UNFPA Office for the Pacific (which is a sub-regional office of the Asia Pacific Division) provided financial and technical support to fourteen Pacific Island countries through its third Multi-Country programme covering the years 2003-2007 (CP3). In line with UNFPA’s global mandate, assistance covered the areas of Reproductive Health and Population and Development. The work was coordinated by a Suva based programme and administrative team supported by a small group of technical advisors which provided assistance to the same fourteen countries, as well as to the Papua New Guinea UNFPA programme.

The primary focus of the Programme was on five Least Developed Countries (Kiribati, Samoa, Solomon Islands, Tuvalu and Vanuatu). UNFPA also provided some assistance through a number of regional and country specific projects involving nine other countries (Cook Islands, Federated States of Micronesia (FSMic), Fiji, Nauru, Niue, Palau, Republic of Marshall Islands (RMI), Tokelau and Tonga). Figure 1 below provides a map of the region covered by the Regional Office.

In line with current international development practices, a results-based management approach was developed during the programme cycle. This approach emphasized the achievement of outputs, rather than outcomes, and within this context, a comprehensive planning, monitoring and evaluation programme was developed. As part of this system, an end-of-cycle evaluation is normally required. However, for the following reasons, it was not practical to conduct a holistic programme evaluation - because of the nature of the region covered, the diversity of the programme components, the small size of many project budgets and their different start dates, as well as the relative cost of undertaking evaluations. Another factor was whether sufficient quality data was available against which to assess performance. The increasing availability of detailed project monitoring data has improved the ability of programme managers to assess the quality of their work.

Figure 1: Map Of UNFPA Pacific Partner Countries
information to inform decision making also reduced the need for formal evaluations for some projects.

Therefore, external evaluations were confined to the two relatively large, thematic projects which had been implemented for some years i.e. the Regional Reproductive Health Training Programme and the Adolescent Health and Development project, and to a pilot project, the Male Involvement in Reproductive Health project. Other projects were reviewed through an assessment of mission reports, annual reviews, studies, surveys and situation analyses, country reproductive health and population and development surveys, surveys by other agencies and reports of joint programme partner consultations. The latter included the annual regional Management and Reproductive Health technical meetings, as well as the recent end cycle regional consultations for managers of Reproductive Health and Population and Development programmes held in August and September 2007, respectively.

Together, this information provided the basis for this composite review of the achievements and lessons learnt from the Third Multi-Country Programme of UNFPA assistance to Pacific Island countries. The report provides a comprehensive overview of programme implementation and the levels of effectiveness at meeting the programme’s objectives.
CHAPTER 2
THE NEEDS

2.1 SITUATION ANALYSIS OF PACIFIC ISLAND COUNTRIES AND POPULATION AND REPRODUCTIVE HEALTH RELATED NEEDS

The Pacific region is spread across approximately 155 million square kilometres of ocean, the largest expanse of water in the world. It is geographically and culturally diverse, with three principal geographical and cultural groupings: Melanesia (comprising Fiji, Papua New Guinea, Solomon Islands and Vanuatu); Polynesia (Cook Islands, Niue, Samoa, Tokelau, Tonga, Tuvalu); and Micronesia (FSMic, Kiribati, Nauru, Palau and RMI). All countries are islands, some large and mountainous while many others are tiny, uninhabited or sparsely populated atolls. Populations vary in size from 1,400 in Niue to 6.2 million in Papua New Guinea. It is almost impossible to generalise about the region as it is not homogenous.

Economically, the region is challenged, being influenced by the global economy, but without the means to fully participate in it. Because of their small populations, geographical isolation and vulnerability to natural disasters, countries in the Pacific region are unable to benefit from economies of scale. Consequently, there are limited opportunities for economic growth. Although extreme poverty is rare, many people suffer from a lack of opportunities of all types, including education, access to adequate health services and information and most significantly, to remunerative employment. Despite remittances from abroad, the proportion of the population living below the poverty line is increasing in several countries.

The number of people entering the labour market is outstripping the number of available jobs, even in countries with high emigration rates. This has resulted in rising youth unemployment and its attendant problems, especially in urban areas where the rate of population increase is up to 4% in some (mainly Melanesian) countries. On the other hand, depopulation is an issue in countries such as Niue and the Cook Islands, with dependency ratios being negatively affected because of out-migration of young/mid adults to New Zealand, Australia and the USA. In the central and eastern Pacific the high levels of migration have halved or even negated population growth.

Natural population growth is high at about 2 per cent. Total fertility rates have stalled at 3 to 4 children per woman in much of region. In Melanesia (excluding Fiji), rates have been declining, but only slowly from 4.5 children per woman. Table 1 lists the current populations of each country.

Table 1: Populations of Fourteen Pacific Islands Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Population*</th>
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<tbody>
<tr>
<td>Cook Islands</td>
<td>13,600</td>
</tr>
<tr>
<td>Federated States of Micronesia</td>
<td>110,200</td>
</tr>
<tr>
<td>Fiji</td>
<td>831,300</td>
</tr>
<tr>
<td>Kiribati</td>
<td>93,500</td>
</tr>
<tr>
<td>Republic of the Marshall Islands</td>
<td>56,000</td>
</tr>
<tr>
<td>Nauru</td>
<td>10,100</td>
</tr>
<tr>
<td>Niue</td>
<td>1,600</td>
</tr>
<tr>
<td>Palau</td>
<td>20,000</td>
</tr>
<tr>
<td>Samoa</td>
<td>185,200</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>487,200</td>
</tr>
<tr>
<td>Tokelau</td>
<td>1,400</td>
</tr>
<tr>
<td>Tonga</td>
<td>99,300</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>9,700</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>221,400</td>
</tr>
<tr>
<td>Total for island countries</td>
<td>2,140,500</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>6,187,100</td>
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</tbody>
</table>

* Source: Selected Indicators UNFPA Pacific 2006

The low status and educational levels of women contributes to high fertility and poor reproductive health. Contraceptive prevalence rates have remained below 50 per cent throughout the region, with most countries ranging between 20-40% with declines in some countries and small increases in others. A particular achievement has been that the majority of women now deliver in a health facility in all countries, although the maternal mortality rate is still unacceptably high in many countries. Most women attend Antenatal Clinics more than five times but often commence attendance later than recommended. The rate of Sexually Transmitted Infections (STIs) amongst pregnant women is very high in a number of countries. Chlamydia, for example, has been identified in approximately 40% of pregnant women in some countries.

Access to health services is often problematic, because of distance, terrain, weather and lack of affordable transport. Services often struggle to provide adequate care when reached, being poorly equipped and staffed. The widespread prevalence...
of malaria is a serious contributing factor to maternal ill-health in both Solomon Islands and Vanuatu. In Polynesian and Micronesian countries extremely high levels of obesity and non-communicable diseases, largely due to poor modern-style diets and sedentary lifestyle, also affect health and well-being.

However, despite these constraints there have been recent improvement in reproductive health status in some of the countries such as the Cook Islands which has achieved the majority of the MDG indicators. All PICs except PNG have reached some of the targets. The situation in other countries, such as Kiribati, Tuvalu, Vanuatu and the Solomon Islands, remains challenging with little chance of them achieving all of the MDGs within the next decade, although Solomon Islands and Vanuatu have made significant improvements in Reproductive Health.

In most countries, a large proportion of the population is young, with about 60% being under the age of 24 years. This group represents a very large cohort of young people entering the sexually active phase of their lives, with consequent increasing demands for RH related education and services. Recent surveys report high levels of unprotected sexual activity among young people. High rates of sexually transmitted infections among young people as well as teenage pregnancies strongly indicate the need for intensive programming focused on adolescent reproductive health and development.

Almost all Pacific Island countries continue to experience low levels of reported HIV infection (only a handful or no cases officially reported in many countries, except for Fiji where over 270 positive cases are recorded). PNG is at a much more advanced stage of the epidemic with approximately 46,275 cases reported. However, the region is “fertile terrain” as shown by the high rate of sexually transmitted infections, the low level of condom availability and use, the lack of voluntary, confidential counselling, the amount of travel around and out of the region, the lack of employment opportunities, the extent of alcohol abuse and gender based violence and beliefs that HIV is a disease only of certain groups such as prostitutes.

Culturally, women tend to be disadvantaged throughout the region but increasing levels of education, media campaigns, projects and activism are helping to increase awareness of, and access to, women’s rights. Traditional culture still plays a major role in Pacific societies, blended with Christianity and some modern influences. While families are still very strong and provide significant social and economic support to their members there are signs of that changing, especially in urban areas. Gender-based violence is widespread although efforts are being made to address the issue through legal means, policing, media campaigns, provision of services and the promotion of human rights. Also of concern is that women’s political participation in both local and national government remains amongst the lowest in the world.

In regard to human rights, most Pacific Island countries have constitutions that contain basic civil and political rights, and all have ratified the
Convention on the Rights of the Child and most have ratified the Convention on the Elimination of All Forms of Discrimination against Women (Tonga, Palau, Nauru have not). While generally low, rates of domestication vary within the region. Also, the region has the lowest ratification rate for the core international human rights treaties.

National budgetary constraints have made it difficult to mobilize sufficient national financial resources for population and sexual and reproductive health initiatives, resulting in heavy dependence on donor support. Poor governance, low absorptive capacity, inadequate human resources and lack of institutional capacity, including for data analysis and planning, have limited the impact of development programmes. This is despite the plethora of regional and other development agencies which exists in the Pacific and the fact that the region receives the highest per capacity aid income in the world. This situation is partly because transaction costs in the Pacific remain very high due to the vast distances, the unavailability of direct and frequent flights and their very high costs.

A major challenge is the loss of skilled human resources. Despite extensive contributions to capacity building in most areas of economic and social development over past decades, countries continually report a loss of capacity. Poor salaries, inadequate supplies and poor conditions, as well as inadequate numbers of positions in key areas contribute to issues of morale and inability to perform effectively and are compounded by out-migration.

In addition to the above challenges, political upheavals/security problems in three countries, as well as climatic disasters, have challenged partner governments during the past five years.

These factors impede or have slowed down progress in the region, including the implementation of development assistance. The diversity of the Pacific also makes for challenges in terms of the management of Reproductive Health programmes and the need to adapt to the different cultures.

However, despite the above, the Pacific also has some very positive features including strong traditional family ties, wonderfully rich cultural practices, including musical and artistic skills and survival mechanisms for times of climatic disasters. Christianity also provides a strong basis for community life in all countries and Islanders are very proud of their common heritages but also their individual nationalities.
CHAPTER 3
THE RESPONSE

3.1 UNFPA’S MANDATE

The United Nations Population Fund (UNFPA) is the lead UN agency for the follow-up and implementation of the (Cairo) 1994 International Conference on Population and Development (ICPD)’s Programme of Action. Its mandate is to promote the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA’s focus is on Reproductive Health and Population and Development and supports countries in using population data for policies and programmes to reduce poverty. The objective is to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV and AIDS, and every girl and women is treated with dignity and respect. UNFPA’s expertise complements that provided by other UN agencies, for example UNDP in poverty mapping and alleviation, WHO in technical standards and UNICEF in the area of services for children. For more detail on such partnerships see Chapter 4.6.

Table 2 below lists the various areas of expertise offered by UNFPA, all of which are relevant to helping address the Reproductive Health related needs described in the previous chapter and many of which were used in CP3.

Table 2: Major Areas of Assistance Offered by UNFPA

<table>
<thead>
<tr>
<th>AREA</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH Commodity Security</td>
<td>Provision of commodities, including contraceptives; capacity building for strategic planning including forecasting, logistics, warehousing, distribution, record keeping etc., country level reviews and assessment</td>
</tr>
<tr>
<td>RH Services and information on FP, Maternal Health including, Ante-natal and Post-natal care, Obstetrics, EmOC and STIs/HIV</td>
<td>Advocacy for RH; capacity building through training and technical advice at the regional and national level; contributing to formulation or updating of policies and preparation of policies, protocols and guidelines; provision of medical equipment, supplies and IEC materials and training courses; advocacy for addressing other needs; TA for operations research, STI/HIV prevention and treatment and condom programming.</td>
</tr>
<tr>
<td>Management of RH programmes, including evidence based planning, project financial management, operations research and monitoring and evaluation</td>
<td>Capacity building/training in planning, assist in design of operations research, monitoring and evaluation plans and tools, technical assistance in data collection and analysis and use of results for planning, advocacy and publications.</td>
</tr>
<tr>
<td>Adolescent RH information and services</td>
<td>Advocacy; capacity building through TA for workshops on adolescent SRH education and youth friendly services, integration of family life education in school curricula, assistance with formulation or updating policies and guidelines, preparation of IEC materials and provision of equipment and supplies for youth friendly services and peer education, training and operations research.</td>
</tr>
<tr>
<td>Population and Development Strategies (including data collection, analysis and use in planning)</td>
<td>Capacity building/technical assistance in the collection, analysis and use of population data for national policies and plans, including analysis of data, use of data in advocacy and dissemination of information, including preparation of publications</td>
</tr>
<tr>
<td>Information, Education, Communication/Behavioural Change Communication</td>
<td>TA for developing guidelines and strategies, training programmes, strategies for behavioural change, capacity building in media campaigns, production of IEC materials and community education approaches</td>
</tr>
<tr>
<td>Gender and other Socio-Cultural matters</td>
<td>TA and support for advocacy, gender analysis of needs and project designs and monitoring of programmes, planning and conducting operations research and use of data to inform.</td>
</tr>
</tbody>
</table>
3.2 THE UNFPA PACIFIC SUB-REGIONAL OFFICE FOR THE PACIFIC

The UNFPA Pacific Sub-Regional Office is part of the United Nations regional team based in Suva, Fiji. The UN team includes FAO, ILO, OHCHR, UNAIDS, UNESCOP, UNDP, UNESCO, UNFPA, UNICEF, UNIFEM, UNHCR, UNOCHA, UNOPS and WHO. All agencies are currently working closely together to plan and implement an increasingly cohesive UN programme of assistance to the region. UNFPA covers fourteen Pacific island countries (plus Papua New Guinea for technical assistance). Five of these countries have been selected by the UN as priority countries because of their Least Developed Country (LDC) status.

The Pacific Office is part of UNFPA’s Asia and Pacific region and is therefore a sub-office of the region but for the purpose of this report it is referred to as the Pacific Sub-Regional Office.

UNFPA Staff include two managerial staff including the representative/director and the deputy representative who are responsible to UNFPA Headquarters in New York for overseeing a technically sound and cost-effective regional programme of assistance relevant to UNFPA’s mandate. Four advisors provide technical assistance in the areas of Population and Development, Reproductive Health, Reproductive Health (Operations Research and Monitoring and Evaluation) and STI and HIV. As well, the Regional RH Commodities Manager is based in the Suva office along with four programme officers and eleven support staff including human resource, administrative and finance officers and drivers. Regular staff include six international, one Samoan and nineteen Fijians whose expertise is occasionally supplemented by consultants recruited on a short term basis for specific tasks.

The Office performs a multiplicity of tasks, including fund raising, advocacy and media coverage for population and reproductive health issues, as well as planning and overseeing execution implementing agencies’ work in carrying out planned programme of activities. This work includes overseeing project expenditure in the fourteen countries and by regional agencies, responsibility for reporting to UNFPA HQ, including meeting audit requirements. In addition, technical and management advice is provided by the advisors and programme officers and the Office is responsible for implementing a comprehensive monitoring and evaluation programme. The complex and time consuming distribution of RH Commodities to the fourteen countries is also overseen from the Suva Office.

As well as providing in-country training, Office staff also organize regular regional workshops and meetings as part of planning, management and technical training (for RH and PD) and for Parliamentarians. Sub-regional trainings are also organized. New publications are also distributed throughout the region on a regular basis, as well as other materials on request.

UNFPA Regional Office staff at their 2007 Retreat -planning to serve the Pacific even better
3.3 OVERVIEW OF THE THIRD MULTI-COUNTRY PROGRAMME, 2003-2007

The UNFPA third cycle of assistance included country-specific activities and sub-regional initiatives in partnership with fourteen Pacific Island countries. The CP3 Programme was developed in 2002 based on the findings of the UN common country assessment and the United Nations Development Assistance Frameworks (UNDAFs) for the five LDCs, the findings of the Evaluation of the second Country Programme and other lessons learnt during the previous cycle.

The strategic framework for the new cycle was agreed to by consensus with stakeholders from fourteen countries at a programme strategy meeting held in March 2002. The programme was formulated to strengthen countries’ capacities to achieve the ICPD goals and the MDGs. Emphasis was placed on capacity building and forming effective partnerships to address national priorities.

3.3.1 Planned Outputs

Two sub-programmes were supported, Reproductive Health and Population and Development, with the following planned outputs:

The Reproductive Health sub-programme was designed to achieve the following outputs:

- Improved quality of and access to reproductive health services, especially in rural and remote areas.
- Improved management of reproductive health programmes.
- Increased responsiveness to the reproductive health needs of adolescents.

The Population and Development sub-programme aimed to achieve the following outputs:

- Strengthened country and regional capacity to monitor and report on progress toward the achievement of the ICPD goals and the MDGs.
- Enhanced awareness and understanding among policy makers and key stakeholders of population trends and their implications for sectoral planning and policy formulation.
- Strengthened partnerships with key groups – parliamentarians, policy makers, religious and community leaders, civil society organizations and the media – to broaden the network of population and development advocates.

The ultimate objective: healthy Kiribati mother and baby
3.3.2 Sub-Programme Component Projects

In order to achieve the above outputs, the following projects were implemented under two sub-programmes

Table 3: UNFPA Sub-Programmes

<table>
<thead>
<tr>
<th>Reproductive Health Sub-Programme</th>
<th>Population and Development Sub-Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening Availability of Quality RH Services and Information, $1.5m (Cook Islands, Fiji, Federated States of Micronesia, Kiribati, Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu ie 10 countries)</td>
<td>Integrating Population, Gender and Development Issues into National and Sectoral Plans, $0.7m (10 countries)</td>
</tr>
<tr>
<td>Regional Reproductive Health Training, $0.8m (ten countries)</td>
<td>Capacity Building for Data Collection and Analysis in PICs, $0.3m. (10 countries) Developing Comprehensive Framework of Indicators for Programme Monitoring and Evaluation, $0.1m (Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu)</td>
</tr>
<tr>
<td>Reproductive Health Commodity Security, $2.5m (14 countries) Improving Adolescent Reproductive Health, $3.3m (10 countries)</td>
<td>Increasing Political Support for Poverty Reduction and the ICPD-POA, $0.3m (14 countries)</td>
</tr>
<tr>
<td>Male Involvement in Reproductive Health, $0.5m (Fiji and Solomon Islands)</td>
<td>Socio-Cultural Research on Gender-Based Violence and Child Abuse in Melanesia, Micronesia and Polynesia, $2m (Kiribati, Solomon Islands and Samoa)</td>
</tr>
</tbody>
</table>

Other forms of assistance included:

- The Programme Coordination and Assistance project ($0.3m a year), which supported un-programmed, ad hoc requests for activities such as participation in international conferences and events such as World Population Day (14 countries)

- Capacity Building for an Intensified Response to HIV, ($0.073m) provided for a regional HIV advisor and regional communications officer hired to assist regional and in-country strategies

- Technical Assistance Project, $0.7m (15 countries) which supported the travel/mission costs of the regional advisors and local salaries of programme staff and programme evaluation costs.

UNFPA projects were:

- Implemented by: Secretariat for the Pacific Community (SPC), fourteen Pacific Island Governments, fifteen NGOs, International Labour Organization (ILO), the Fiji School of Medicine (FSM) and UNFPA.

Funding Sources:

- UNFPA
- Australian Agency for International Development (AusAID)
- New Zealand Aid (NZAID)
- Global Fund
- UNAIDS
- Human Security Fund
- UN Foundation.

Commencement Dates: One of the features of CP3 is that projects commenced at very different times during the cycle, some as late as 2006. Figure 2 illustrates the range. There were a number of legitimate reasons for this situation. Formulation of the various projects was very time consuming, due to the multi-country nature of the programme. This was partly because of the need to obtain separate agreements with the 10 countries and the various regional partners which had to be accomplished by only a few staff. In addition, while the RH sub-programme was formulated on a timely basis, the one for PD was only finalized in 2005, for a variety of reasons.
The following component projects were designed to contribute to achieving the Reproductive Health programme outputs:

Component Projects

- **Strengthening Availability of Quality RH Services and Information**, $1.5m (Cook Islands, Fiji, Federated States of Micronesia, Kiribati, Marshall Islands, Solomon Islands, Tonga, Tuvalu and Vanuatu - 10 countries)
- **Regional Reproductive Health Training**, $0.8m (ten countries)
- **Reproductive Health Commodity Security**, $2.5m (14 countries - including the above 10 and Tokelau, Nauru, Niue and Palau)
- **Improving Adolescent Reproductive Health**, $3.3m (10 countries)
- **Male Involvement in Reproductive Health**, $0.5m (Fiji and Solomon Islands)
- **Strategies on HIV and AIDS**, $0.07m (10 countries)
- **Reproductive Health Related Research** (13 countries through various projects)

Linkages:

- The Reproductive Health Services project was at the heart of the Reproductive Health Sub-Programme, with the other projects closely linked and inter-dependent.
- The Commodities project (RHCS) assisted to provide the supplies needed for the services to be effective, including through community outreach to non-service outlets.
- The Regional Training Programme (RHTP) helped mid-level health workers to up-grade their skills and knowledge and consequently deliver more effective services.
- Both the Adolescent (AHD) and the Male Involvement (MIRH) projects relied on the capacity of the health services to deliver family planning, counseling, STI treatment etc., to meet the demand these projects generated.
- The HIV strategies work was also linked to RH services in various ways.
- The RH-related Research informed the work of all projects by providing base line data and evidence based information, thereby enabling them to be more effective.

Together these projects contributed to the achievement of the Sub-Programme output of improved quality and access to services, improved management and increased responsiveness to the reproductive health needs of adolescents (and men).

The work of the Population and Development Sub-Programme also contributed through the identification of data through the census and Demographic Health Surveys (DHSs) and Indicator projects, the use of data in planning (including for informing budget decisions) and the educating of parliamentarians.
CHAPTER 4
THE FINDINGS

The following are the findings of the composite review in both the management and technical areas of UNFPA’s Third Multi-Country programme.

4.1 PROGRAMME MANAGEMENT

4.1.1 Capacity of the Pacific Sub-Regional Office, Suva

A broad range of measures were put in place during CP3 to improve the situation of the Sub-Regional Office in Suva as well as programme management by the Sub-Regional office. This emphasis was partly in response to the managerial weaknesses revealed by the CP2 Evaluation. Special attention was paid to monitoring and evaluation and to national execution modalities. The strengthening of the Office was partly a result of UNFPA Headquarters giving higher priority to the capacity of its country (or regional) offices around the world, in recognition of the heavy workload being experienced by all offices since ICPD. In the Pacific this workload was particularly onerous because of the number of countries and the huge geographical area being covered.

The following management-related developments occurred during CP3:

- As a result of the findings of the UNFPA headquarter’s 2003 field office needs assessment and realignment process, the Regional Office was significantly upgraded. This included the provision of an international deputy representative position, three new programme staff and one new technical advisor (STI/HIV) and four additional support staff, as can be seen from the following table.

<table>
<thead>
<tr>
<th>Year</th>
<th>Programme</th>
<th>Technical</th>
<th>Support</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>2007</td>
<td>9</td>
<td>6</td>
<td>11</td>
<td>26</td>
</tr>
</tbody>
</table>

- Information and communication technologies were enhanced, improving the capacity of the country office to monitor the programme on a systematic basis without incurring the high costs of constant missions to widely scattered Pacific Island countries. Complementing this development, the capacity of several Pacific Island countries in information and communication technologies increased considerably in recent years, enabling regular e-mail communication. Another example of new technology helping service delivery has been the provision of mobile phones to RH nurses in the Tonga districts.

- A new global on-line financial management system (ATLAS) was initiated in all UNFPA offices in 2004, providing integration between finances, procurement, personnel and programmes for the first time. It also enabled up-to-date financial information to be available both in New York and the field office, and an easier way to track results. Its introduction meant that all office staff and partners had to be trained in aspects of the new system. Monitoring tools also had to be adapted to accommodate the unique nature of the Pacific’s multi-country programme.

Also, as part of the strengthening process, the regional technical advisors’ team was merged with the Regional Office in 2003, with the director combining his role with the Representative’s duties. This has enabled advisors and programme staff to work much closely together and provide more cohesive programmatic as well as technical assistance to Pacific countries. However, during CP3 the office was constrained to some extent by three changes in Representatives over the five year period, including an eighteen month gap. The current incumbent has now been in place since early 2005, providing much needed stability.

As well, UNFPA’s in-country capacity was strengthened by the establishment of a sub-office in the Solomon Islands staffed by a national programme officer. UNFPA also recently took up the responsibility of establishing and leading a joint UN in-country presence in FSM and RMI and joined with UNICEF to establish a combined post in Samoa. UNFPA will also be represented through UNICEF’s leadership in Vanuatu and Kiribati and by UNDP in Nauru, Tuvalu and Palau. The latter arrangements commenced in 2006 and their implementation will help to provide a much needed in-country presence.
• Regular meetings were held with executing agencies such as SPC, maintaining communication, addressing issues and ensuring that projects were adjusted accordingly.

• Country partners were provided with management training, covering use of the logical framework design, results-based management and financial reporting. As well, annual regional technical workshops were held.

• Investments were made in training new and existing staff by providing them with opportunities to upgrade their technical and managerial skills to monitor and support the programme more effectively, especially in the areas of monitoring and evaluation, media and use of ATLAS.

• As part of UN Reform, all UN agencies worked far more closely together to develop the UNDAF and forge complementary partnerships wherever possible to increase the effectiveness of UN development assistance.

• Improvements were made to the monitoring and evaluation systems.

Conclusions: As a result of these developments the Suva Sub-Regional Office is now in a much better position to manage what is a particularly demanding regional programme.

4.1.2 Programme Monitoring and Evaluation

One of the most obvious achievements of the Third Country Programme has been the establishment of a very impressive and comprehensive monitoring and evaluation programme. This has greatly strengthened the ability of the Regional Office to assess progress, highlight issues which require addressing and improve the capacity to realize results based management. The following have been put in place or undertaken:

• A comprehensive Monitoring and Evaluation framework and annual work-plans which have provided a clear strategy for what is to be examined, when and why, providing the Regional office with a strong basis for results based management.

• The logframe was used as the original planning tool for sub-programmes but it was not relevant at the country output level. Hence regional project and country specific logframes and annual work-plan monitoring tools had to be developed, clearly illustrating the enormous amount of work required to adequately monitor fourteen (relatively small) island nations. The idea of these tools was to simplify and minimize reporting and for attaching to the quarterly (or six monthly) financial reports. Many countries have found them very useful and used them for other tasks as well while others have found them a challenging new experience.

• A regular programme of monitoring activities has been conducted, and over twenty-five country monitoring missions have been undertaken by UNFPA programme officers, sometimes with technical advisors during CP3. Comprehensive follow-up action-oriented reports which identified who was responsible for doing what were completed for each mission. Because of the number of countries and the cost and time required, these missions covered all areas of UNFPA work in a particular country, rather than being project/sector specific. Such missions largely replaced Annual Review meetings from 2003 and were generally annual (complemented with regular email and phone communication). Unfortunately, because of the multiplicity of duties, and limited numbers of programme staff it was not possible to make an annual visit each year to all fourteen countries.

• A monitoring checklist was also developed and has helped to guide monitoring and standardize reporting by programme officers and technical advisors for in-country missions. Other monitoring related tools were also developed, including a Health Centre checklist, Adolescent Reproductive Health monitoring tools and a Rapid Needs Assessment Toolkit for Condom Programming.

• An Indicator project was designed and implemented in order to address the lack of sound health information systems and comprehensive national and regional data bases which has made for a long standing paucity of accurate and valid RH and Population and Development data in the region. This project focused on identifying the gaps in the indicator database and the collection of information from other sources which would fill those gaps. Where data was not available a particular study has been undertaken. To this end a series of mid-line surveys were completed. Endline surveys will be undertaken in 2008. Areas covered included Emergency Obstetric Care/Family Planning. Rapid Needs Assessments were also undertaken for FP and
STIs and four situation analyses on Adolescent Reproductive Health were completed. The information is currently being transferred for use as DevInfo through the UNFPA PacificInfo web based programme.

- Over twenty research activities were undertaken to provide evidence based guidance to project implementation and to provide baseline data (see 4.2.6).

- External evaluations on three major projects were undertaken in 2005 and mid 2007, as explained in the introduction to this report. Evaluations were undertaken of the Adolescent Reproductive Health, implemented by SPC, the regional Fiji School of Medicine based Reproductive Health Training Programme and the Male Involvement in Reproductive Health project implemented by ILO.

- In addition, self-administered questionnaires on Reproductive Health and on Population and Development were completed by most countries in late 2007 as part of the end of cycle review. These provided further information on what progress had been achieved from each country’s point of view.

- UNFPA did not just work alone on assessment. Joint Monitoring and Evaluations were undertaken with other UN agencies and other partners, including on the Pacific CCA/UNDAF, MDGR, DHS, FEMM, Forum Leaders, the Joint Strategy meeting and a Donor Round Table.

- Other agencies also undertook studies relevant to RH and PD and which could be referred to. These included UNICEF’s Situational Analyses for Children, Youth and Women in Cook Islands and RMI (to which UNFPA contributed) and the State of Pacific Youth, the STI and Second Generation Behavioural Surveillance studies (WHO), the Fiji Census, and the ADB funded “Cultures and Contexts” matter study.

Conclusions: The greatly enhanced monitoring and evaluation system which has been developed has provided the Sub-Regional Office with a wealth of data and other information by which to assess progress, to assist countries in decision making and planning for the next Country Programme based on lessons learnt. This will form a strong basis for future results based management and helped to imbue partners, to some extent, with this philosophy. However, despite the on-going work of the Indicator’s Project there are still some gaps in data which would be needed for the region to be able to document progress towards achieving the MDGs.

4.1.3 Financial Management

The Sub-Regional Office finance team consists of two staff (one of whom was only recently recruited) had the overall responsibility of ensuring financial records are compiled using the web based ATLAS system. They were supported by five Programme staff, each of whom were in turn responsible for a number of countries. Sub-Regional Office staff were responsible for ensuring that all financial responsibilities were understood by the national project director/finance officer and in place and that accurate acquittals were submitted in a timely manner. They followed-up financial matters during in-country missions as well as by email and phone.

Financial management was also supported by annual Regional Project Management Meetings (2004-2007) at which all fourteen countries were represented. Subjects included: the need for strengthened project management; the definition of Results Based Management (RBM); an introduction to the new ATLAS financial system; the responsibilities of implementing agencies and project directors; the Monitoring and Evaluation framework and tools and work-plans and budgets. Practical step-by-step lessons in how to complete financial reports were also given. Countries reported on their experiences and shared lessons learnt. Such meetings provided a much appreciated opportunity for Reproductive Health partners to compare notes, to be up-dated on developments and to learn new management skills.

Participants were usually but not always, senior or mid level RH staff who had been nominated as “project directors” and other mid-senior health staff. As well, most country teams included a finance officer as it was they who would ultimately complete the financial reports.

However, it is unfortunate that few attended more than one meeting. Forty participants attended only one meeting, thirteen attended two and only one attended all three. This has implications for the subject matter of each meeting and the ability of each country to sustain the training provided.

The main issue arising at Management Meetings was financial reporting and monitoring progress. National execution was the preferred option under CP3, aimed at helping countries to take full responsibilities for the implementation of their projects. However, it is also the most problematic form of execution, with far less problems occurring with executing agencies such as SPC and UN agencies. However, some exceptions to
the latter occurred because financial management was the responsibility of the agency headquarters and not the UN agency's Suva office, requiring much long distance communication.

However, many of the lessons at the Management Meetings do not appear to have been translated into correct practice and this caused many problems, both for the UNFPA office and the countries themselves. As the Representative pointed out in his opening speech at the 2006 meeting “... there are some persistent issues that continue to haunt us...” In 2005, the Assistant Representative reported that the status of financial and project reporting was “sub-optimal”. Late and inconsistent reporting, inaccuracies in accounting, incorrect use of forms and lack of justification as to why changes were made to workplans and budgets and inconsistent attempts to integrate RBM principles of planning have regularly occurred in almost all countries. Sub-Regional Office staff reported that most countries had to be given constant reminders about the need to submit acquittals.

These problems resulted in extra work for both country and UNFPA staff and also contributed to some delays in implementation in most countries.

Reasons for these issues include work overload, due to too few national staff and too many responsibilities. High project related staff turnover which resulted in loss of knowledge on how to report was also an issue and also the ones who attended the Regional Meeting (and training) were not always the one who was responsible for reporting. In some cases, Health staff had to meet different reporting requirements for different donors, in addition to those of UNFPA. The change to the new ATLAS system which occurred mid-cycle, also contributed to some confusion. That all communication had to be done long distance was an additional challenge in trying to addressing such matters.

**Conclusions:** Regional Programme Management Meetings were a valuable and valued opportunity to share experiences and learn better ways of managing projects. However, given the financial management issues, and their long-standing nature, it is apparent that a more viable option for accounting for funds needs be found. While financial training was provided, in some countries improvement in financial reports was not observed. This could have been due to staff turnover, heavy workloads and lower priority given to small UNFPA projects. This is especially so for those countries where the amount of money is small (eg under $30,000 a year).

### 4.2 FINANCIAL SUMMARY, FUND RAISING AND IMPLEMENTATION RATES

The following tables provide an overview of the total income for CP3. This includes:

- Regular funding from UNFPA HQ as approved by the Executive Board in 2003 for the Pacific
- Other resources raised from other sources (such as bilateral donors) which are recorded in the budget and approved by the Executive Board
- Parallel resources Parallel funds are those mobilized by the Pacific Sub-Regional Office but which are provided by and recorded as expenditures by other Divisions/Units within UNFPA or other agencies and are not recorded in the Sub-Regional office budget
- Leveraged funds are those which were sought by UNFPA to complement the work of UNFPA projects but which do not enter any UNFPA budget
- Note that technical services are funded from regular resources and separately from project funds but contribute to the effective implementation of projects
- Implementation rates for regular resources are also shown below.

#### a) Total Resources

**Table 5: Financial Summary, Total Income, 2003-2007 (US$)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Resources* - provided by UNFPA HQ</td>
<td>7.44m</td>
</tr>
<tr>
<td>Other Resources - result of fund raising</td>
<td>3.6m</td>
</tr>
<tr>
<td>Parallel Resources - result of fund raising but not entered in Pacific budget</td>
<td>4m</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td>15.04m</td>
</tr>
<tr>
<td>Technical Support Services -</td>
<td>2.5m</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>17.54</td>
</tr>
<tr>
<td>Plus: Leveraged Funds</td>
<td>1.67m</td>
</tr>
</tbody>
</table>
b) Fund Raising

The Office was very successful in mobilizing an additional $US7.6 million from other sources, as shown in the table 18 and 19 below.

**Table 6: Other Sources of Funding (2007 is still a current budget) (US$)**

<table>
<thead>
<tr>
<th>Donor</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZAID, for RHCS, MIRH and Adolescents</td>
<td>75,505</td>
<td>160,434</td>
<td>99,683</td>
<td>276,699</td>
<td>565,504</td>
<td>1,177,825</td>
</tr>
<tr>
<td>UNFPA HQ - RHCS</td>
<td></td>
<td></td>
<td></td>
<td>91,272</td>
<td>81,000</td>
<td>172,272</td>
</tr>
<tr>
<td>Global Fund: Condom Programming</td>
<td>10,337</td>
<td>46,732</td>
<td>9,104</td>
<td>48,000</td>
<td>114,173</td>
<td></td>
</tr>
<tr>
<td>UNAIDS: Comm. Officer</td>
<td>17,961</td>
<td>55,594</td>
<td>73,555</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AusAID: ARH, EMoC; Fiji Census</td>
<td>15,134</td>
<td>39,555</td>
<td>486,717</td>
<td></td>
<td></td>
<td>541,406</td>
</tr>
<tr>
<td>*Human Security Fund: RH Services,</td>
<td>396,744</td>
<td>59,297</td>
<td></td>
<td></td>
<td></td>
<td>456,041</td>
</tr>
<tr>
<td>*UN Foundation: ARH</td>
<td>1,018,112</td>
<td>26,622</td>
<td>28,868</td>
<td></td>
<td></td>
<td>1,073,602</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td>1,490,361</td>
<td>256,690</td>
<td>190,417</td>
<td>434,591</td>
<td>1,236,815</td>
<td>3,582,234</td>
</tr>
</tbody>
</table>

*These funds were carried forward from the previous cycle.*

**Table 7: Parallel Sources of Funding (US$)**

<table>
<thead>
<tr>
<th>Funder and Project</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thematic Trust Fund, HQ (for RH Commodities),</td>
<td>509,354</td>
<td>509,354</td>
<td>509,354</td>
<td>509,354</td>
<td>2,037,416</td>
</tr>
<tr>
<td>UNAIDS Programme Acceleration Funds (for HIV activities)</td>
<td></td>
<td></td>
<td>25,000</td>
<td></td>
<td>75,000</td>
</tr>
<tr>
<td>UNFPA HQ Regional and AusAID for 6BV - for GBV study, to SPC</td>
<td></td>
<td></td>
<td></td>
<td>1,800,000</td>
<td>1,800,000</td>
</tr>
<tr>
<td>UNFPA HQ Regional Project (for Emergency Commodities Assistance for Tsunami Relief, Sol. Is.)</td>
<td></td>
<td></td>
<td></td>
<td>112,568</td>
<td>112,568</td>
</tr>
<tr>
<td>Various UNFPA HQ sources: for HIV related activities including conference/meeting attendance and small project activities</td>
<td></td>
<td></td>
<td></td>
<td>75,500</td>
<td>75,500</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td>509,354</td>
<td>509,354</td>
<td>534,354</td>
<td>2,547,422</td>
<td>4,100,484</td>
</tr>
</tbody>
</table>
In addition to the above funds, UNFPA leveraged additional resources totaling $1,675,659 for its projects which were provided by other agencies direct to the implementers of those projects.

### Table 8: Leveraged Funds (US$)

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF - for Adolescents project, funds direct to SPC</td>
<td>206,000</td>
<td>230,000</td>
<td>500,000</td>
<td>936,000</td>
</tr>
<tr>
<td>WHO (SPP) - for RH Services project, funds direct to countries</td>
<td>6,200</td>
<td>52,324</td>
<td>41,135</td>
<td>99,659</td>
</tr>
<tr>
<td>NZAID for Adolescents and Parliamentarians projects, funds direct to SPC</td>
<td>360,000</td>
<td>280,000</td>
<td>640,000</td>
<td>1,675,659</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>212,200</td>
<td>642,324</td>
<td>821,135</td>
<td>1,675,659</td>
<td></td>
</tr>
</tbody>
</table>

### Table 9: Implementation Rates for Regular Resources (US$)

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Expenditure: Regular Resources</td>
<td>355,384</td>
<td>1,221,718</td>
<td>1,550,644</td>
<td>1,921,055</td>
<td>2,330,000</td>
<td></td>
</tr>
<tr>
<td>Ceiling</td>
<td>530,000</td>
<td>1,224,000</td>
<td>1,787,000</td>
<td>2,000,000</td>
<td>2,331,447</td>
<td></td>
</tr>
<tr>
<td>Implementation Rate %</td>
<td>67</td>
<td>100</td>
<td>87</td>
<td>96</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Despite the various constraints experienced throughout CP3, the overall implementation rate during the cycle (for regular resources) has been consistently high, with percentages ranging from 67% in 2003, 100% in 2004, 87% in 2005, 96% in 2006 and an estimated 100% in 2007 (at the time of writing of this report):

The ceiling and related expenditure varied substantially from one year to the next, due to a number of factors:

- Implementation and expenditure in the first year was low, for reasons explained under 3.3.2 but picked up as all projects were commenced. However, considerable amounts of funds from previous years from other resources were available and continued being expended during the initial phase (but which are not counted in the above figures).

- UNFPA implementation and that of regional institutions such as SPC and the Fiji School of Medicine has been close to 100% each year. However, for the ten Governments implementing their component of the RH Services project (on average US$30,000 per year each for the 10 countries), implementation rates have been comparatively low and not consistent. Only a few countries submitted their expenditure reports and monitoring tools on a timely basis. Unspent balances have been carried forward, often year after year. This was despite major efforts by regional office programme and finance staff to provide guidance and support to project staff, as well as annual training on programme management. The NEX modality is obviously problematic and its appropriateness for the next cycle needs to be reassessed.

It is noted that the indicative planning figure originally provided by UNFPA HQ ($1.2 million per year) in 2002 was far from adequate to meet the needs of the Pacific, especially given that it is such an expensive region in which to function, as explained in the Introduction to this report.

**Conclusions:** The amount of funds initially available for CP3 from UNFPA HQ (US$7.44m) fell far short of what was required to implement such a comprehensive programme. However, the Sub-Regional Office was very successful in managing to raise an additional $7.6m from a variety of sources, as well as leveraging a further $1.7m for partner contributions.

The Office was also successful in managing to maintain a high level of implementation, despite its earlier staff shortages.
A particularly striking feature of the funding tables is the range of additional funds. While they were much appreciated, the provision of funds from such a multiplicity of sources was a challenge for managers and programme staff, both in terms of the time needing to be spent on seeking additional funds and addressing the programme shortfall and also for separate accounting of the funds from so many different sources. This is not an ideal or efficient system of financial management, especially with such a tiny financial unit.

While adequate funds were provided for the existing technical advisory team it is to be noted that no funds were allocated for monitoring and quantifying project outcomes/impact and there were no full time Monitoring and Evaluation staff. Hence a significant amount of time was dedicated by the RH Advisor (POAR) to determining these data gaps and resolving them. As discussed previously, additional positions would greatly enhance the capacity of the Office to provide appropriately multi-sectoral assistance.

4.3 TECHNICAL SUPPORT

The Regional Office includes a small team of technical advisors (one in 2003, two in 2004, three in 2005-6 and four in 2006-7). The latter cover the areas of Reproductive Health, Reproductive Health, including Adolescent (Programme Assessment and Operations Research), Population and Development and STI and HIV. In addition, the RHCS Manager and the Office Communication Officer were considered to be part of the technical advisory group and their services are available to the PICs, including PNG. Areas of expertise included Emergency Obstetric Care, FP, RHCS, AHD, STIs and HIV, Programme Assessment, Monitoring and Evaluation, BCC, Population and Development Policy and Data, Gender.

When CST advisors were not available to respond to a country need the technical advisory programme flexible funding was available for recruiting regional or international consultants. Approximately twenty six of the latter were contracted for 1-3 weeks during CP3, for expertise provided included eleven Pacific countries.

Together, these staff provide a wealth of high level technical knowledge and experience which is accessed by the countries (including PNG), complementing that which is also available within country and from other regional organizations.

Countries are able to call upon the assistance of an advisor which will be provided, depending on the timing of the request and other work commitments. It is not always possible to meet requests, especially those which are ad hoc. In most cases missions should be undertaken with programme staff.

Another role that advisors play is that of identifying local expertise whose local knowledge is very important in effectively addressing national contexts. However, the number available is quite small. Advisors have also contributed to the further training of local experts, through the various projects.

Advisers provided technical assistant through missions and nonmissions and participated in/contributed to the following during CP3:

- Proving technical advice to countries on particular aspects of policy and programme work in RH, PD, HIV and STI and gender, including policy and guidelines development
- Contributing to evidence-based policy dialogue through development of analytic papers
- Contributing to programme and project planning and design, ensuring that technical issues are fully integrated and facilitating more technically competent programming including development/review of multicountry programme documents and country programme action plans
- Training in particular skills and areas of knowledge, such as programme management, monitoring and evaluation, and operational research and both at the regional and national level
- Undertaking country reviews, situation analyses, monitoring and evaluation
- Reviewing of technical and programme documents, including technical publications, research papers and information for advocacy from UNFPA Subregional office, UNFPA HQ and other regional and country partners

- Contributing to resource mobilization through reviewing and developing proposals

- Participating in regional agency coordination meetings, including chairing interagency technical committees and UNDAF processes

- Participating in global and regional conferences for updating and knowledge sharing purposes; contributing papers at conferences and contributing sessions at other agencies’ meeting and workshops

- Participating in global expert group meetings and in meetings at UNFPA HQ

Figure 5: Nature of UNFPA Technical Assistance, 2006-7, Pacific

<table>
<thead>
<tr>
<th>Nature of TA (Number) by Pacific SRO, 2006-7</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity Building</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Policy Advocacy</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Policy/Strategic Plan</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Prep/Dis/Del/Prop</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Regional Policy/Decision</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Research</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Resource Mobilization</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Technical Publication</td>
<td>15</td>
<td>20</td>
</tr>
</tbody>
</table>

Number of missions by advisors (ie not including programme staff missions):

- 2003: 10 missions by 1 advisor, 5 of which were in the Pacific
- 2004: 18 missions by 2 advisors, 12 of which were in the Pacific
- 2005: 29 missions by 3 advisors, 14 of which were in the Pacific
- 2006: 48 missions by 3 advisors, 42 of which were in the Pacific
- 2007 to date: 54 missions by 4 advisors, 45 of which were in the Pacific

Total Missions: 159 of which 118 were in the Pacific, from 2003-2007

Length of missions varied from 3 - 14 days with most being around 5 days, not including travel time (which in the Pacific can be a number of days, rather than hours).

Advisors also contributed intensively from the SRO office, assisting with technical programme reports, manuals, development, monitoring and evaluation, preparing workshops and advising programme staff and countries etc.

As well as assisting the Pacific region, the Advisors were also involved in regional UN planning, contributing to UNDAF related activities, including participation in inter-agency groups and also to MDG related activities. Advisors also actively contributed to joint activities with other UN and regional agencies, providing complementary technical inputs to various meetings and workshops and conferences.

That the work of the advisors is appreciated can be judged from the mission reports, the number of requests made and comments made at regional meetings.

Issues include not being able to meet all requests, the time taken in traveling with-in this vast region, the inadequacy of travel budgets because of the very high cost of travel and most of all, the very heavy workload. The lack of dedicated advisors in the areas of socio-cultural /gender, and IEC/BCC is a disadvantage to providing fully effective and adequately multi-sectoral assistance.

The Pacific team is unique in UNFPA because it merged in late 2002 with the programme team, with the UNFPA Representative also being the Country Support Team (CST) Director. This arrangement proved to be very successful, allowing for much closer and regular communication between advisors and programme staff, and resulting in much clearer operational linkages between programmatic and technical functions. The combined missions have also benefited, with a much more systematic approach to assessing, identifying and providing tailored technical support. It also enables more effective follow-up on the outcomes of technical missions and more constructive discussions and better planning at the regular joint staff meetings. This arrangement has proved to be very successful and provided considerable synergy to the regional work, essential when running a programme for fourteen different countries.

Conclusions: The team of advisors is an invaluable technical resource for the Pacific programme, both for their Suva based work and that provided during in-country missions. All advisors are highly skilled.
4.4 REPRODUCTIVE HEALTH SUB-PROGRAMME

The following chapters 4.4.1 - 6 provide a description and review of each project.

4.4.1 Reproductive Health Services Project ($1.5m)

**Implementation:** UNFPA and ten recipient countries  
**Start Date:** Mid 2004  
**Countries:** Ten

**Description:** The RH Services project aimed to improve the quality and availability of RH services by updating technical knowledge and skills of service providers and improving management capacity, thereby contributing to improving the RH status of women, men and adolescents, especially in remote and rural areas of the ten countries (Cook Islands, Fiji, FSMic, Kiribati, RMI, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu). The needs of each country were to be addressed according to their own particular priorities.

**Regional Strategies:**
1. Regional technical training for 2-3 participants from each country, on the introduction of new service protocols and in-country technical assistance provided on the adaption and introduction of service guidelines
2. Regional technical workshops for RH trainers from each country, including the development of country-specific training plans
3. Regional annual RH management workshops for 2-4 participants from each country
4. Equipment, supplies and commodities

**Country Specific Strategies:**
1. In-country follow-up training on specific subjects, such as contraception, obstetrics, midwifery, the health card and RH awareness
2. In-country management training on planning, managerial skills, supervision and control, health information and planning, data collection and use, results based monitoring and evaluation, and referrals
3. Attachments of rural health nurses for off-site clinical training
4. Supervision of RH activities
5. Printing of protocols and other materials

**Positive Findings:** An external evaluation of the project was not undertaken because of its short duration (start date mid 2004), the relative dearth of available information on reproductive health indicators, limited funding and the extent of feedback which has already been provided through the various surveys and missions which had been undertaken. In addition, this information was supplemented by responses to the 2007 Comprehensive RH Survey which was completed by nine out of ten of the countries (Kiribati RH questionnaire was not received so the numbers included in the survey report were obtained from mission reports and verified by country presentation at a regional technical follow-up meeting).

The various surveys, rapid needs assessments, mission reports and the questionnaire over the past years provide a multi-angled view of the state of RH services and the impact of project inputs. They present a mixed picture, with an impressive array of activities undertaken and extensive and valued inputs.

On the positive side, a policy basis is gradually being established with all countries having the subject of RH included in national sectoral plans/strategies. However, only four countries have had their FP policies or service guidelines developed or updated during CP3 and only two yet have RH policies and one a safe motherhood policy. The provision of up-to-date and localized service guidelines is playing a key role in helping to upgrade the quality of services with UNFPA having contributed support to nine of the PICs. As described below, updated tools such as Family Planning Guidelines (WHO’s Medical Eligibility Criteria and Selected Practice Recommendations) and WHO’s Guidelines for the Management of STIs, and new tools such as the RH Library, the Guidelines on the Medico-Legal Care of Victims of Sexual Violence were introduced. The Family Planning (FP) Wheel which was adapted to the Pacific and introduced at regional and national meetings, was found to be extremely popular with more than 2,000 wheels distributed.

**Equipment, supplies and commodities** have been provided, including $1.24m worth of antenatal, birthing, neonatal and postnatal related drugs and hospital and medical equipment, including labour beds, delivery kits and obstetric-related drugs. Procurement was usually processed on an annual basis but emergency and ad hoc requests
were also occasionally met. All goods are sent to the UNFPA Regional Warehouse in Suva and then distributed to the respective countries.

**Management skills**, including planning, monitoring and evaluation have been improved through inputs including those in the annual regional management meetings. The latter has had included the development of national and subnational RH workplans and national staff development plans. Regional RH programme management meetings were held in 2004 and 2006. These Annual Reproductive Health Management Workshops, while expensive, were deemed very useful by both UNFPA and RH programme managers. These meetings translated to annual RH programme planning and review meetings in the 10 PICs. Participants were RH programme directors and managers. Topics in these meetings included RH & PD updates, Translating regional initiatives to national programmes, workplan development, Results Based Management, Monitoring and Evaluation, and financial and programme reporting. It also provided the opportunity for PICs RH programme managers to be updated on UNFPA programming process and to follow-up on outstanding issues.

**Training** constituted a major portion of the project. Eight regional RH technical meetings were held, with approximately one hundred and sixty staff from ten countries participating. The details are described at the end of this section.

**Annual Regional Technical Reproductive Health Workshops/meetings:** Another major project input were the RH Regional Technical workshops/meetings which were held annually. As mentioned above under Positive Findings, five to ten day regional Technical workshops were held each year, often in cooperation with partner agencies such as WHO and UNICEF. They were attended by, on average, twenty-five representatives from ten countries. Eight regional RH technical meetings were held, with approximately one hundred and sixty staff from ten countries participating. The meetings were aimed at providing countries with the opportunity to report on and share experiences in implementing RH services in their countries and to obtain technical updates and new skills. As well, UNFPA used these opportunities to provide the participants with comments and advice on project implementation and reporting, to plan future technical assistance missions and to introduce new approaches and tools.

Subjects included: updates on Family Planning; Emergency Obstetrics Care; the Management of STIs; Neonatal Mortality Resuscitation; Maternal Mortality Auditing and WHO Medico-Legal Guidelines and Health Worker Guidelines for addressing Gender Based Violence Voluntary Counseling and Testing. Other subjects included Behaviour Change Communications for HIV/STI and RH, and introduction of the Female Condom. As well, new tools such as the Family Planning wheel and the RH Library were introduced. The meetings have also provided opportunities for guiding the adaption (where appropriate) and use of updated manuals.

**Useful IEC materials – on various forms of contraception**

The profile of participants at regional workshops included:
- Obstetrician/Gynaecologists, Staff Physicians, national Family Health Advisors, Senior Medical Officer and a Medical Assistant.
- Clinical Nurses, Chief/Principal Nursing Officers, Nurse Managers, Nurse tutors and heads of Nursing Schools, Public Health Nurses, Nurses from Public Health or RH Clinics, Midwives
- Directors of RH Divisions, RH Project Coordinators
- Adolescent Health Development Coordinators, Safe Motherhood Coordinators

The majority would appear to be appropriate attendees, being in a position to include the subject matter in their workplans where appropriate, to initiate follow-up training/protocol development etc and/or to conduct it themselves, or to share information about new developments. However, while annual national-level RH meetings occurred in all PICs, follow-up at the subnational level did not always eventuate.

The annual regional technical meetings have provided a valuable adjunct to the RH Service project inputs and are obviously considered to be valued opportunities to share experiences and be
exposed to the latest RH information, especially to the content of new manuals. It is apparent that the meetings were found to be stimulating and motivating and they also provided a very valuable mechanism for obtaining an up-date on the status of each country’s RH services. Because of the high quality content they essentially provide in-service training which might not otherwise be available to them. However, the time allowed (i.e. limited by funding and participants’ absence from their duties) was often too short and the programmes were consequently packed, which was a challenge for some participants. Because so few attended a full series of these meetings there was also an issue of how effective they were in terms of reinforcement and sustainability of the knowledge gained.

UNFPA/WHO Strategic Partnership Programme (SPP) funds were also used for in-country follow-up activities, including “cascade” trainings and trainings for the introduction of adapted Family Planning protocols, supported by those trained and, a CST advisor in Tonga, Solomon Islands and Vanuatu, and rapid needs assessments in FP/STI in three countries by a regional consultant.

In addition, as Table 10 below shows, the number involved in national and sub-national training has been particularly impressive. Over 4000 health staff from ten countries have had their technical knowledge and skills upgraded in one hundred and twenty-eight one week (usually) long workshops at the sub-national or national level.

<table>
<thead>
<tr>
<th>Family Planning</th>
<th>Obstetrics</th>
<th>Sexually Transmitted Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of workshops</td>
<td>Number of participants</td>
<td>Number of workshops</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Cook Is</td>
<td>12</td>
<td>244</td>
</tr>
<tr>
<td>FSMic</td>
<td>2</td>
<td>52</td>
</tr>
<tr>
<td>Fiji</td>
<td>14</td>
<td>140</td>
</tr>
<tr>
<td>Kiribati</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>RMI</td>
<td>3</td>
<td>97</td>
</tr>
<tr>
<td>Samoa</td>
<td>8</td>
<td>472</td>
</tr>
<tr>
<td>Solomon Is</td>
<td>11</td>
<td>158</td>
</tr>
<tr>
<td>Tonga</td>
<td>12</td>
<td>300</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>1</td>
<td>163</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52</td>
<td>1568</td>
</tr>
</tbody>
</table>


Table 10: National and sub-national RH workshops conducted in the Pacific, and numbers of participants, 2004-2006
Figure 7 below illustrates that the Cook Islands, Fiji, Samoa, Solomon Islands and Tuvalu conducted a significant number of follow-up in-country national and subnational training in FP. Cook Islands and Samoa conducted the greatest number of obstetric trainings, followed by Solomon Islands, Tonga and Vanuatu. Cook Islands also led the way on Sexually Transmitted Infection (STI) related trainings, closely followed by Samoa, Tonga and Vanuatu. Federated States of Micronesia (FSMic), Kiribati, Republic of Marshall Islands (RM) and Tuvalu reported the least number of all types of national and subnational training, partly related to their smaller populations. It is notable that the subject area covered most frequently was Family Planning (FP) which, when combined with the improved supply of commodities, gives hope for a much needed and significant decrease in unmet need for family planning.

Figure 6: In-country Workshops in 2004-6 in each sub-discipline area

The figures show a variable picture, with Cook Islands, Solomon Islands, Tonga and Vanuatu increasing their numbers of trainings between 2004 - 2006, while FSMic and RMI stayed at about the same low level. Fiji, Kiribati and Tuvalu reported providing FP training in 2004 but none since then. Samoa provided a different picture with a high level in 2004, decreasing in subsequent years due to industrial action, from which they are now recovering. Fiji conducted further FP training in 2007 and led the introduction of Jadelle in the region.

Figure 7: Total number of participants at FP workshops by country and year

Several national staff had further developed their capacity to deliver trainings to their colleagues and to plan staff development more effectively (see Table 11 below).

### Table 11: Types of in-country trainers at national/sub-national workshops by country

<table>
<thead>
<tr>
<th>Type of Trainer</th>
<th>Frequency</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH Director/Coordinator</td>
<td>8</td>
<td>Cook Is, FSMic, Fiji, Samoa, Solomon Is, Tonga, Tuvalu, Vanuatu</td>
</tr>
<tr>
<td>Obstetricians</td>
<td>8</td>
<td>FSMic, Fiji, RMI, Samoa, Solomon Is, Tonga, Tuvalu, Vanuatu</td>
</tr>
<tr>
<td>Midwives</td>
<td>5</td>
<td>RMI, Samoa, Solomon Is, Tonga, Vanuatu</td>
</tr>
<tr>
<td>National Consultants</td>
<td>2</td>
<td>RMI, Tonga, Vanuatu</td>
</tr>
<tr>
<td>UNFPA Technical Advisers</td>
<td>8</td>
<td>Cook Is, FSMic, Fiji, RMI, Samoa, Solomon Is, Tonga, Vanuatu</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Cook Is (AHD Focal Person, Principal Tutor)</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>Solomon Is (School of Nursing, NGOs –SCFA, SIPP, OXFAM, ADRA, Churches – COM, UC, SDA, RC, SSEC)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Tonga (Health Information)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vanuatu (HIV coordinator, pediatrician, WHO consultants, other program officers within the ministry)</td>
</tr>
</tbody>
</table>


**Regional Meetings:** In August 2007, because of the forthcoming end of CP3, a regional meeting, Reproductive Health Regional Consultation Meeting, was held in Suva to review progress, achievements and lessons learnt of CP3 in each country. Thirty-two high level representatives from eleven countries participated. Participants included five Secretaries for Health, two Assistant Secretaries, six directors and thirteen project coordinators. The Australian High Commissioner made the opening speech and the acting New Zealand High Commissioner closed the meeting. A number of other regional ambassadors and High Commissioners also attended the opening session and reception, making it a truly high level regional opportunity to mutually confirm Pacific Island country RH needs and UNFPA’s commitment to assisting in meeting them in CP4. Also participating were eighteen representatives from other UN, local and regional partner agencies and staff.

This meeting provided an opportunity to identify and prioritise strategies and activities for the next cycle of assistance. The UNFPA Representative/Director of CST highlighted the role they were all playing in implementing the ICPD Programme of Action and the importance of ensuring that the new CP would be results based and how this related to availability of future funding from donors. An overview and review was provided on each project and the role of UN Reform was also explained.

**Positive Findings on Regional Workshops and Meetings:** Based on a review of the meeting reports, participants’ comments and their country reports and subsequent field monitoring mission reports, the following observations can be made about the effectiveness of the regional technical meetings as a tool to support project partners in improving their technical and planning capacities:

- The regional workshops have been well prepared and organized and very well resourced with the latest in RH-related information, resources and skills and with information provided by high level technical advisors (including specialists from agency
headquarters such as WHO Geneva and local representatives of other UN agencies)

- They are very useful and valued opportunities for the participants to share experiences and learn from those of other countries.

- These meetings also provided an opportunity to identify “talent” for future consultancies in the region to assist with “cascading” of the training.

- The meetings provided opportunities to introduce new aspects of Reproductive Health such as the Guidelines for Medical Treatment of Victims of Sexual Violence.

- They have been excellent examples of UN agency cooperation, with WHO’s state-of-the-art technical inputs complementing UNFPA’s support to the countries’ implementation of guidelines which WHO has developed. Other agencies such as UNICEF, ILO, and UNIFEM also contributed in various ways, as well as FSM and SPC.

- WHO-UNFPA SPP funds enabled follow-up “cascade” training on family planning and sexually transmitted infections in three countries by those who attended the regional meeting, with the help of participants, advisors or consultants and some countries have successfully completed their localization of family planning manuals, with TA. While other countries may have required extra funding and assistance to do so, their need was not clearly articulated.

- All participants prepared annual action plans with the guidance of UNFPA staff, thereby developing their planning capacities for subsequent overseeing of programme implementation and some prepared Human Resource development plans.

**Challenges:** Despite all of the above achievements, many challenges remain: facilities assessments showed that, in some countries, conditions in many facilities are still poor with basic water and sanitation problems in the majority of six countries surveyed; there are significant staff shortages; staff still need considerable up-skilling as well as increased supportive supervision; supplies and equipment are often inadequate; record keeping is generally less than optimal and data is often of poor quality or not collected and the geography continues to challenge service delivery in most countries, especially those with many outlying islands. There is a widespread need for competencies in operational research and using the results and other data in planning and programming.

While a large number of participants have been trained, and some “cascading” has taken place,
In terms of Family Planning, the surveys showed that the basic minimum of three contraceptives was available in all health facilities of the six countries surveyed and they had some capacity to deliver FP services, for which there was some demand. However, it was noted that all would benefit from inputs to upgrade the quality of services, including widening the range of contraceptive options available. In term of capacity to provide Emergency Obstetric care, the surveys showed that there is need to increase capacity in all countries. However, because of the small populations, it needs to be done in a limited way, with equal emphasis on enabling pregnant women to reach one of those specialized facilities in good time.

One of the features of the work is that Pacific RH personnel have annually been provided with access to the latest internationally accredited information at the Regional meetings. However, while international guidelines were introduced at the regional level, only a small number of countries have adapted them for national use. Analysis showed that those countries which

**Examples of Guidelines**

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One of the features of the work is that Pacific RH personnel have annually been provided with access to the latest internationally accredited information at the Regional meetings. However, while international guidelines were introduced at the regional level, only a small number of countries have adapted them for national use. Analysis showed that those countries which
had received additional support from the Technical Advisors and/or the WHO-UNFPA Strategic Partnership Programme were more likely to have adapted, introduced and utilized them. Reasons given for not doing so included lack of time due to competing priorities and limited financial and/or technical resources. All countries stated the need to adapt guidelines to be in line with national practices and available diagnostic and therapeutic capabilities, as well as the need to ensure national ownership of standards of practice.

There is a need to ensure that adequate follow-up resources are available, where it is known that government cannot do so. SPP seed funds have filled this role in some cases but they have not been adequate to meet all needs in all countries. Another issue is that while new topics such as GBV were introduced, there was limited in-country uptake of follow-up activities due to various factors.

It is apparent that many demands are placed on project-related staff, they are subject to “multiple pressures”, or “wearing too many hats” as participants put it e.g. to complete field visit monitoring forms, prepare and follow annual work plans, under-take maternal death reviews, submit proposals for funding to donors, complete commodity documentation, submit SPRs, form and contribute to Project Coordination Committees, to complete survey questionnaires, be responsible for monitoring and evaluation, complete financial reports and ensure annual audits are undertaken. Administrative responsibilities are often additional to their technical duties. As one of the speakers at the 2005 meeting said “…sometimes the stream is too full”.

Given the shortages of staff and a lack of other resources in most countries in both urban and rural areas compounded by the geographical challenges of the island countries, some staff were not able to fully implement planned in-country follow-up activities after regional meetings. Participants are reported to have greatly appreciated the technical inputs which have been provided but have been unable to always implement strategies related to transfer of the new knowledge and skills to others in-country. If participants did not feel familiar enough with the content” TA was provided in-country technical assistance.

The specific needs of adolescents are still not yet being met by many clinics (with the exception of those involved in the AHD project) or of men (with the exception of those involved in the MIRH project) for reproductive health services. However, a number of countries now recognize the need. No country has yet formulated a policy or strategy on GBV, although there is increasing recognition of the need to do so. The latter situation was partly inspired by the initiation of the research project in Samoa, Solomon Islands and Kiribati and the introduction of the guidelines for the treatment of victims of sexual violence. There was some recognition that community-based issues were affecting their ability to provide effective services. These included negative attitudes and the prevalence of myths about various aspects of reproductive health, the role of churches as well as the prevalence of gender inequality, the lack of employment and low levels of literacy.

Enabling factors for improvements in services but which are outside UNFPA’s mandate include items such as water supplies, building refurbishment, solar panels and the upgrading of storage. The lack of access to water in so many facilities was of great concern, completely undermining other efforts to improve basic health services and emphasizing the importance of providing a full package of integrated assistance, rather than single elements. UNFPA can continue to play a very useful role in continuing to advocate to donors about those needs which are not within its mandate. The information it has recently collected on the state of facilities will be very useful for providing detailed justification of the needs.
Conclusions: The RH services project provided an appropriately multi-pronged approach to achieving its objectives. It has made contributions in the areas of policy development or updating, the introduction to new protocols and their localization, the training of health workers in key technical areas and in management. Trainers have increased their technical repertoires. The project has also contributed significantly to documenting the situation and helping staff to understand the importance of collecting accurate data and using it in planning for results based management. The provision of commodities, including contraceptives and equipment, have also enabled services to function better. The extensive research undertaken has provided for evidence based planning, especially important when each country has a slightly different set of needs. The introduction of new areas such as adolescent and male-oriented services and GBV has appropriately begun to expand service repertoires.

The RH Services project was appropriately supported by the RHTP, RHCS, AHD and MIRH projects, all of which played an inter-related role and help to reinforce each other’s contributions. These inputs have undoubtedly helped, to varying extents, to improve the national capacity to deliver safe motherhood and family planning services and contributed to HIV prevention. While regional meetings played an important role in this, their approach may need to be revised if transferring new skills incountry is the aim.

However, despite the extent of these complementary inputs, there are many challenges, including issues outside UNFPA’s mandate, especially the inability of governments to provide adequate budgets to the health sector for implementation of RH services. As well, some aspects such as training need to be revised to ensure sustainability and quality at the subnational level.

It is notable that UNFPA’s inputs are especially significant as it is the main technical agency in this field in the Pacific. It is also apparent, despite the extent, quality and range of achievements, that much remains to be done to reinforce past achievements and address new challenges.

RCM participants Suva - 2007

4.4.2 Reproductive Health Training Programme ($0.8m)

Implementation: Fiji School of Medicine and UNFPA
Start Date: 2003 (continuing)
Countries: Ten (regional)

Description: The Fiji School of Medicine (FSM) has implemented seven residential, twelve week RHTP courses annually since 1999. The course is designed for mid-level health service providers or managers with priority given to those from the LDCs. The purpose is to improve knowledge and skills related to Sexual and Reproductive Health so that graduates will be in a better position to provide quality care and programme management (including capacity building) on return to their home countries. Funds are used for the scholarships, travel and living allowances, for two administrative staff, and administrative fees. The course costs approximately US$7,000 per head.

An external Fiji-based evaluation was undertaken between October and November 2005, but it was largely limited to process and curriculum review. An additional advisor was recruited to make recommendations on Behaviour Change Communication aspects of health promotion. The accounting and reporting aspects of the project were not reviewed but are reported on in project reports. Other observations have been gleaned from mission reports and the RH Questionnaire which was completed by almost all countries.

Positive findings:
- The course provides a unique, cost-effective service for the region, with its content largely based on local needs
• Ninety three graduated with a Certificate in Reproductive Health during CP3, sixty percent being female. Only two have failed, due to language difficulties (being Francophone).

• Skill and knowledge of participants were upgraded and up-dated, enabling them to manage or provide more effective RH services (if the other elements are in place and they keep working in the area).

• Trainees found the course re-energizing and motivating to do RH better and gave them greater confidence in their work.

• A tracer study has not been done but there is some evidence to show that the majority have returned to their home countries and used their new skills and knowledge in their work, to varying extents.

• There is some evidence of positive follow-up impact which can be directly related to the training eg in Solomon Islands. It would be useful to instigate a formal tracer/impact study in order to definitively demonstrate course effectiveness.

• Regional training is very cost effective, with the cost per head being approximately US $7,000.00 for the three month course (including travel, accommodation and living allowances).

Challenges:

• During the initial stages of the course, there were some administrative challenges relating to financial reporting, audit delays, and delays in sending out the course invitations to the PICs, however, much of these issues were resolved.

• In some cases, it was noted nominations did not match the selection criteria. To help address this, FSM sent out detailed briefing packages on the course content and target group to the Ministries of Health, and to follow-up through the country RH Programme Coordinators. This process would be helped by the existence of a regional/country human resource data base which would make planning selection of candidates more rational and also help inform them of number of courses needed, and its content. It would also be useful for FSM and UNFPA to participate in the selection process.

• The follow-up of graduates was not as consistent and systematic as it could have been. This may have contributed to missed opportunities to further support their learning and skills.

• Some participants indicated that the course was too intense and too theoretical. On the basis of feedback, revisions were made to tailor the course to better meet the needs of the countries and ensure that it was attuned to the Pacific regional needs and capabilities.
• The course would benefit from a gender analysis, and more socio-cultural inputs

• The curriculum modules may be useful for continuing education

• The allocation of places in the course for the countries had to be reviewed due to the increased requests for additional places. The limitation of the course to only 10 PICs was seen as a restriction for other PICS. However, recently the course was offered to PNG and open to IPPF affiliates in the PICs. The possibility of including students from other countries and including more candidates from larger countries e.g. Solomon Islands, needs to be considered.

• The investments of the course are not fully optimized when returning graduates are posted in areas where their new skills and knowledge is not fully utilized. Some graduates indicated that their qualifications are not adequately appreciated. However, a large number of graduates are able to apply their skills and knowledge in their work, and in some cases, received promotion and initiated creative interventions as a result of RHTP.

Table 12: RHTP Graduates characteristics, 2003-2007, by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
<th>Nurse</th>
<th>N/Midwife</th>
<th>Health Officer</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solomon Islands</td>
<td>18</td>
<td>18</td>
<td>0</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Samoa</td>
<td>13</td>
<td>2</td>
<td>11</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Vanuatu</td>
<td>12</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>1 Doctor</td>
<td></td>
</tr>
<tr>
<td>Kiribati</td>
<td>11</td>
<td>1</td>
<td>10</td>
<td>9</td>
<td>1</td>
<td>1 Dir. Nursing</td>
<td></td>
</tr>
<tr>
<td>Tonga</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>FSMic</td>
<td>7</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>1 P Educator</td>
<td>1 H Educator</td>
</tr>
<tr>
<td>RMI</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td></td>
<td>1 Dir. Nursing</td>
<td></td>
</tr>
<tr>
<td>Tuvalu</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiji</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cook Is</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PNG</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1 Dir. Nursing</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>93</td>
<td>34</td>
<td>59</td>
<td>66</td>
<td>17</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: FSM Records

Table 13: Number of participants by year

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004 - 16</td>
<td>2006 - 24</td>
<td>TOTAL: 93</td>
</tr>
</tbody>
</table>

Source: RHTP records

Analysis of Data:

Gender: The data on gender in Table 12 above raises a few questions: The data illustrates that two thirds of participants are female which is not surprising given that world wide, and in the Pacific, most nurses are female and the course is aimed at mid-level health workers – who tend to be nurses. However:

• Solomon Islands has only sent males (they have many more male nurses)

• FSMic and Cook Islands have sent only females

• Samoa, Tuvalu, Vanuatu, RMI, PNG, Kiribati and Fiji have sent mostly females

• Tonga has sent equal numbers

In terms of equal opportunity for skills enhancement and career advancement there would appear to be a need to encourage the countries to review the selection process from a gender equity view point. It would also be useful to obtain a gender breakdown of nurses in source countries.

Profession: In terms of profession the vast majority were Nurses or Nurse Midwives, Health Officers, doctors, Directors of Nursing, Doctors and Peer Educators.

Age: The majority of participants were aged between their mid twenties to mid forties, which one would expect. Registered nurse was very young (18 years) and another hospital based midwife was older.

Numbers per country: The RHTP policy was to provide the most opportunities to those countries with the greatest need (ie high
maternal death/infant mortality ratio) and with the largest populations. In terms of the country sending the most students during 2003-7, Solomon Islands was ahead with 18, which is appropriate given its comparatively large population and high level of need. Vanuatu and Kiribati also sent relatively large numbers (eleven each), again appropriately. Compared to the other countries, Samoa and Tonga have sent thirteen and eight respectively, which is somewhat high given the basic criteria. Fiji, also with a large population, only sent 5 because their health workforce has more opportunities for higher education and is in less need of a course like RHTP. Cook Islands sent the least number, appropriate given the comparatively healthy state of their services. PNG, with its very large need has only sent participants in 2006.

**Issues:** The above data raises questions about the selection process and the need to ensure that appropriate staff are chosen ie have had some work experience and those who will be well placed to put their training into practice by being able to influence or practice reproductive health and to be able to do so for at least ten years. There is also a question about whether it is important for those with midwifery qualifications to participate and what the proportion per country should be.

Another feature of the data is the variation in numbers each year (from 16-24), (see Table 13). Obviously the more in each course the more cost-effective it is but only as long as the institution can cope and maintain quality of teaching and accommodation. Solomon Islands has indicated that it would like to send more and Papua New Guinea is now included. The delays in sending offers of places could have placed restrictions on the selection of candidates. As FSM has been able to adequately cope with as many as 24 since 2005, it is unfortunate not to have as many participants as possible making the most of this valuable opportunity, budget permitting.

Another point of interest is whether the students come from the capital or from outlying areas/provinces. Solomon Islands has followed a policy of sending only provincial staff (which is partly why they are all males). While the data on this aspect is incomplete it does indicate that at least a third are community, rather than hospital based. At least nineteen were hospital based. In addition, two were in senior management positions and two came from nursing schools. It would be worth ensuring that this information is included in the RHTP data base and examined in more detail in future.

A review of the above characteristics would help add to the basic information provided by national staff development data bases to guide a rational selection of candidates. Then it would require an agreement to be reached with the respective countries about improving the effectiveness of the selection of candidates. Some investment would also need to be made in developing this process, with UNFPA Advisors and/or Programme staff playing a role, as well as FSM, working with countries to come up with the most appropriate candidates.

**Conclusions:** The RHTP is a valuable, cost effective regional resource which is continuing to meet its objectives of helping to strengthen the capacity of Pacific health workers to deliver quality RH. However, the selection of candidates could usefully be a joint one, with FSM, UNFPA and the governments, which should help to address the issues raised in discussion of the tables on the characteristics of participants. A Pacific human resource data base would be helpful for determining the size and nature of the need for the course (as well as for other reasons) which could use the information provided by the training needs assessment done by FSM and Tonga in 2006 – and contribute to informed discussions with countries about who should be nominated. Also, a tracer study could usefully be undertaken in order to confirm effectiveness of this contribution to the achievements of the CP outcome - although some evidence is already available. Some follow-up activities with graduates through the other UNFPA projects would also help to maintain interest and motivation about RH matters.

The training may not pay off if certain key elements are not in place in the home country when they return ie RH related positions, adequate facilities, equipment and supplies. It will be
important to ensure that such training is part of an integrated package of assistance, not an unrelated entity.

Most of the administrative and curricula related issues have since been rectified, or are in the process of being addressed and monitoring should ensure that efficiency is maintained. Overall, the programme plays a valuable role in providing in-service capacity building in RH and should be maintained as a regional resource. For reasons of efficiency it should continue to be centrally managed. It would be productive for UNFPA to maintain closer links with FSM, contributing from its technical expertise, as well as participating in selection of candidates.

4.4.3 Reproductive Health Commodities Security Project ($2.5m)

*Implementation:* UNFPA
*Start Date:* 2003
*Countries:* 14

*Description:* The concept of Reproductive Health Commodity Security (RHCS) was first introduced to the Pacific in the previous country programme cycle and endorsed at the 2003 Pacific Ministers of Health meeting. The RHCS Pacific Plan of Action maps the strategic direction and commitment of Pacific Governments to improve RHCS status of their island nations. The project was designed to ensure a secure supply and choice of RH commodities including quality contraceptives and condoms as well as RH equipment such as delivery kits and HIV test kits, to meet national needs. The project not only procures commodities but also contributes technical support and capacity building, strengthening national coordination, forecasting, logistics management and distribution systems.

**Table 14: Number of trained personnel in RHCS by country 2006 and 2007 through national workshops**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>NUMBER of PERSONNEL TRAINED</th>
<th>TYPE of PERSONNEL TRAINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook Islands</td>
<td>3</td>
<td>Nurses</td>
</tr>
<tr>
<td>FSMic</td>
<td>42</td>
<td>nurses, pharmacy officers, health officers</td>
</tr>
<tr>
<td>Fiji</td>
<td>102</td>
<td>nurses, nurse practitioners, pharmacy officers, doctors</td>
</tr>
<tr>
<td>Kiribati</td>
<td>3</td>
<td>nurses, medical officers</td>
</tr>
<tr>
<td>Marshalls</td>
<td>25</td>
<td>nurses, pharmacy officers, medical officers</td>
</tr>
<tr>
<td>Nauru</td>
<td>1</td>
<td>health promotion officer</td>
</tr>
<tr>
<td>Niue</td>
<td>1</td>
<td>medical officer</td>
</tr>
<tr>
<td>Palau</td>
<td>1</td>
<td>medical officer</td>
</tr>
<tr>
<td>Samoa</td>
<td>14</td>
<td>nurses, pharmacy officers</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>109</td>
<td>provincial health directors, provincial RH coordinators, nurses, medical officers.</td>
</tr>
<tr>
<td>Tokelau</td>
<td>1</td>
<td>Medical officer</td>
</tr>
<tr>
<td>Tonga</td>
<td>3</td>
<td>nurses, pharmacy officers</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>16</td>
<td>nurses, pharmacy officers, obstetrician</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>26</td>
<td>pharmacy staff</td>
</tr>
</tbody>
</table>

No formal evaluation was undertaken of the project but information is available from the country reviews for most countries, the RH Questionnaire 2007 responses and from the Pacific Plan of Action: 2007 Status of Implementation report and the 2007 Regional RHCS Workplan.

**Positive Findings:**

- The first ever RHCS Pacific Plan of Action was endorsed by Pacific Health Ministers in 2003 as a result of UNFPA advocacy.
- A Regional Warehouse was established in Suva Fiji in October 2004, in partnership with the Fiji Ministry of Health (MoH) to assist in reducing long lead times as well as hold buffer stock for both contraceptives and for other RH-related commodities such as medical equipment and RH related-drugs.
- A Regional RHCS Manager was appointed in mid-2006. He is also responsible for conducting RHCS training, assessing technical needs in PICs, providing substantive inputs into programme design and formulation, organizing bulk procurement (and subsequent cost savings) and monitoring quality control. The Manager is backstopped by a technical advisor.
- Two regional trainings for RH Project Directors, Chief Pharmacists and nurse managers were held in 2004 & 2006 with emphasis on forecasting, logistic management information systems (LMIS), distribution and pipeline planning, warehousing, disposals of expired / damaged medicines and quality monitoring. Software training on LMIS and forecasting were also part of these capacity building initiatives using Channel and CCM (country commodity manager) software.
- The first ever regional capacity building training for twenty-two NGOs in the Pacific was held in July 2006, in recognition of their crucial role in providing RH information and services and as part of scaling up access to HIV & STI prevention to the Most-At-Risk-Groups.
- Pacific branded male condoms, procurement of lubricants and a Rapid Needs Assessment Toolkit have been developed as an innovative approach for condom promotion.
- Approximately 347 health staff have been trained in RHCS in eight countries through national and subnational RHCS workshops during the past three years. The number and type of trained personnel to date are captured below in Table 14.
- There has been an expansion in method mix (beyond the basic pills, injectables and condoms), to include implants and the female condoms in many countries.
- There has been an elimination of stock-outs in some PICs, including Fiji and Solomon islands from 2006 to date, while others are still experiencing challenges with the effectiveness of their stock management. However, other countries, in order to prevent stock-outs given the length of time it takes to receive orders, were over-stocking, which also causes problems with expiry dates and storage challenges.
- Formation of RHCS coordinating mechanisms and or focal points within some Ministries of Health, have helped in prioritizing RHCS issues, nationally, although some countries have not managed to do this yet.
- Increasingly, countries are including contraceptives in their Essential Drug Lists and including funds for contraceptives in national budgets.
- Sixteen NGOs in eight countries promote and distribute free commodities, especially Pacific branded condoms through partnership agreements with UNFPA Pacific Sub Regional Office.
- A speedy humanitarian response for the Solomon Island Tsunami disaster situations in April 2007 in terms of provision of emergency RH kits was achieved.
- An RHCS “champion” was recruited and advocacy to policy makers has contributed to the above successes.
- Successful resource mobilization for commodities from the Thematic Trust Fund ($1,246,536), NZAID ($460,340), AusAID ($145,047) and the Global Fund ($135,209), totaling $1,987,132.
- A comprehensive regional data base on RHCS status has been established with some indices as shown in Table 15.
4.4.4 Adolescent Health and Development Project ($3.3m)

**Implementation:** SPC, UNICEF and 10 governments  
**Start Date:** 2001 (continuing from 2003)  
**Countries:** Ten

**Description:** The project aims to promote health and development of Pacific youth by providing information, education, life skills, training and services. The current project grew out of the original UNFPA Adolescent Reproductive Health project which was later integrated with UNICEF’s Pacific Stars Life Skills project.

There are three main components: strengthening adolescent health information through life skills based education; expanding youth friendly health services and strengthening management and delivery. It also attempts to establish mechanisms for building sustainability within existing government and NGO programmes and structures. Activities included: Funding of national AHD coordinators in six countries, a Life Skills Coordinator and a short term Media and IEC specialist; National level stakeholders review workshops; Revision of the FLE curriculum; Training workshops in FLE and for Youth Trainers and in Peer Educators, Parent-Child Communication; Introduction of the FLE programme in three new countries; Development of Media and IEC materials; Supporting development of Youth Friendly Services and School Based Clinics and a Supporting Adolescent Mothers programme.

A very thorough external review was undertaken in April/May 2007. Additional information was available from mission and annual reports and from the 2004 Evaluation of the Fijian Family Life Education component.

**Table 15: Current Status of RHCS Indicators by country, 2007**

<table>
<thead>
<tr>
<th>Activity</th>
<th>No. of Countries</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHCS Coordinating Committee</td>
<td>6</td>
<td>FSMic, Samoa, Solomon Is, Tonga, Tuvalu, Vanuatu</td>
</tr>
<tr>
<td>Contraceptives in Essential Drug List</td>
<td>6</td>
<td>Cook Is, Fiji, Samoa, Solomon Is, Tonga, Vanuatu</td>
</tr>
<tr>
<td>RHCS training</td>
<td>9</td>
<td>Cook Is, FSM, Fiji, RMI, Samoa, Solomon Is, Tonga, Tuvalu, Vanuatu</td>
</tr>
<tr>
<td>Stockouts in last 12 months</td>
<td>5</td>
<td>Cook Is, FSM, RMIic, Tonga, Tuvalu</td>
</tr>
<tr>
<td>Dedicated budget line for contraceptives</td>
<td>4</td>
<td>Fiji, Nauru, Palau, PNG</td>
</tr>
</tbody>
</table>


**Conclusions:** In its short life time of three years, this project has enabled UNFPA to achieve something of a milestone for the Pacific. For the first time, a relatively secure base for the supply and quality control of RH commodities has been established for most countries. Consequently, the project is playing an essential role in enabling all aspects of UNFPA’s RH work to be effective, both in the areas of family planning as well as HIV prevention and maternal health. A comprehensive regional data base on RHCS status has been established and a programme of action designed to address outstanding issues is in place and being implemented. The Suva regional warehouse is playing a major role in servicing the region, not only for contraceptives but also for other RH related commodities.

However, there are still many national constraints, such as inadequate numbers of staff, poor logistics management information systems and inadequate storage, as well as poor estimation of needs, both for contraceptives and other RH commodities—resulting in time consuming ad hoc demands on the Sub-Regional Office and subnational stockouts and over-supplies— and, most importantly, inadequate services. In addition, there is a need to focus on opinion leaders and community education in order to dispel the myths and increase understanding of the benefits. It should be recognized too, that FP, is a major empowering force for women, with significant economic (and health) benefits to the family.

Consequently, these efforts will need to be greatly intensified in the next CP, because of the looming widening of the gap between supply and demand, due also to the increasing numbers of young people entering their sexually active years. This would be in addition to the general increase in demand for family planning methods and condoms by adults. This is a niche area for UNFPA but additional funding will be required to meet the needs of the region in the coming years.
which noted that more constraining than enabling factors existed for the educational system-based components.

**Positive Findings:**

- The project is helping to meet a key area of need in the region ie adolescent reproductive health
- The objectives and components are appropriate
- It has helped to place the subject of adolescent sexuality on national agendas
- It is helping to increase acceptance of the need for SRH education for youth
- Considerable progress is being made in terms of meeting outputs, in terms of the number reached by the project including workshops and training of trainers held
- It has addressed lessons learnt from the past projects (but needs to do more)
- Information, Education and Communication (IEC) materials are in high demand
- The advertisement campaign in Fiji demonstrated good research practices and the latter has proved to be very popular
- Some countries have utilized the findings of the Adolescent Situation Analyses research to inform their project components, although all should do so
- The range of advocacy modalities has been impressive

- Over 500 Life Skills Youth Trainers have been trained since 2002. In 2006 seven trainings were conducted for 230 young people from ten countries
- Nearly ten thousand young people participated in life skills programmes in 2005-2006.
- In Tuvalu and Tonga 20% or more of young people have participated since 2002.
- Fourteen youth centres/youth clinics have been initiated or further developed
- The introduction of operational research methodology and the publication of their eleven research reports to the AHD coordinators has considerable potential for informing future strategies
- As a direct result of the project Family Life, education is to become compulsory in schools in Fiji
- AHD health services run by NGOs and in-school clinics were the most effective way of delivering adolescent friendly services
- Implementation in Tonga demonstrated effective collaboration between government, UN and NGOs
- The project has led the way in UN collaboration for joint programmes
- Good networks across and within countries have been established.

**Challenges:**

- The geographical, diversity and ambition of the project is unmanageable for the current level of staffing.
- Lack of in-country capacity in the required competency areas is a major impediment to the depth and quality of implementation and for long-term sustainability
- A major constraint has been a lack of staffing and infrastructure in many countries to absorb the inputs, a shortage which can be partially but not wholly addressed with project inputs
- The project needs to be more strategic and integrated and less ambitious
- The agencies need to integrate Life Skills and SRH more effectively
• Trainings of peer educators have been too short and participation equated with having mastered knowledge and skills. Also, reliance on trainers with limited experience does not ensure quality outputs

• Mentoring and support for peer educators are inadequate in many countries and their capacity and knowledge levels vary considerably

• Community education has been undertaken in a limited number of ways, with an over-reliance on workshops

• While there has been some national level record keeping and monitoring, it has been of variable quality

• There has been a lack of base line data and specific research throughout the project to provide information on impact of various strategies

• Working with Ministries of Education Curriculum Development Units is a complex and lengthy process but a worthwhile approach

• Educational methodologies have generally been participatory but not fully learner-centred

• Gender and rights are largely missing from programming, training and materials

• The life skills manual has considerable weaknesses

• Many youth centres and AHD information and counseling rooms are under-utilized

• Integration of Youth Friendly Services into government health services has been the least successful model

• Insufficient focus has been placed on adolescent pregnancy.

• Monitoring and evaluation need to be strengthened so that impact can be determined.

**Conclusions:** The project is making a useful contribution to the Pacific in helping to meet the needs of the youth for sexual and reproductive health information and services. This assistance is especially important at a time of decreasing traditional methods of social control and increased risks, including HIV.

The Adolescent Health and Development project has achieved some major successes, especially in the way it has helped to put the subject of adolescent reproductive health on the Pacific agenda, helping to break down what was previously something of a cultural taboo. This has been a major break-through with support being obtained from a wide range of government and community leaders. It has reached thousands of youth in ten countries, although it is not clear to what extent the education provided has reduced risky behaviours.

However, there are a few implementation issues which need to be addressed, including a need for more staff, a review of some training methodologies and follow-up activities, on
assessment of scope and the development of a comprehensive monitoring and evaluation system which includes impact assessment. There is a need to focus more on quality rather than quantity and to consolidate before considering further expansion. The project links well with reproductive health services and its implementation is an example of UN collaboration.
4.4.5 Male Involvement in Reproductive Health (MIRH) ($0.5m)

**Implementation: ILO and UNFPA**

**Start date: 2003**

**Countries 2: Fiji and Solomon Islands**

**Description:** This project grew out of the Men as Partners project which was completed in 2003. The project, which was implemented by ILO, aimed to provide Sexual and Reproductive Health (SRH) information, counseling and services to men in the workplace so as to enable them to be active and positive partners for women on SRH related matters, to reduce risky behaviour and to improve workplace productivity. It was implemented in Fiji and the Solomon Islands.

An external evaluation was undertaken in June/July 2007, including a mission to the Solomon Islands, meetings in Suva and Honiara with ILO, UNFPA, unions and participants and reviews of the project documentation. Other information was obtained from mission reports and discussions.

**Positive Findings:**

- The project was very warmly received by participants and clearly demonstrated a need for men to be provided with SRH information
- Effective collaboration with the private sector, a non-traditional partner, was a first for UNFPA, as was the collaboration with ILO
- The project increased openness to discussing SRH matters outside traditional contexts - a major break-through
- The project trained more trainers and peer educators than planned (87 of each) and 549 workers were reached through a total of 8 Fijian and 7 Solomon Islands workplaces. They included members of the Fiji Electricity Authority, the Tropik Wood Industry, the Honiara City Council and Solomon Airlines, amongst others
- A training manual, eleven RH Information Education Communication materials, a video and a Behaviour Change booklet were produced, and some materials were/are being translated
- There has been a heavy demand for sessions and for IEC materials which cannot yet be met, both in the workplace and the community
- There was reportedly some evidence of improved family relationships, improved workplace morale, union delegates opting for dialogue rather than confrontation and of trained staff improving their communication skills
- Successful project launches were held, which helped to publicise the concept with management and workers and generally raise awareness of SRH issues.

**Challenges:**

- The project rationales are too complex, unrealistic and needs simplifying
- Some aspects of the teaching materials and staff training need to be refined, including gender-related aspects
- Raised awareness needs to be more closely linked with improved capacity for service provision
- Monitoring and evaluation needs to be improved so as to be able to identify progress towards project outcomes
- Workers only participated in one session (1-2 days) which is not sufficient to internalize learning, especially about gender relationships. There is a need to increase the number of sessions (and not foreshorten them) although it is appreciated that this can be difficult in the work environment. But innovative ways of getting around this constraint should be found if this education is to be fully meaningful. Other mechanisms to reinforce the learning such as linking to community education activities and local RH services would be potentially useful
- Attendance at a session should not be equated with changing one’s behaviour, as the Evaluation noted
• The claims of positive impact on family and work life need to be validated through impact assessment

• While the unanticipated inclusion of females in the sessions provides for appropriate balance in discussion groups there is also a need to continue to address issues of masculinity and sexual behaviour in single sex groups

• The focus is on SRH facts rather than on social aspects of sexual behaviour which need to be addressed if positive changes are to be maintained

Conclusions: The project addresses a relatively un-served population ie men, and especially those working in the private sector. It is obviously helping to meet a real need for SRH-related information. The strategy of working through unions is a very useful one although somewhat limited by the amount of time participants are available - but partially compensated for by the provision of a variety of informative pamphlets. The breaking down of the barriers to discussing such subjects was a significant achievement and the partnering with ILO and the private sector was a positive form of collaboration. This project also usefully links with the provision of RH services.

However, some aspects of the project design and educational methodologies need refining and the project should be reinforced before it is expanded. There are many advantages to maintaining a focus on meeting male needs for information and providing a forum for discussion of such issues in an all-male environment and increasing the inputs on the role of the socialization of masculinity. By the same token, mixed sessions can also be very educational for both sexes and opportunities could usefully be provided – but not at the cost of omitting all-male sessions.

A continuation of the project would require more adequate funding.

4.4.6 Reproductive Health Related Research

Implementers: UNFPA, consultants, government staff
Start Date: Various
Countries: 13

Description: A wide range of research activities were undertaken during CP3 (see Table 16) in order to provide a firm, evidence based approach to programming, resulting in a very valuable and comprehensive data base. Methodologies included surveys, rapid needs assessments, socio-cultural research, feasibility studies, reviews and literature searches. Subjects included various aspects of health systems, behaviour and attitudes and cultural issues. Specific target areas included youth, women, men, commodities, and sexual behaviour.

Activities were funded though different projects e.g.:

• The EmOC/FP surveys in six countries were undertaken as part of the Indicator project

• The STI and FP Rapid Needs Assessments in three countries were undertaken with SPP funds with WHO and Fiji School of Medicine

• The Adolescent Situation Analyses in four countries were undertaken under the Adolescent project

• The Gender Based Violence research in three countries is part of a global study

• The RHCS surveys in eight countries were funded under that RHCS project

• The DHS and Census’s were (partly) funded from the Data project

• The eleven ARSH Operational Research projects were funded from the AHD project

All of these exercises were operationally oriented with the findings, in many cases, being used immediately to inform planning and implementation. In some cases, the results provided base line information and some studies will be repeated towards the end of the cycle as surveys.

An Adolescent SRH operational research methods workshop was also held in 2006 to help build research capacity of fifteen participants who were mostly national Adolescent Health and Development Coordinators from the ten countries. Eleven proposals were developed, research undertaken and eleven reports disseminated to key stakeholders in nine countries.

Most of the information resulting from the various studies has been published (see the publication list under 4.6.3) or kept as internal reports. In all cases the reports have been distributed to the particular countries and used as reference documents for planning and strategizing. Research conducted by other agencies has also been used to inform the programme eg the WHO/SPC/UNSW Second Generation Surveillance Studies on STIs. In future, it will be important to include evidence of use of findings as part of base line data as the research is only justified if the results are used to improve programme effectiveness.
Table 16: Population and reproductive health related research, 2003-2007

<table>
<thead>
<tr>
<th>STUDY SITUATION</th>
<th>SUBJECT AREAS</th>
<th>COUNTRIES</th>
<th>MAIN CONCLUSIONS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyses</td>
<td>Emergency Obstetric Care and family</td>
<td>Kiribati, 2005</td>
<td>• Need to improve EmOC in all countries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>Vanuatu, 2006</td>
<td>• Getting mothers to EmOC facility in time is priority/waiting houses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Solomon Islands, 2006</td>
<td>• Also imp is ANC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tonga, 2006</td>
<td>• EmOC equipment needed to improve QOC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Samoa, 2006</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tuvalu, 2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid Needs</td>
<td>FP and STIs</td>
<td>Solomon Islands, 9/2005</td>
<td>• Essential base line data</td>
<td></td>
</tr>
<tr>
<td>Assessments</td>
<td></td>
<td>Tonga, 11/2005</td>
<td>• All countries have basic capacity, variable quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vanuatu, 4/2006</td>
<td>• Need to increase, priority of FP, demand for and range of FP options/skills/</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>sociological aspects</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All centres have at least 3 contraceptives</td>
<td></td>
</tr>
<tr>
<td>Adolescents RH</td>
<td>Adolescent SRH</td>
<td>Vanuatu, 2005</td>
<td>• Needs increasingly recognized by Govt / Churches</td>
<td></td>
</tr>
<tr>
<td>Situation Analysis</td>
<td></td>
<td>Solomon, 2005</td>
<td>• Teen pregnancies major concern</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Samoa, 2005</td>
<td>• STIs/HIV increasing concern</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kiribati, 2005</td>
<td>• Un-employment major issue</td>
<td></td>
</tr>
<tr>
<td>Condom Social Marketing</td>
<td>Feasibility of using social</td>
<td>PNG, Solomon Islands, Kiribati</td>
<td>• Condom use data very limited but use appears very low</td>
<td></td>
</tr>
<tr>
<td>Feasibility Study, end of 2002/03</td>
<td>marketing for condoms in the Pacific</td>
<td></td>
<td>• Need for social marketing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Govt. facilities tend to “control” access to condoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Need for “Pacific-Specific” condoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Bulk purchase useful for region but distribution systems/promotion would vary</td>
<td></td>
</tr>
<tr>
<td>Female Condom</td>
<td>Review experiences, determine</td>
<td>Vanuatu and Fiji, 2005</td>
<td>• There is support for introducing FC . There is potential for initially</td>
<td></td>
</tr>
<tr>
<td>Programming Study</td>
<td>political commitment, identify</td>
<td></td>
<td>targeting vulnerable groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>potential advocates, determine</td>
<td></td>
<td>• Need to establish Task Force and use existing distribution mechanisms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>training needs, identify mechanisms</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>for its introduction, estimate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>requirements,</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Findings being used to guide introduction of FC**
<table>
<thead>
<tr>
<th>STUDY SITUATION</th>
<th>SUBJECT AREAS</th>
<th>COUNTRIES</th>
<th>MAIN CONCLUSIONS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHCS Reviews</td>
<td>Review situation of status of RHCS PoA in countries</td>
<td>Fiji, Tonga 2005 Samoa, Tuvalu 2007</td>
<td>Varied findings in forecasting, LMS and LMIS capacity</td>
<td>Capacity building in RHCS</td>
</tr>
<tr>
<td><strong>BEHAVIOURAL RESEARCH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Socio-Cultural Research - Global project | Gender Based Violence and Child Abuse | • Samoa, 2003 (Polynesia)  
• Solomon Islands, 2007/8 (Melanesia)  
• Kiribati, 2008 (Micronesia) | • Base line data  
• Hard data for advocacy  
• Definition of issues  
• Avenues for action identified  
• Contribution to global data base  
• Research capacity enhanced | • Samoa Findings informing interventions  
• SI study about to commence,  
• Kiribati study being planned |
| Adolescent SRH Operational Research | Teen pregnancy; Evaluation of peer educators; Use of adolescent services; Outcomes of teen deliveries; Evaluating IEC material | Projects in 11 countries | Varied findings | Findings and recommendations currently being implemented and used to inform CP4 AHD programme in each country |
| Sexual Net-working Study | To investigate the role of sexual networking and attitudes and behaviours of vulnerable groups to HIV | RMI, 2004 | • Sex initiated very early  
• Multiple partners common  
• Alcohol abuse common  
• Rate of teen pregnancies and STIs high  
• Lack of understanding of and protection from risks/ | Unpublished |
| Teenage Pregnancy study | To obtain an understanding of the circumstances for teen pregnancy in order to be able to address the issues, quantitative and qualitative | • Tonga, 2004 | • Many difficult first births  
• Most pregnancies unintentional  
• Pregnancy concealed for long periods  
• Social reaction shame/stigma  
• Late or no ANC  
• Ltd knowledge of sexuality  
• Double standards  
• Divided opinions re FP for teens | • Findings used to educate health workers and guide RH services and Adolescent project, and advocacy with policy makers |
| **REVIEW** | | | | |
| Demographic Health Surveys | Designed to monitor population and health situation including fertility, RH, FP and HIV/ | Solomon Is, RMI, Tuvalu and Nauru | Varied findings | RMI preliminary report, Aug 2007 Other surveys in preparation |
**Conclusion:** Research has been used during CP3 to inform programming and for evidence based advocacy. It has been used at the regional and country level in various aspects of reproductive health, population and development and gender. In reproductive health they have been used for monitoring and evaluating programme successes and for planning interventions for CP4. Such research activities should be well planned and well funded during CP4 at the regional level in all countries in all aspects of the programme.

## 4.5 POPULATION AND DEVELOPMENT SUB-PROGRAMME COMPONENT PROJECTS

The Population and Development Sub-Programme was designed to produce the following outcomes and outputs:

**Sub-programme outcome:** National, sub-national and sectoral policies, plans and strategies that take into account population and development linkages.

**Component project outputs:** Improved national, sub-national and sectoral policies, plans and strategies that take into account population and development linkages.

The following component projects were designed to contribute to the above outputs and outcomes:

**Population and Development Component Projects**

- Integrating Population, Gender and Development Issues into National and Sectoral Plans, $0.7m (10 countries)
- Capacity Building for Data Collection and Analysis in PICs, $0.3m. (10 countries)
- Developing Comprehensive Framework of Indicators for Programme Monitoring and Evaluation, $0.1m (Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu)
- Increasing Political Support for Poverty Reduction and the ICPD-POA, $0.3m (14 countries)
- Socio-Cultural Research on Gender-Based Violence and Child Abuse in Melanesia, Micronesia and Polynesia, $2m (Kiribati, Solomon Islands and Samoa)

The following provides a description and an assessment of how well the various components projects contributed to the outputs and outcome. The review is based on information obtained from meeting, workshop and mission reports, annual reviews and a data and policy related questionnaire which countries completed in August/September 2007. None of these projects were externally evaluated as planned because they started late (ie early in 2005 for the data and policy projects) and funds did not warrant what would have been an expensive exercise. Also, because of the late starts, the planned establishment of baseline estimates was not done so it is not possible to provide a definitive assessment of achievements.

*Enumeration, Fiji Census, 2007*
4.5.1 Integrating Population, Gender and Development Issues into Policies and Programmes ($0.7m)

Implementation: UNFPA, SPC, governments
Start Date: Early 2005
Countries: 10

Description: The project aimed to improve national and regional capacity to integrate gender, population and development issues into national, sectoral development policies, strategies and action plans in line with the ICPD Plan of Action. Planned activities included:

- The recruitment of a Population Policy and Development Planning Expert based at SPC for three years to provide technical support to UNFPA’s projects;
- Support for regional meetings on population and development;
- Regional meetings on population and development planning issues;
- Preparation of a guide to Population and Development Planning in the Pacific (which was not done as the concepts were integrated with a UNDP guide);
- Sub-Regional activities, including workshops on the principles and methodologies of population policy development and integrated population-development planning;
- In-country activities including workshops for national, sectoral and regional planners on population patterns and trends using Population Geographical Information Systems (PopGIS) and similar technologies and seminars on policy implications of recent census and survey results in selected countries;
- Workshops on integrating population factors into national development strategies, plans and programmes;
- Workshops or seminars in support of national population policy formulation.

Positive Findings:
- Countries have indicated that UNFPA’s expertise in this area is much appreciated, and that it was missed during CP2
- A major contribution to the region was the funding of a PD Specialist position based at SPC, which accounted for just over half the project budget. This position was filled by an appropriately qualified and experienced Pacific demographer who has provided three years of technical inputs, including analyses of data and documents, the provision of technical advice to countries and organized regional and a series of in-country workshops in the areas of PopGIS. The Specialist played a valuable role in expanding SPC’s capacity to service the needs of the PICs, and oversaw the implementation of the project for countries to which UNFPA contributes.
  - Technical support to project activities was also provided by the UNFPA Regional Technical Advisors for Population and Development (the second one joined in 2006 on retirement of the first one). Inputs included technical contributions to sub-regional or national-level workshops on the Future of Statistics, Data Processing, Demographic Health Surveys, MDG Planning, Census Planning and Population Policy revision, the Heads of Statistics and Planning regional meetings and project review mission to Noumea. The Advisors also contributed to UNDAF related planning missions to Solomon Islands and Kiribati, and to desk based data analysis and document reviews. There was close collaboration with SPC in this work.
  - A series of workshops (eleven in all) and two meetings were conducted during CP3, largely as planned.
    - The first-ever meeting of regional statisticians and planners was held in 2005 resulting in growing understanding each other’s roles, in order to get the best out of data. As one of the participants noted “…the traditional roles of statisticians and planners…”, and observed that in fact these needed to be merged to some degree, “…that statisticians needed to be planners and planners to be statisticians.” This included statisticians recognizing how data can be used - which wasn’t always apparent. Another such meeting was held in September 2007 reviewing progress in all areas of population data and analysis and again the value of such meetings was reiterated.
    - PopGIS was introduced in RMI, SI, Vanuatu, Kiribati and FSMic and has proven to be very popular, at least partly because it is visual and can be used to put information together in an innovative and easily recognizable way. This is a valuable tool for advocacy, including with parliamentarians, and should be used by the PPAPD
project. A similar approach could well be undertaken in other PICs but there is an issue of the data available not being up-to-date (or even accurate) in some countries which would negate the value of the exercise.

- Tuvalu and Kiribati held national workshops to review the results of their censuses for their policy implications, providing them with a chance to analyse and learn from very recent data.

- A sub-regional workshop on the principles of integrating issues into policies was held in Guam for RMI, FSMic, Palau, Nauru, Kiribati, Vanuatu and Solomon Islands with all countries requesting follow-up assistance.

- The planned workshop on integration of population issues into sectoral plans was not required because of the situation with the policies and instead national level population policy review and formulation workshops and policy consultations which were held in Solomon Islands and Vanuatu.

• Two consultancies are currently underway to undertake gender analysis on data. One is on the Fiji Household Income and Expenditure Study (2002/3) and the other on the labour force in the Kiribati 2005 census. These are the only studies being undertaken on the subject of gender although all data gathered is now sex disaggregated.

• Assistance was provided for the revisions of a number of policies, a list of which appears below in Table 17:

- Publications produced included the RMI population Atlas, two Solomon Island Provincial Profiles, a MDG Planning Guide and contributions to the draft Parliamentarians’ Advocacy Kit and a Population Planning Guide.

• There has been some productive coordination and cooperation between UN and other agencies eg UNFPA and UNDP planning to cooperate on a chapter being planned for UNDP’s planning guide for pro-poor policies and MDGs and costing/budgeting. UNFPA also cooperated with UNESCAP on Training Workshop on Population, Development and Poverty in the Pacific in 2007.

Comments:

- There is no doubt that the project has contributed to increased awareness, to varying extents, amongst policy makers in all countries of the significance of population issues and data to development planning. This has been reinforced, partly as a result of the pressure exerted by the MDG’s campaign and the pressure to have so many conventions ratified and partly due to on-going advocacy by UNFPA and their reiteration at various regional meetings over the years.

- It is noted that most activities involved many hours of intensive work which is not always apparent from the list of outputs e.g. both the Vanuatu and the Solomon Islands’ population policy review included over 100 hours of consultations with stakeholders, including traditional chiefs, and many hours of drafting and obtaining and incorporating feedback, before finalizing for publication.

- UNFPA provides support for the identification of baseline population indicators and for analysis and use in policy formulation, for which there is a large need in the region.

### Table 17: Population Policy Status in Pacific Island Countries

<table>
<thead>
<tr>
<th>Type of Policy</th>
<th>Country</th>
<th>Status and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Policy</td>
<td>FSMic, Kiribati</td>
<td>- Short draft exists</td>
</tr>
<tr>
<td></td>
<td>RMI, Samoa, Solomon Is*, Tonga, Vanuatu*, PNG</td>
<td>- Policy document (2005), not complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Policy document exist, (2005)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Draft rev. population policy, (2007)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Document (1998), under revision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Draft rev. population policy, (2007)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Draft revised policy, (2006)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Policy (1992), revision</td>
</tr>
</tbody>
</table>

Source: Project documents
Despite the long list of interested partners and some funds being available, their assistance is mostly for data collection and preparation of standard reports with insufficient support being provided to use of data. The need is to translate the data into useful information.

- It became evident during project implementation that many policy makers, administrators, planners and even statisticians, needed to learn how to undertake analysis of existing datasets, including from administrative sources. Also, many needed skills in interpretation of indicators and their application in policy analysis and development. Some also recognized the need for data as they complained during in-country missions that there was little for them to use to support their decision making. Related to this point, it was noted during the 2005 Meeting of Regional Heads of Planning and Statistics (which was supported by the project) that senior government staff often did not fully understand the importance of having up-to-date quality data across all sectors to inform their planning. In turn this meant that there was insufficient resource allocation for data collection and analysis – and hence the need for the PPAPD project to be active in addressing this issue. Further to this point, improved understanding of the importance of data might also reduce political interference with data, as happens occasionally, and also to help countries be guided on rational data access policies.

- The diversity of demographics in the region reinforces how important data analysis and use of the results in planning is for countries and for the priority which should be given to this subject.

- The training method of five day workshops is insufficient for capacity building. This is especially so when the participants are new to the subject matter (which most were), as was noted about the Solomon Islands and Vanuatu workshops. An analysis of the original project budget shows that workshops (sub-regional and national) took up about 30% of the total budget, amounting to approximately $165,000. In order to ensure that the knowledge and skills learnt are able to be practiced after the initial training, it is essential that follow-up support is provided. There was also an issue about whether appropriate personnel were nominated to participate in the workshops.

- As the September 2006 review meeting noted, despite the various inputs over the years, there was still a low level of analytical ability/lack of experience in analyzing data and identifying issues for government. The various reports and the questionnaire also indicated that there are insufficient personnel to perform the tasks which ideally should be done to ensure that population issues are taken into account by governments in planning. According to the questionnaire results, all countries, to varying degrees, required considerable support for policy formulation/revision. Further to this point, SPC noted in its report to the 2007 HOPS meeting the high turnover of staff. It further stated “Early successes in some of our member countries are already losing impact with (many) trained personnel no longer in key positions”.

- The budget was not adequate to meet the regional and country needs of the policy project, nor was there sufficient technical assistance to meet the country requests e.g. some sub-regional and in-country workshops could not undertaken because the advisors had to concentrate on assisting other priority countries. Some countries made additional requests which could not be met e.g. gender indicators (Vanuatu), youth profiles (Vanuatu and Palau) and policy assistance (FSMic, Nauru and Tuvalu) and funds were not available for planners and administrators from the lower levels of government, especially from those countries with decentralized systems - although such support was in the project document. A future project will require an adequate budget if progress is to be made, especially for technical assistance.

- The interpretation of data is a challenging task, requiring considerable skills and experience. Partly because of the small numbers in the planning area and because of the loss of staff (as reported at the 2007 HOPS meeting), there is very limited capacity in the region, and especially at the sectoral level. Consequently considerable technical and financial assistance is still required to help develop capacity to analyze the increasing

**Challenges:** The following are the main constraints to achieving the project’s objectives and need to be addressed in any future plans for support to PD activities.

- The diversity of demographics in the region reinforces how important data analysis and use of the results in planning is for countries and for the priority which should be given to this subject.

- The training method of five day workshops is insufficient for capacity building. This is especially so when the participants are new to the subject matter (which most were), as was noted about the Solomon Islands and Vanuatu workshops. An analysis of the original project budget shows that workshops (sub-regional and national) took up about 30% of the total budget, amounting to approximately $165,000. In order to ensure that the knowledge and skills learnt are able to be practiced after the initial training, it is essential that follow-up support is provided. There was also an issue about whether appropriate personnel were nominated to participate in the workshops.

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amounts of national data and use it to inform government. Alternatively, an innovative regional mechanism could be developed to address data analysis needs.

- In terms of population policies, some progress has been made when there have been intensive technical inputs and government support, although only PNG has a completed one (see Table 18). Formulation, including the consultative process, is time consuming e.g. it was estimated that over 100 hours was taken both in Vanuatu and Solomon Islands to consult with stakeholders, including traditional chiefs, in addition to drafting and obtaining and incorporating feedback before finalizing for government approval. Inter-departmental consultations are also time consuming but useful for helping staff gain an understanding of the issues. However, there are questions of how useful population policies are given the intensity of inputs required to develop them and the number of other policies governments have to develop. An alternative might be, especially when planning staff are few, to put the time into ensuring that population-related issues are incorporated into the major national development plans. However, it is still important to ensure that each sector is enabled to understand the role its area plays in helping to achieve population-related goals. Once policies are approved it will be important for future project to document how much they are used by government in planning, as a baseline for judging the usefulness of investing in population policies.

- While obviously very popular, the continuing use of PopGIS inputs is questionable without regular on-going technical support and updated data bases.

- Some countries reported that the MDG-related reporting requirements (while appropriately putting some pressure on governments) have put an additional burden on countries which do not have the capacity to produce all of the required information - which are additional to the already heavy burden they are carrying. This is an issue which will require attention in CP4.

- Population related data has considerable educational and advocacy potential (especially when mapping is used) and can be very valuable for parliamentarians to better understand the needs of their own countries. To this end it would be beneficial if this project worked more closely with the PAPPD project to ensure that at least some of its publications are pitched at an appropriate level. Adequate budgetary allocations need to be made for both technical and public information, including provision of a writer who can translate technical material appropriately for lay audiences (including MPs).

**Conclusion:** The use of population data in planning, for the identification of baseline indicators and for analysis and use in policy formulation is an important niche area for UNFPA. It appears from the information available that the project has contributed, to a limited extent, to the desired outcome of strengthened national capacity to incorporate population and development issues into national plans. Its MDG-related component has also helped to raise awareness of the importance of data for measuring progress.

UNFPA’s work has also complemented and supported that being undertaken by SPC (and other agencies) and has included effective collaboration with other UN agencies. The provision of a Specialist position enhanced the capacity of SPC to carry out this work, with additional support from the UNFPA Regional Advisors. Ten countries benefited to varying extents, in regard to policy revision and to being exposed to various types of technical information and skills.

However, future activities need to be better focused to take into account the reality that exists on the ground ie the small size of offices and especially the significant staffing constraints, (including the loss of those previously educated and the challenging nature of the subject). These issues have implications for the type of education that is needed, and for whom, and for the expectation of what can realistically be achieved at the country level. The traditional focus on short workshops without significant follow-up may not be effective. The aim of trying to build local capacity may need to be assessed and the possibility of using a more practical alternative explored.

In regard to population policies (and the process of developing them), their role in helping governments understand population issues is important. However, it may be appropriate to review the usefulness of focusing on population policy development, given the constraints (including multiple demands on too few staff), the previous history of such policies including their lack of use, and the existence of a viable alternative.

Future budgets need to allocate sufficient funds for publications, including for lay audiences and especially for Parliamentarians. The PPAPD project would benefit from being more closely linked with this one. Some minor improvements need to be made to project management and to communications between partners, including reporting and the establishment of a baseline and outcome assessments in order to be able to demonstrate actual impact.
4.5.2 Capacity Building for Data Collection and Analysis ($0.3m)

Implementation: SPC
Start date: Early 2005
Countries: 10

Description:
a) 2010 Pacific Census Round:

The project aimed to strengthen country and regional capacity for data collection and analysis for policy development and to monitor and report on progress towards the achievement of ICPD goals and the MDGs. In regard to the latter, UNFPA’s focus was to be on ensuring that additional data required for monitoring MDGs and ICD goals was collected through censuses and DHS’s.

The project strategy included providing technical inputs to regional census and DHS planning workshops, regional training workshops in data processing and common questionnaire design. All of the above were to be undertaken in cooperation with SPC which was executing the AusAID funded “Regional Support to the 2010 Round of Pacific censuses” project. As well, supplementary support was provided to the censuses in Kiribati, Tonga and in Fiji.

Specifically, the following inputs were provided:

- Technical contributions to the Census Data Processing workshop, March 2006
- Financial and technical support for the Regional Census Planning Workshop for the Pacific, in Nadi in March 2006, with SPC, and at which UNSD and UNFPA HQ also participated. Technical contributions included presentations of “Population and Housing Censuses as providers of Key Development Data and Indicators”, “Data Analysis, Dissemination and Utilization for Planning” and “How to Address MDGs Indicator Related Data Coverage in census.”
- Technical advice for the development of a model census questionnaire which was used by a number of countries
- Supplementary funding of approximately $75,754 for the Kiribati census for equipment, pilot exercise, questionnaire, enumeration and publication and dissemination of the results, $12,841 for Tonga and $60,000 worth of equipment for Fiji as well as technical assistance inputs, including to the Data Users’ Committee in 2007
- Participation in the Future of Statistics in the Pacific Region Workshop, Noumea, March 2007
- Advocacy for and preparation of a proposal to AusAID for funding for the Fiji census in mid 2007 for which an amount of $276,420 was received
- Funding of, and participation in, the first and second Regional Meetings of Heads of Statistics and Heads of Planning in Noumea in 2005 and 2007

- Maintaining regular contact/dialogue with the UNFPA funded Population Specialist based at SPC (on-going)
- Provision of support for data entry for Cook Island Census

As shown in Table 18 below, nine countries were supported to undertake their national census during CP3:

UNFPA provided regional technical assistance to all countries through planning and questionnaire design. Financial inputs during CP3 are marked with an *

Table 18: Censuses Conducted in Pacific Island Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Last census</th>
<th>Population last census</th>
<th>Next Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solomon Islands</td>
<td>1999</td>
<td>409,042</td>
<td>2009</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>1999</td>
<td>186,678</td>
<td>2009</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>1999</td>
<td>50,840</td>
<td>2009</td>
</tr>
<tr>
<td>FSMic</td>
<td>2000</td>
<td>107,008</td>
<td>2010</td>
</tr>
<tr>
<td>Palau</td>
<td>2000</td>
<td>19,129</td>
<td>2010</td>
</tr>
<tr>
<td>Kiribati * (Suppl. Funding)</td>
<td>2005</td>
<td>92,533</td>
<td>2010</td>
</tr>
<tr>
<td>Cook Islands * (Suppl. Funding)</td>
<td>2006</td>
<td>19,569</td>
<td>2011</td>
</tr>
<tr>
<td>Tokelau</td>
<td>2006</td>
<td>(2001) 1,537</td>
<td>2011</td>
</tr>
<tr>
<td>Nauru</td>
<td>2002</td>
<td>10,065</td>
<td>2012</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>2002</td>
<td>9,561</td>
<td>2012</td>
</tr>
<tr>
<td>Tonga* (Suppl. Funding)</td>
<td>1996</td>
<td>97,784</td>
<td>2006</td>
</tr>
<tr>
<td>Fiji * (TA,GPS tech, resource mobiliz.)</td>
<td>1996</td>
<td>775,802</td>
<td>2007</td>
</tr>
</tbody>
</table>

Source: SPC report and UNFPA project reports

Comments:
- UNFPA’s expertise in census and survey operations and health management and information systems complemented and reinforced the expertise in SPC but was not used as much as it could have been during CP3. It was mainly requested by SPC for power point presentations and group leading at meetings. Technical assistance by the PD adviser was provided for census analyses in Fiji and Kiribati. However, technical inputs were made to various documents and reports, including draft questionnaires which were used by a number of countries.

- A niche role for UNFPA, in line with the UN global mandate, was to introduce the need for MDG indicators at the Regional Census Planning Workshop in 2006 and to provide follow-up by checking that countries were able to identify the indicators and any gaps which need to be filled. The presentation stressed the importance of census related MDGs, their update and the importance of their use for policy formulation and planning.

- Statisticians at the Regional Heads of Planning and Statistics meeting in April 2005 noted that "...the MDGs presented a huge burden to produce additional data".

- It was also noted that the National Statistics Offices did not have adequate capacity to meet data requirements and that MDGs had further contributed to their burden. They felt that while the national leaders had endorsed MDGs, the statisticians were not consulted, and that their capacity to produce additional data was not assessed. Evidence of which countries inserted MDG indicators can be found in census questionnaires of those countries which conducted a census between 2005-6 and it is apparent that not all did so.
Another activity specific to the UN and to the data area was the ICPD+10 review which was completed in 2004 and which UNFPA coordinated for the Pacific. It was noted at HOPS 2005 that the findings were somewhat different from those of the SPC review and that was because the UN informants were primarily health staff while planners completed the SPC forms. This highlighted an obvious need for a multi-sectoral approach in the future, and also a single survey.

It is also noted that there is a plethora of (technical and financial) partners for data (although mostly for collection), including Asian Development Bank (ADB), AusAID, Australian Bureau of Statistics, (ABS), NZAID, New Zealand Statistics (NZStats), ESCAP, UN Statistical Division (UNSD), as well as SPC which spearheads regional activities. This means that coordination is very important and unfortunately it has not always been as effective as it should have been. However, the agreement that the approach to the 2010 Census Round should be a regional one and the holding of a joint 2005 DHS planning meeting were both positive examples of coordination and collaboration.

Also in regard to partnerships and enhanced cooperation, the first ever HOPs meetings played a useful role in helping both types of professionals to understand and appreciate each other’s expertise.

The Pacific with its numerous nations, multiple widely dispersed islands and diverse demographic scenarios makes for unique demographic and geographic challenges which means that data collection processes must be somewhat different from those in other countries/regions. In addition, government ministries, including Statistics and Planning offices, have relatively small numbers of staff. This scenario makes both for a different approach to data collection and also for a great need for accurate information to inform governments and regional and international organizations as that solutions to Pacific issues cannot be homogenous. Consequently, it was disappointing that the Pacific Census Planning Manual on conducting censuses in the region was not updated as planned.

In order to gain some indication of how much capacity has been built by UNFPA, SPC and others over the years a self-reporting questionnaire was sent to fourteen countries in July 2007. Nine countries responded. The results were not always consistent with known capacity, nor were all sections completed by all countries. However, there was a consistent pattern that national capacity declines when it moves from census and DHS planning and questionnaire design to data editing, processing, analysis and report writing. It also revealed the following:

- That there has been some level of consistency in permanent staffing in five census offices over the years, with 46% of their staff having worked on the previous one. All census commissioners of those who reported had participated in the previous census and three were already commissioners. Three countries also reported that they have staff who have competencies in undertaking census planning, questionnaire and data entry/editing. Others said that they mostly needed on-going support/refresher training for the first two activities and more often “extensive/specific training” for the third activity. For data processing, only two countries said that they have staff to do it while 3 needed extensive training. One country had staff who could do data analysis and none said that they could write the report by themselves. RMI, Fiji, Samoa and Cook Islands reported having high capacity while FSMic, Niue, Tuvalu and Tonga reported low. Solomon Islands also rated itself as high. RMI is well recognized in the region as having high level of technical capacity. Solomon Islands, RMI, Tuvalu, and Nauru now have some experience in conducting a DHS.

- In regard to policy, countries can capably handle the consultative process (with some support for making it as relevant as possible and for dealing with political pressures) but require assistance with analysis.

- An increasing awareness of the importance of gender data was shown, with some countries requesting support for studies of single mothers, GBV and poverty for the purpose of providing evidence for changing attitudes and eventually policies.

In short, when combined with other sources of information, it is apparent that there is a basic level of capacity for some aspects of data related work, up to a point. However, all countries still need varying levels of support, including financial and some need a lot. In order to know more precisely what is needed, it may be useful to update (and expand) the brief regional data base which SPC included in
its 2005 Census project document annexes. This would help to quantify the capacity more precisely and provide a baseline, although it is known anecdotally that loss of trained staff is a common problem. Some of the improvements which have been made over the years can be attributed to UNFPA's contribution but because of the lack of specific indicators and many joint activities it is not possible to say exactly to what extent.

- Despite much data being available (but much not analysed) there are still significant gaps which need to be filled if a complete picture of the Pacific development needs situation is to be obtained, if adequate national and regional information is available to government for planning purposes and if the Pacific is to be adequately included to the global data base. Consequently, the need for data collection strengthening and especially for analysis and use continues.

**b) Demographic Health Surveys (DHSs):**

*Description:* In order to obtain a better understanding of current demographic and health related situations in the Pacific island countries support was also provided to the Pacific round of DHS's. Such surveys have never before been undertaken in the Pacific islands (although PNG is currently undertaking its second). The information to be collected was expected to make an important contribution to the Pacific database as data from civil registration and health information systems is currently quite inadequate to meet requirements for planning and monitoring. UNFPA involvement also aimed to ensure that data related to the MDG indicators (ie maternal mortality, universal access to RH, child mortality, HIO and malaria) were included. Gender based violence was added. Joint funding was provided by ADB, AusAID, NZaid and UNFPA with SPC housing the ADB funded MACRO team leader. All parties contributed to planning and technical processes.

**UNFPA’s specific contributions were:**

- Technical assistance for the joint planning process
- Implementation, including preparations for the initial planning meeting, the chairing of sessions and contributing to group and plenary discussions on technical issues. Areas covered included review of the objectives, agreement on the core set of questions, finalization of implementation strategies and operational plans and agreement on resource requirements and budgets.
- Funding of two ten day long national workshops on DHS planning and training in how to conduct a DHS in two pilot countries (RMI and Solomon Islands)
- Technical assistance at critical stages, including for the development of the methodology and adaption of the questionnaires, and analyze and repeat writing of relevant FP, RH and population chapters
- Provision of $17,000 for Field Editors in the Solomon Islands
- Technical assistance for planning with all partners to develop a regional strategic approach to DHS
<table>
<thead>
<tr>
<th>TYPE OF SUPPORT</th>
<th>CENSUS RELATED</th>
<th>POP POLICY RELATED</th>
<th>DHS RELATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Information sharing, Technical Updates and Coordination</td>
<td>Heads of Planning and Statistics Meetings, 2005/7</td>
<td>Heads of Planning and Statistics Meetings, 2005 and 2007</td>
<td>DHS planning meeting, Sydney 2005</td>
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<td></td>
<td>International Statisticians Meeting, NZ, 2005</td>
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<td></td>
<td>ESCAP, Bangkok, 10/2005</td>
<td></td>
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<tr>
<td>Financial support</td>
<td>Kiribati and Tonga Censuses 2005</td>
<td>Tech. Position, SPC (3 years) Project workshops, including TA</td>
<td>$17,000 Solomon Islands for planning and field editors</td>
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<td></td>
<td>Resource mobilization request for Fiji Census 2007, to AusAID</td>
<td>Gender analysis of Kiribati labour force and Fiji HIES</td>
<td>Attendance at meetings</td>
</tr>
<tr>
<td></td>
<td>Data processing workshops 5/06</td>
<td>Pop Policy Formulation and development, revisions Guam 2006, plus Vanuatu, SI, Kiribati, RMI, FSMic, Palau, Nauru,</td>
<td>2 DHS workshops, in Solomons and RMI, 2006</td>
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<td></td>
<td>Analysis of gender issues in Fiji HIES, 2007</td>
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<tr>
<td></td>
<td>Census questionnaire assistance: Cook, Tonga, Fiji.</td>
<td>Attachment to SPC for SI, RMI, Niue (07) and Nauru staff members /06</td>
<td>Analysis of the RMI DHS Solomon is DHS (Tuvalu and Nauru in CP4)</td>
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<tr>
<td></td>
<td>Equipment for Fiji Census, 2007</td>
<td>Pop Policies drafted, Vanuatu and SI</td>
<td></td>
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<tr>
<td></td>
<td>Technical Support - Country specific</td>
<td>Revision of RMI policy (4th quarter 2007)</td>
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<td></td>
<td>Completion of three provincial profiles in SI and Atlas in RMI (2 SI provincial profiles and RMI atlas published)</td>
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<tr>
<td>TYPE OF SUPPORT</td>
<td>CENSUS RELATED</td>
<td>POP POLICY RELATED</td>
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<tr>
<td>Publications</td>
<td>Publications</td>
<td>Three Solomon Is provincial profiles</td>
<td>22 DHS Reports (RMI, Solomon Islands in process)</td>
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<td></td>
<td>Handbook project (cancelled by SPC)</td>
<td>ICPD+10 Progress in the Pacific (published 2005)</td>
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<td></td>
<td>Revised Questionnaire sections on labour force, MDG and health issues</td>
<td>MDGs: RH and Population Policies progress report</td>
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<td></td>
<td>Population Atlas, RMI</td>
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<th>Partners</th>
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*Workshops and meetings were held in conjunction with SPC and other partners*
Conclusions: During CP3 UNFPA contributed to improving the capacity of Pacific Island countries to produce accurate data and to ensure that the MDG indicators were included. It contributed financially to two national censuses and mobilized funds for another. As well, it provided a range of technical inputs to various aspects of the planning and documentation, including to regional and national training activities. UNFPA advocated for the inclusion of MDG and ICPD related questions in questionnaires although the extent that this was done was variable. It also funded the position of the Specialist at SPC who is the only Pacific professional in the island region who has DHS experience, thereby contributing to SPC’s capacity to serve the region.

While globally UNFPA has pulled back from its previously strong support of national censuses, the under-use of UNFPA’s expertise in this area during CP3 was unfortunate, as was the decision not to update the Pacific Census Planning Manual which would have made a useful guide for those new to the subject and an update for others.

From UNFPA’s point of view, the DHS is a very important survey, providing as it does, comprehensive and crucial sexual and reproductive health related information which cannot be obtained from other sources. It was unfortunate that UNFPA was not sufficiently resourced to contribute a significant amount to what were the first such surveys for the Pacific Islands. While not major funders, it did however, make a useful contribution to the initial Pacific DHS’s, especially in terms of ensuring that that RH and other MDG indicators were included through technical support as well as providing some funds.

Given its mandate and expertise, it would seem very appropriate for UNFPA to not only support use of the data produced but also increase its funding contribution in future programmes. If this is not possible, then UNFPA should continue to contribute its PD and RH expertise to the country specific designs, ensuring that MDG /RH related issues are addressed. It could also make good use of the data produced and disseminate it in appropriately lay-friendly formats, as well as assisting countries take the findings into account in their policies and programming.

4.5.3 Developing a Comprehensive Framework of Indicators for Programme Monitoring and Evaluation ($0.1m)

Implementer: UNFPA
Start date: Mid 2005
Countries: Six, including five priority countries (Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu)

Description: The project successfully addresses a key issue identified in the CP2 Evaluation ie an inability to determine outcomes because of poor project designs, including lack of monitoring and reporting against baseline data. This project aimed to help address the latter aspects of that weakness.

Monitoring development assistance in the Pacific is particularly challenging because of the number of small, widely dispersed island countries and populations. Also, the supply of quality, up-to-date statistical information has, until recently, fallen short of that which is required to meet the demand generated by the MDG, ICPD PoA and UNFPA’s MYFF. Some of the major gaps were the state of reproductive health in a country or sub-national area, management of reproductive health programmes and reproductive health knowledge, attitudes and behaviours. There were also gaps in information concerning policies and the existence of protocols and guidelines. The complexity of the region demanded an innovative approach to providing adequate data for monitoring and results based management.

The project undertook an extensive array of work to address these issues, as follows:

• The identification of data gaps and the design of instruments for the collection of data to fill those gaps
• The development of the indicator framework and data base
• The development of the UNFPA Pacific info database and compilation of information from the instrument on policy related indicators
• Logframes and annual workplans developed for each country and regional project (this was because the logframe developed for the sub-programme was regional so was not relevant to monitoring projects at the country output level)
• The planning and implementation of midline surveys in the six countries (EmOC/FP and FP/STI) (there was insufficient time and finance to do the endline surveys but they will be undertaken in 2008)

• Annual workplan monitoring tools developed in 2004

• A standard monitoring check list developed for use by programme staff when undertaking in-country monitoring and resulted in more comprehensive and better organized reporting

Comments: While the endline surveys and the policy data base have not yet been done, the project has produced a wealth of valuable information and tools which has greatly enhanced the capacity of CP4 to be monitored and evaluated. The survey information has also been used already to guide the RH Services project, in terms of country-specific needs for equipment, supplies and training, including for RHCS and the monitoring tools have greatly improved the ability of staff to monitor projects effectively

In addition, the Adolescent Situation Analyses and the Gender Based Violence Studies described elsewhere will also add to the regional information data base. While UNFPA has a consultant database in RH, PP and Gender a regional Reproductive Health human resource data base for all levels would also help to make training opportunities more strategic and add to the regional data base and could be undertaken in CP4. There are still substantial gaps in data eg community based data, including studies for determining impact of UNFPA’s interventions, as well as the extent of un-met need for FP. In regard to facility based surveys, only six countries have been covered so far - because they are expensive (not to mention time consuming). Additional financial and technical resources would need to be allocated if other countries were to be covered.

Conclusions: The Indicator project has already produced an impressive array of information, most of which is already proving useful in project implementation. The tools are also helping to improve monitoring and national staff have gained experience in conducting service oriented research.

The project has helped to address the issue raised in the CP2 Evaluation about the inability to determine the effectiveness of interventions and has made a very useful start on filling in the data gaps, without which it will not be possible to effectively monitor and assess progress. While commencing too late for CP3, the project’s outputs will be very useful for the CP4 evaluation, and also to some extent, to the design process.

Table 20: Selected Demographic, Social and Economic Indicators* 2006

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Fertility Rate</th>
<th>Contraceptive Prevalence Rate (Modern Methods)</th>
<th>Proportion of Pop. Urban (%)</th>
<th>Population Density Per sq.km 2006</th>
<th>Proportion of Pop. below national poverty line %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook Is</td>
<td>2.9</td>
<td>43.8</td>
<td>68</td>
<td>57</td>
<td>12.0 (1998)</td>
</tr>
<tr>
<td>FSMics</td>
<td>4.1</td>
<td>56.0</td>
<td>21</td>
<td>157</td>
<td>27.9 (1998)</td>
</tr>
<tr>
<td>Fiji</td>
<td>2.7</td>
<td>44.0</td>
<td>46</td>
<td>115</td>
<td>25.5 (1990)</td>
</tr>
<tr>
<td>Kiribati</td>
<td>4.3</td>
<td>21.0</td>
<td>43</td>
<td>309</td>
<td>50.0 (1996)</td>
</tr>
<tr>
<td>RMI</td>
<td>5.7</td>
<td>34.0</td>
<td>68</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Nauru</td>
<td>4.0</td>
<td>-</td>
<td>100</td>
<td>482</td>
<td>-</td>
</tr>
<tr>
<td>Niue</td>
<td>3.0</td>
<td>22.0</td>
<td>34</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Palau</td>
<td>2.5</td>
<td>17.2</td>
<td>81</td>
<td>41</td>
<td>-</td>
</tr>
<tr>
<td>Samoa</td>
<td>4.6</td>
<td>42.6</td>
<td>12</td>
<td>63</td>
<td>20.0 (2002)</td>
</tr>
<tr>
<td>Solomon Is</td>
<td>4.8</td>
<td>6.8</td>
<td>16</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>Tokelau</td>
<td>4.9</td>
<td>-</td>
<td>0</td>
<td>117</td>
<td>-</td>
</tr>
<tr>
<td>Tonga</td>
<td>3.8</td>
<td>32.8</td>
<td>32</td>
<td>153</td>
<td>22.3 (2002)</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>3.7</td>
<td>31.6</td>
<td>47</td>
<td>371</td>
<td>29.0 (1994)</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>4.8</td>
<td>28.0</td>
<td>21</td>
<td>18</td>
<td>40.0 (1998)</td>
</tr>
<tr>
<td>PNG</td>
<td>4.6</td>
<td>19.0</td>
<td>13</td>
<td>13</td>
<td>37.5 (1996)</td>
</tr>
</tbody>
</table>
4.5.4. Increasing Political Support for Poverty Reduction and the ICPD Programme of Action ($0.3m)

Implementers: SPC with Pacific Parliamentarians Assembly on Population and Development (PPAPD)
Start date: Early 2004
Countries: 14 countries

Description: The project aimed to develop increased political support for population and development in national poverty alleviation strategies through collaboration with the Pacific Parliamentarians Assembly on Population and Development (PPAPD). Its strategies were to:

- Support the functions of the PPAPD secretariat
- Develop an advocacy and information package for MPs
- Support the formation of national level parliamentary groups to support population and development and support community based initiatives.

Comments: The following is based on mission and project reports.

- The Secretariat was initially established at the Fiji Parliament and then moved to SPC Nabua, Suva office following the 2006 political upheavals. This also resulted in the loss of the Speaker of the Fiji Parliament who had enthusiastically taken on the role of PPAPD chairman. The loss of such a key figurehead somewhat affected project implementation. A project officer was appointed in mid 2005 to coordinate the functions and activities of PPAPD and to liaise closely with country members. The performance of the secretariat needs to be strengthened if it is to meet the need of maintaining close communication with MPs and supporting them to be active in their home countries.

- An important component of the project was support for regional meetings. The inaugural meeting was held in 2004 in Suva, focusing on the role of parliamentarians to fight against HIV/AIDS. Over 150 people attended this meeting, including 71 MPs coming from seventeen Pacific countries. The Prime Minister of Fiji opened the meeting and the keynote speaker was Dr Nafis Sadik, the Secretary General's Special Envoy on HIV and AIDS for Asia and the Pacific. The second meeting, held in Apia in May 2007 focused on Youth-related issues, a very important subject given the size of the cohort and the prevailing issues. Forty-six MPs participated at these meetings. It is notable that only two MPs attended both meetings. The PPAPD executive also met during each meeting to plan their workplans and discuss progress.
• During the Apia meeting a focus group discussion was held to discuss the effectiveness of the PPAPD and strategies to strengthen it. It was agreed, among other things, that PPAPD was a useful organization for MPs but that face-to-face contact was essential i.e., regional and in-country meetings; that communication from the Secretariat needed to be increased and that contact was best maintained through the Parliamentary Clerks who were more “permanent” than the MPs and that meetings should be held back-to-back with theirs. It was noted that most MPs knew very little about population issues and that they needed more regular communications e.g., newsletter.

• High level political support for Reproductive Health issues was demonstrated by the agreement to and the signing of two declarations: “The Suva Declaration on HIV/AIDS”, Suva, on 13 Oct 2004 and secondly, “The PPAPD Framework for Action on Safeguarding Pacific Youth: Accelerating Actions Through Partnerships with Pacific Parliamentarians 2007-2010” on May 24, 2007. However, follow up on actions taken in responding to these declarations is needed.

• National seminars were held for MPs in Kiribati (2 days) and in Fiji (1 day), with the latter including Parliamentary Clerks. They provided very useful opportunities to educate MPs on a range of Population and Development issues and an opportunity to discuss how they could actively advocate for Population and Development matters. This type of activity can be very worthwhile, and should be followed up with concrete action plans.

• The formation of national level parliamentary groups did not proceed as planned, apparently because of lack of active support from the Secretariat and also because their formation would require a Standing Order initiated by the Speaker for them to be established, a formal process which takes time and persistence. The one most likely to have succeeded was the Fiji group but the political instability prevented further action. Such an activity needs considerable in-country support to get it established and to maintain the momentum. Working through the Parliamentary clerks (who are permanent staff) appears to have more potential in terms of maintaining contact with MPs. However, the distances, the extent of changes in MPs and their many other priorities poses significant challenges to the strategy.

• Support to MPs in carrying out community-based initiatives was not fully taken advantage of. One Fiji MP did, however, support the production of a training manual on HIV and AIDS translated into local languages. Another Fiji MP undertook a field visit to a rural community working on forestry to advocate for population and development issues.

• Two Fiji MPs were identified as “Ambassadors” one for Population and Development and the other for HIV and AIDS and performed a number of useful advocacy tasks in these areas.

• An advocacy/information package for MPs was developed during a rather prolonged process. It was finally distributed to MPs in draft form at the second regional meeting in Apia in June 2007. The office is still awaiting responses from MPs on its usefulness before finalizing it and may require some person-to-person contact to elicit responses. As this
was an important product of the project it is unfortunate that it was not completed in the first year as two years of potentially effective advocacy/education have been lost. However, the draft has the potential to be a very useful publication, being attractively laid out and with sections of key RH and PD information with clear suggestion on follow-up actions. It should prove to be a very useful, quick reference kit for MPs. With regular update of key data information the booklet can remain a current source of information on RH and PD issues for Parliamentarians.

The objective of the project to help educate MPs on population and development issues is a very important one and a potentially valuable avenue for guiding increased financing policy and budgetary allocations for all aspects of RH, as well as for helping policy makers understand the demographics of island countries and their implications for development. The project has made an initial attempt to establish relations with Pacific MPs but needs to be strengthened and more focused in future in order to consolidate its gains. It has been successful in having two important Pacific Declarations agreed to and in reaching one hundred and seventeen MPs from sixteen countries through the two regional meetings, as well as one for Clerks. However, in-country follow-up action has been limited and needs to be encouraged and supported, especially educational sessions on key population issues.

In order to facilitate continuity, the Secretariat needs to establish close links with Parliamentary Clerks and also the most motivated MPs in order to support their advocacy and educational work in-country. This is probably the most realistic approach to take, given MPs’ multiple responsibilities and busy schedules. The Secretariat also needs to work more closely with the Population Policy project which is a valuable source of data which can be produced in user-friendly formats (such as PopGIS) to capture interest and enhance understanding of the complex issues.

4.6 CROSS-CUTTING ISSUES

4.6.1 HIV and STI Strategies

Implementation: Various UN Joint Programme Partners
Start Date: Late 2006
Countries: 40

Description: UNFPA’s mandate regarding HIV is to focus on prevention and other STIs through the undertaking of advocacy, targeted prevention programmes, including using BCC, media and supportive environments, condom procurement and support for in-country condom programming, and progressing linkages and future integration of SRH with HIV/STI programs and services and collaborating over joint programming for STI prevention and control.

In CP3 UNFPA’s main contribution to addressing HIV was through the various RH and PD projects, all of which contributed in their own way to the Pacific Regional HIV Strategy, including data collection and analysis, the research on GBV, Adolescent SRH and mainstream health services and Commodity Security.

There was no specific HIV and STI project in CP3, however, in addition to the above, a wide range of additional small-scale activities were undertaken to contribute to the UN joint programme on HIV/AIDS Unified Workplan which in turn supports the Pacific Regional Strategy.

An HIV Advisor, funded from the Global Fund, commenced in January 2007 so no evaluation of the work has been undertaken as yet. The position is part of UNFPA’s intensified response to HIV and AIDS funded to provide support to UNFPA projects and to UNFPA’s mandated aspects of the UN regional strategy.

It is too early to provide an assessment but the following are UNFPA inputs and activities in CP3.
Supply of Pacific branded male and female condoms and lubricants and training in use of the female condoms supplied to MOHs, and increasingly to NGOs

Developing Rapid Needs Assessment and Community Based Distribution manuals

Undertaking of reviews of status of implementation of both the PPAPD’s Suva Declaration and the PCC’s Nadi Declaration on HIV and AIDS

Undertaking of media campaign and advocacy with Parliamentarians

Strengthening linkages and commencement of a number of interventions with “Most At Risk Populations” are in the process of commencing

Plans were made for promoting linkages between of SRH/ANC/MCH and HIV/STI services

Participating in regional planning for up-scaling comprehensive STIs case management, prevention and control, including updating individual PICs STI treatment protocols

Supporting PICs in preparing a GFATM proposal

Funding of PIC delegates to regional meetings

Participating in regional and international meetings (ICAAP)

Participating in Fiji HIV strategy development

Undertaking of a technical advisory missions to PNG, FSMic, Samoa and Vanuatu

Preparing a strategic plan for UNFPA projects.

Conclusions: The objective has been to ensure that UNFPA’s work addresses HIV/STI prevention as effectively as possible in each sub-theme area and contributes to the Pacific Regional Strategy in ways which are complementary with those of other UN and regional partners and in line with the Pacific strategic directions. The above activities are contributing to meeting those requirements. The inclusion of an HIV Advisor is an asset to the UNFPA advisory team which will help to ensure that all aspects of RH also address HIV/STI prevention issues, and that specific interventions help to accelerate the Pacific response. A challenge is to ensure that UNFPA’s core RH inputs are recognized as contributing to HIV and STI prevention, which they certainly are (eg youth friendly services, condom procurement, counseling training, service improvement, increasing use of Family Planning and the education of men on SRH).

Male involvement in parenting is very important too.
4.6.2 Gender

a) Mainstreaming

An important bedrock of UNFPA’s mandate is the promotion of gender equality and to this end all programmes benefit from being analysed for their gender sensitivities, both during design as well as during implementation. Such analysis helps to ensure that gender differences are identified and addressed appropriately, enhancing the potential for the project interventions to be effective and helping to ensure that inequities are not perpetuated. Unfortunately the UNFPA Pacific office lacked the technical capacity to ensure that detailed analyses were taken during CP3 and as a result, these were deficiencies in some of the projects e.g. The Male Involvement in RH project where the manual and a brochure were wanting in gender matters and where an issue arose regarding the involvement of women. There is much potential in the Adolescent Health and Development Project to also explore gender issues. For example, the lack of focus on teen pregnancy (as identified by the Review in 2007) and the 2004 Life Skills Evaluation noted that there was a need for more discussion of sexuality issues and that this had not happened by the time the main evaluation was done in May 2007.

The RH Services related project would also benefit from use of a gender lens eg in terms of examining how many women are being offered training opportunities and at what level; how gender affects promotion and posting opportunities and whether there are gender-related impediments in undertaking outreach activities and delivering babies. There are also many elements of gender sensitivity and other aspects of cultural relevance related to clients and how services are offered. There are other aspects of socio-cultural elements which are not described in project documentation but which are alluded to occasionally in reports eg the lack of sharing of training information (i.e. ownership of information) and inadequacies in supervision (because of social expectations). Also, health matters, especially in small communities, are often driven by social expectations but are not explicitly addressed in the documents. This is an area where social analysis (and gender analysis in particular) would usefully help define the situation. However, in terms of data, all data collection now specifies sex desegregation which is helping to provide a gender lens on information collected.

Conclusions: Specialized socio-cultural advice, especially on Gender issues, would have benefited the design and implementation of CP3. This was an omission and means that not only were opportunities missed to make projects more “Pacific appropriate” and gender sensitive, but also to make them more effective. There would appear to be much potential for reviewing all projects from a socio-cultural perspective (including gender) in the next cycle.

In order to address this weakness, efforts are being made to recruit a Gender Advisor.

b) Gender Specific Activity: Research Social-Cultural Research on Gender Based Violence and Child Abuse in Melanesia and Micronesia

Implementer: SPC ($2m)
Start date: CP2 (continuing from mid 2006)
Countries: Samoa, Solomon Islands and Kiribati

Description: This project is part of CP3’s programme of research and the only project completely focused on gender issues. The subject is an important one for UNFPA, focusing as it does on a crucial aspect of women’s disempowerment and also because of its relationship to reproductive health, including the spread of HIV infection. The research is helping to paint a clear picture, for the first time, of the nature and extent of GBV and will usefully inform interventions and provide evidence for advocacy work (and already is doing so, in Samoa).
The study uses an international WHO methodology and has already been completed for Samoa (Polynesia). In order to cover Melanesia and Micronesia in the global database, research in the Solomon Islands and Kiribati is currently being undertaken. The project aims to identify the determinants, causes, consequences, and protective mechanisms for domestic violence and would allow for comparison across countries and cultures. It will also conduct a more focused study on child abuse and implement appropriate interventions addressing GBV in all three countries. The latter will include advocacy for government and public recognition of the issue and for legislation, capacity building training, victim support services and development of protocols and the incorporation of the subject into health curricula. Interventions will link with other UNFPA funded activities, including data collection, HIV prevention, safe motherhood, adolescent SRH and RH health services and the commodities projects.

**Positive Findings:**
The Samoa research was completed, published (eventually) and an integrated programme of interventions is currently being undertaken by the Samoan Government and selected NGOs. The research publication has provided a valuable source of convincing information for policy makers and “gate keepers” and has guided the implementation of interventions. The report also provides a tool for advocating to other countries in the region to address the subject, which cannot now argue that GBV is not a “Pacific” issue.

**Challenges:**
The very nature of a research project means that the obtaining of government clearance, recruitment and training of researchers takes a considerable period of time and effort, as does the field work and analysis and writing up of the results. This is especially so in regard to a subject such as GBV which is very sensitive for some people in the region.

However, it is important that the research is done as quickly as possible so that the findings can be used to inform the addressing of this very key aspect of women’s empowerment and RH (including HIV infection) in culturally appropriate ways, before CP4 is too well advanced. The long delays experienced in reaching the publishing and implementation stage in Samoa should be avoided.

Another issue is that the length of time taken from the initiation of the research during CP2 (pre-2003) suggests that the methodology used may be now out of date. The Solomon Islands and Kiribati studies may need to review how new approaches could be incorporated even if it means that the final products are not strictly comparable with the earlier work.

A further comment is that while it is “nice” for the global research to be able to include examples from the region, the cost of such research is very high and may not necessarily provide significant information to guide implementation. A rapid survey might be more cost-effective and be sufficiently informative to enable implementation to commence much sooner. In a day of increasing HIV infection (apart from the other equally important reasons) it is not justified to spend years researching a subject which is quite well understood and for which there are a basic set of activities which need to be undertaken, common to all countries. It is the local cultural nuances which need to be investigated in each country.
Conclusions: GBV is a key element of gender equality and of reproductive health and as such makes a valuable and well justified addition to the UNFPA Pacific programme. These studies are helping to put the subject of GBV on the Pacific agenda and are also providing a firm basis for planning and implementing culturally appropriate interventions.

The current research methodology was eventually updated. The subject should be firmly integrated with other aspects of UNFPA's work, especially the adolescent work so that at least the next generation will be aware that violence against women (and children) is not acceptable, is illegal and against human rights and that there are alternative ways of resolving family issues. The studies also illustrate the need to understand and address men's needs, as distinct from those of women, including the socialization of masculinity which so strongly shapes their behaviour.

4.6.3 Information, Education and Communication (IEC)/BCC

One of the short-comings in the design of CP3 was that it lacked provision for communications activities aiming at behaviour change among programme beneficiaries. However, necessary adjustments were made to allow for the inclusion of certain Behaviour Change Communication (BCC) activities eg BCC training in the regional workshop. BCC concepts were included in the revised FP manuals and the development of BCC materials and media campaigns.

Up until December 2006 there was no staff position responsible for overseeing such matters and any activities had to be done by programme staff. The appointment of a Sub-Regional Communications Officer has eased the workload for other staff and enabled the Office to undertake a more extensive programme of assistance based on a strategic plan. Work includes analysis and dialogue, advocacy, strategic planning, development of IEC materials and a website, the training of partners, including the media and country staff and the testing of messages. As well, the officer is responsible for arranging media coverage of UNFPA events. While primarily focusing on STIs/HIV and Reproductive Health, she also covers other subject areas such as census and increasingly, the work will include countries beyond Fiji. The following is a brief description of the various contributions made before and after the creation of the Communications position during CP3.

Positive Findings

It is evident from past experiences globally, that IEC alone is insufficient for changing behaviour and that social and cultural factors are major influences, including on sexual and reproductive related behaviour. Consequently, UNFPA needed to include what has become known as BCC in its Reproductive Health related work, which involves seeking community participation, researching the needs of the audience, identifying target groups, establishing specific objectives and developing implementation strategies and monitoring and evaluation plans. For IEC, research, prototype development, pre-testing, production and dissemination were the steps to undertake.

The first step taken by the Office was to develop a BCC tool kit which was aimed at providing health planners and managers with a systematic approach to understanding the methodology and for developing a practical strategy for carrying out a change process which could help create sustained favourable attitude and behaviour change amongst both individuals and communities. The draft was completed in May 2007 and is currently undergoing revision. It will be introduced to country level programme staff and its use encouraged in as many project activities as possible.

IEC materials including brochures, films, manuals, radio and TV campaigns and programmes, wall charts and posters were also produced during CP3, as can be seen from abbreviated list of publications. Some were project related, such as the Men as Partners in Reproductive Health educational brochures and the teen pregnancy posters. Others were more general such as the “Selected Indicators UNFPA Pacific 2006 wall chart and the pamphlet “Pacific Island Countries at a glance”
and others on specific topics such as Family Planning brochures.

Once the Communication Officer came on board in late 2007 a more concerted media campaign work was possible, including pre-Census Communication for the Fiji Census and for the various international days. A particular highlight was a Cinema campaign in Fiji targeting young males and females about pregnancy. The Officer also played a major role in overseeing the revision of an Advocacy Package for Parliamentarians which is in draft form and will be finalized when feedback is obtained from MPs. Through focus group discussions a need for a safer sex kit was identified. It was produced and has been trialed in selected night clubs and bars. Particularly enjoyed by the participants at the Regional Consultation Meeting in August 2007 was a mini newspaper which was produced each day, covering the previous day’s events. Another task accomplished has been the development of a UNFPA catalogue and an expanded mailing list which will further help distribution of materials.

**Publications**
The number, range and quality of publications produced by the Sub-Regional Office during CP3 was very impressive. Not only are there academic standard publications like the Gender Based Violence study (“The Samoa Family Health and Safety Study”) but there were also booklets such as “Before It’s Too Late” on adolescent reproductive health for easy reading by programme managers. Some documents were produced in partnership with other agencies.

The publications covered the areas of Sexual and Reproductive Health, Family Planning, Reproductive Health Commodity Security, Adolescent Sexuality and Reproductive Health, Population and Development, Gender and Reproductive Health, STI and HIV, Research Methodology and publications about UNFPA and its Pacific partner countries. They included research reports, training manuals, protocols, advocacy tools, meeting reports, status reports and narratives (such as “The Voice of Young People: HIV/AIDS, youth participation, adolescent reproductive health”). Over thirty documents have been produced over the past five years.

Publications are made available to the Reproductive Health Coordinator in each country who is tasked to distribute them further and to major institutions such as the Fiji School of Medicine and the University of the South Pacific. They are also advertised through the Catalogue and online and made available through the Fiji office in response to individual and institutional requests. Most documents are also available in CD format. However, it has been observed that at least some publications and IEC materials did not arrive in-country or are not distributed to health centres, indicating a need to review the distribution process, especially in-country. An abbreviated list of publications is provided. Details can be found in the “Catalogue of Education, Information and Training Material, Reports and Publications 2002-2007”.

**Conclusions:** Communication is a very important part of the Office’s work and an impressive amount of information in various formats was produced during CP3. However, in-country distribution was not always optimal. The addition of a Communications officer position was a valuable addition to the Office team and a great help in sharing the workload which was previously shouldered by programme staff. This has enabled UNFPA to improve its visibility, especially in terms of publications, promoting and media campaigns.

As well, because of the importance of socio-cultural factors on behaviour and the differences in cultures across the Pacific, it is very important that BCC-type of approaches be further strengthened in UNFPA’s work. In order to be able to do this it would seem desirable to have a BCC advisor to serve all projects, especially considering how much need there is in the region. A fully fledged BCC project could be developed with a national team member in each country to guide localization or else coordinated components of each project. This, when combined with operations research, would have great potential for really making a difference and picking up on the psycho-social aspects of people’s lives.

A BCC approach would also mesh well with the “Stepping Stones” approach which has been recently introduced to the region and should also help to increase the focus on community aspects of health.

**SEXUAL AND REPRODUCTIVE HEALTH**

- Reproductive Health Knowledge and Services Country Reports
- Family Planning Wheel
- Evidence-Based Guidelines in Family Planning for Health Workers- Tonga, Solomon Islands, Vanuatu and FSM
- Facility Based Assessment for Family Planning (FP) and Emergency Obstetrics Care (EmOC) in Kiribati, Samoa, Solomon Islands, Tuvalu, Vanuatu, Tonga 2005 - 2007 - A Country Technical Service Team (CST) Research paper
- Behaviour Change Communication (BCC) Toolkit for Reproductive Health Programmes in the Pacific

**REPRODUCTIVE HEALTH COMMODITY SECURITY**

- Reproductive Health Commodity Security in Pacific Island Countries and Pacific Plan of Action
- Reproductive Health Contraceptive Supplies and Female Condom Review Mission Reports: Fiji and Vanuatu
- Condom Programming Rapid Needs Assessment (RNA) Toolkit for the Pacific Region
- Reproductive Health Commodity Security Workshop for the Pacific Report
- Training Manual: Community Based Distribution programmes for the promotion of condom use and distribution in the Pacific

**ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH**

- Sexual knowledge and Attitudes of Adolescents Country Reports: Cook Islands, Kiribati and Samoa
- The voice of young people: HIV/AIDS, youth participation, adolescent reproductive health
- Teenage Pregnancy in Tonga: A study conducted by the Secretariat of the Pacific Community

through the United Nations Population Fund Office for the Pacific -funded Adolescent Reproductive Health Project in collaboration with Tonga Ministry of Health and Tonga

Before it’s too late Pacific Experiences Addressing Adolescent Reproductive Health

Reports on Adolescent Sexual and Reproductive Health Situational Analysis for Pacific Island Countries: Kiribati, Solomon Islands, Vanuatu and Samoa

Teenage Pregnancy: “Take control of your life” Poster

Investing in our Future A framework for accelerating action for the sexual and reproductive health of young people

Investing in our Future - Policy and Planning Brief A framework for accelerating action for the sexual and reproductive health of young people

Adolescent Sexual and Reproductive Health Research Methodology Manual for the Pacific Eleven ARH operational research reports (monograph series)

**POPULATION AND DEVELOPMENT**

- ICPD +10 Progresses in the Pacific
- ‘Selected Indicators UNFPA Pacific 2006’ Wall chart
- The Pacific Parliamentary Assembly on Population and Development (PPAPD) Advocacy Package

**GENDER AND REPRODUCTIVE HEALTH**

- The Samoa Family Health and Safety Study
- Men as Partners in Reproductive Health Educational Brochures
- Men as Partners in Reproductive Health through organised workforce - training manual for trainer and peer counselors on reproductive health, gender and counseling skills

**STI & HIV**


**ABOUT UNFPA**

- UNFPA Office for the Pacific, UNFPA in Asia and the Pacific – Pacific Island Countries at a Glance
4.6.4 Partnerships

An important characteristic of UNFPA’s work is that, in order to enhance effectiveness and sustainability, its activities are always undertaken in partnership with government ministries, other UN agencies, regional organizations such as SPC, NGOs and/or FBOs. In addition, UNFPA has worked closely with other development partners such as AusAID and NZAID, both in terms of using their funds and also cost-sharing. The benefit of partnerships is that implementation can be greatly enhanced and reinforced because the particular strengths of one agency can complement another. Partnerships also mean that outreach can be far more effective as government, for example, can do things that NGOs and the private sector cannot and vice versa.

The partnerships formed during CP3 have been extensive, as can be seen from Table 21, and much time and work has been invested in developing and maintaining the various relationships. Capacity building is often required to enable some partners to contribute effectively. In summary, some examples of UNFPA’s partnerships during CP3 are as follows:

**UN Agencies**

UNFPA maintained close working relationships with other UN agencies during CP3 for the preparation of the new cycle of assistance (2008-2012), and on the preparation of UNDAF. This has included participating in working groups on core UN areas of assistance and in various consultations with PICs. UNFPA has also taken a lead role in the development of M&E Framework for the UNDAF, through the Inter-Agency Task Force on Development Indicators and MDGs and later UNDAF M&E technical working group, which it chaired. UNFPA also chaired the UN Inter-agency Programme Steering Committee which coordinated the UNDAF exercise. A major development in the latter part of CP3 was when UNFPA worked with its sister agencies to develop and implement plans for a joint presence in some island countries, which should greatly enhance the ability to provide in-country support and follow-up. UNFPA also developed project related partnerships with ILO and UNICEF and is coordinating with UNIFEM on gender-related topics. While coordination is a key strategy of the UN teams in Suva and Apia, there are still challenges regarding communication between agencies and inequitable commitment to "one UN" which need to be overcome – but these issues are not surprising given the heavy workloads, the differences in institutional cultures and the unequal capacities. However, relative to the past, the situation has greatly improved and some productive relationships have been developed.

**Bilateral Agencies**

An example of cooperation with bilateral agencies was when UNFPA pooled a small portion of funds with the Australian Government and the Governments of Kiribati and Tonga, respectively, in the conduct of the census. UNFPA funded and provided technical assistance for the NZFPA Regional RH Advocacy Workshop for IPPF Affiliates. Relations with the bilaterals have been very positive, with UNFPA’s strengths obviously being appreciated, as shown by the additional funds provided by them over the years.

**NGOs**

In recognition of their capacity to reach out into communities UNFPA greatly increased its involvement with NGOs during CP3 as part of it work on HIV prevention. Work with sixteen agencies has been focused on adolescent programmes and on condom distribution. In 2006, for the first time, a capacity building and awareness raising workshop was hosted by UNFPA for participants who came from twenty-two NGOs from eight Pacific countries. The workshop provided technical updates on a range of RH issues and explored strategies for engaging NGOs more in raising awareness about RH and effective management and distribution of RH commodities in communities. Being able to oversee condom distribution to a diverse group of small organizations can be challenging, especially where their capacities are quite variable. It was noted at the 2007 Regional Coordination Meeting that some PIC governments have had good working relationships with NGOs while others have had limited or no experience and were somewhat reticent to commence.
UNFPA’s Third Country Programme of Assistance to the Pacific

Regional Agencies/Organizations

UNFPA works closely with Regional Agencies. For example, SPC executes four of UNFPA’s projects. In order to support SPC’s work in Demography, UNFPA also supports a Population Specialist position in Noumea. UNFPA has also partnered with SPC, along with AusAID, ADB and NZAID, to support a DHS planning meeting with national health officials & statisticians in March 2006 & the DHS’s in Solomons, Tuvalu, Nauru & Marshall Islands. UNFPA Advisors were involved in the planning stages & provided technical support to SPC during the questionnaire formulation and report writing phases. UNFPA also has had a long standing partnership with the Fiji School of Medicine because of the Regional RH Training Programme. Relationships with regional agencies have generally been both congenial and effective. The following table lists those partnerships which continued or were formed during CP3.

Private Sector/Trade Unions

Much neglected in the past by most development agencies, the Private Sector can be a very useful partner, both for media related work and for accessing men and women who would not otherwise be reached.

Table 21 provides an over-view of the partnerships which were formed during CP3, illustrating a broad range of inter-connections which have the potential to reinforce and enhance implementation.

Table 21: UNFPA Partnerships

<table>
<thead>
<tr>
<th>Universities/Research Institutions</th>
<th>Private</th>
<th>Governments Sector</th>
<th>Regional Agencies</th>
<th>UN agencies/funds</th>
<th>Donor Agencies</th>
<th>NGOs/FBOs</th>
<th>Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of the South Pacific</td>
<td>Fiji Trade Unions and Solomon Islands Council of Trade Unions Member Organization</td>
<td>14 Pacific countries</td>
<td>Secretariat of the Pacific Community</td>
<td>UNICEF, UNDP, UNAIDS, ILO, WHO, UNIFEM, UNESCAP, UN CT Samoa</td>
<td>AusAID, NZAID, ADB</td>
<td>IPPF, NZ FPA, *Won Small Bag (Van.), SHFPA, SIPP, SCFSI, TUFHA ATFF SAF FRCS CKIRC Seafarers’ Drop-in Centres</td>
<td>Funds: Human Security Fund, Global Fund, UNFPA RHCS Trust Fund, UNFPA HQ Regional programme</td>
</tr>
</tbody>
</table>

| Fiji School of Medicine           |                     |                     |                   |                   |               |          |       |

Source: UNFPA documents

* NGOs involved in RHCS activities

Conclusions: UNFPA developed a wide range of appropriate partnerships during CP3 which have contributed to its capacity to implement programmes and expand the outreach of activities. Such partnerships can be very beneficial and help mesh activities into government and community systems.

Such diversity in partnerships can be time consuming to nurture, challenging to manage and easily present communication challenges.

A disadvantage of using other agencies to implement UNFPA designed and funded projects is that UNFPA’s profile can be obscured behind that of the implementing agency. Also, the cost of implementing a project increases because of the implementation charges.
CHAPTER 5
KEY ACHIEVEMENTS & LESSONS LEARNT

Any report on the achievements of CP3 must be prefaced with the point that the Pacific is one of the most challenging of all UN areas to work in, because of the challenges presented by its diversity, its geography and island nation characteristics, as described in Chapter 2.

5.1 REPRODUCTIVE HEALTH

5.1.1 Key Achievements

There have been some impressive achievements during CP3, resulting from an array of activities supported by UNFPA and its partners over the past five years. These activities have aimed to improve the regional capacity to address population issues, both in policy and budgetary allocation terms, and also in terms of improving access to accurate knowledge of sexual reproductive health facts and to quality reproductive health services.

The highlights were as follows:

**General**
- The greatly strengthened capacity of the UNFPA Sub-Regional Office to oversee such an extensive programme
- Activities fitting in with Pacific priority plans and strategies and complementing the work of other partners, including all SRH and PD projects, in their various ways, contributing to achieving the objectives of the Regional HIV and AIDS Strategy, as well as to HIV-specific activities
- Increased partnerships with other UN organizations, agencies and NGOs
- Successful fund raising of an additional US$8.5m from donors and other agencies for the Pacific
- The development and implementation of a comprehensive monitoring and evaluation programme and a large investment in identifying data gaps and filling them
- Provision of seventy-nine advisory missions on RH to fourteen countries, providing in-country technical guidance and training
- High project implementation rates

**Specific**
- Technical and financial support to eight regional and 128 sub-regional and national RH level trainings, covering all ten countries
- 1568 people trained in FP; 1350 in Obstetrics; 1194 in STIs (including HIV)
- Introduction of international guidelines in FP, Obstetrics, STIs, Maternal Mortality auditing and Medico-Legal Care of Victims of GBV, introduced at regional level to representatives of ten countries
- Technical and financial support to the development and finalization/publishing of national RH FP, Obstetrics and STI guidelines in a number of countries
- Multiple inputs to the strengthening of RH services, including a greater emphasis on Family Planning, revisions of protocols, provision of equipment and supplies and training of various types of staff
- Approximately 40 people each year from ten countries participated in six annual regional meetings covering the subjects of RH Management and RH Technical subjects
- Extensive and comprehensive strengthening of all aspects of RH Commodity Security for the first time in the Pacific, including the establishment of a regional warehouse, deployment of an RHCS manager, two regional trainings and a swift response to the humanitarian crisis in the Solomon Islands following the 2007 tsunami
- The MIRH initiative to meet the needs of men in the workplace for SRH related information and linking with service delivery
- Integrating activities with UNICEF on the Adolescent Health and Development project to
strengthen its effectiveness

- The continuing success of the Regional RH Training Programme in strengthening the capacity of mid-level health workers
- ARH more strongly on the agenda, GBV and HIV/STI coming onto the agenda
- An increase in involvement outside the formal health sector to address RH issues eg with communities through NGOs and involvement of the private sector (workplace)
- Initiation of HIV specific prevention related activities
- Useful linkages between projects eg adolescents and men with health services
- Provision of RH/obstetric equipment and/or supplies to fourteen countries
- Development or adaption of practical health service tools

5.1.2 Challenges

General
- In many countries, difficult economic situations influenced the extent of delivery of SRH services, and specifically, UNFPA funded inputs. For example, lack of government resources to utilize some of UNFPA inputs and adequately monitor newly trained health staff, inadequate facilities such as no water in clinics
- A number of risk factors that might compromise the success of the new programme were identified in the CP3 document, and in fact did eventuate and, to some degree, affected implementation. These included the political upheavals in the Solomon Islands, Tonga and Fiji, cyclones in various countries and a tsunami in the Solomon Islands
- There were many human resource challenges (as anticipated) including loss of some essential managerial and technical skills including shortages of trained staff, changes in positions, departmental re-structuring, redundancies, out-migration, low salaries and resulting low morale, poor physical conditions, especially in outlying areas and heavy workloads
- Lack of UNFPA presence in-country to support and monitor projects and the high time and financial cost of in-country monitoring of projects more than once a year (the presence of in-country staff in some countries in CP 4 should greatly improve the situation)
- There were some issues related to inadequate coordination between government departments and between donor and technical agencies
- While there were many regional meetings and trainings, for obvious cost and logistical reasons, and they were productive and appreciated, sustainability is an issue unless in-country follow-up occurs.
- Some project related staff had difficulty with fulfilling reporting requirements, including financial reporting, which in turn affected the Regional Office to meet HQ and audit requirements.
- Lack of a Pacific regional and national RH human resource data base which might help for a more logical selection of candidates and subject areas to be covered
- Some projects were large and unwieldy, lacking clear focus, and emphasizing quantity rather than quality
- Gender and other social sociocultural analyses and inputs which would have usefully informed implementation of some projects

Conclusions - Reproductive Health
A very impressive set of high quality technical activities were undertaken in the areas of Sexual and Reproductive Health. These activities were implemented at both the regional, sub-regional and country specific level. The areas of work were a very appropriate “niche” for the organization (maternal health services, including family planning, adolescent sexual and reproductive health, gender and data), focused on capacity building and were much appreciated by the particular countries.

Of particular note was the initiation of an improved monitoring and evaluation strategy and the undertaking of a range of operationally oriented research and the publishing and dissemination of the results. This emerging data base is beginning to greatly improve UNFPA’s capacity for results based management. Also an impressive achievement was the strengthening of RH Commodity Security in fourteen countries, including provision of a warehouse in Suva, a first for the region. In terms of capacity building in reproductive health, over four thousand mid-level and senior health workers from ten countries had their knowledge and skills upgraded and a number of nationally oriented updated protocols were produced. As well, guidelines were introduced and medical supplies and equipment distributed to health
facilities, as well as contraceptives, including male and female condoms. The Adolescent and the Male Involvement projects met important and growing needs and the need to revitalize Family Planning was increasingly recognized. All projects linked together in various ways. UNFPA increased its partnerships with a range of agencies, including UN, government and regional agencies and NGOs.

However, human resource shortages continue to constrain improvements in reproductive health services generally, as does the prevailing negative economic situation in most countries. Transfer of knowledge and skills to staff in outlying areas of each country also continues to remain a challenge. While national execution of health services projects continued in CP3 so too did financial accountability issues. Reporting requirements also continued to present a considerable burden to project directors.

Overall, while the sub-programme for 2003-2007 was very appropriate in its scope, some projects appear to be too ambitious and need, in future, to emphasise quantity rather than quality. Because of the lack of evidence that the health worker training provided has had an impact in improved services a major lesson learnt is that there is a need to concentrate more on in-country follow-up, despite this really being the responsibility of governments.

There is a need for more comprehensive assistance i.e. partnering for support for items such as for water and facility renovation which are outside UNFPA’s mandate. As well, much more community involvement and socio-cultural approaches, especially gender analysis, would enable inputs to be more effective and appropriate.

5.2 POPULATION AND DEVELOPMENT

5.2.1 Key Achievements

No evaluation was undertaken of the PD projects because data. Instead information was obtained from UNFPA and SPC project reports. Globally, UNFPA has traditionally played a very active and effective role in building capacity in data collection over the past three decades. However, in recent years, because of the increased level of capacity and high costs of censuses (and availability of other funds) the organization has reduced its support to this area and concentrated more on building capacity in analysis and use of the results in planning, as well as advocacy to increase awareness of the issues.

A modest contribution to this end was made during CP3 with assistance being provided to countries both regionally, sub-regionally and in-country in the areas of data analysis and its use in policies.
and planning. This is a useful niche area for UNFPA and one which could well be increased in CP4. However, there is a need to more effectively take into account the reality of the human resource situations, the low levels of understanding on the ground (of what is inherently complex information) and the need for follow-up of short training activities. The initial products (policies, provincial profiles and a Population Atlas) demonstrate how useful the products of such work can be for educating about population issues, especially Parliamentarians and senior public servants. The bringing together of heads of statistics and planning for the first time was a useful innovation. Focusing on analysis can also assist the countries requiring analysis and enable more effective advocacy for population issues, which is so important in this demographically diverse region.

5.2.2 Challenges

CP3 inputs to data collection were relatively small and mostly consisted of technical advice, including relating to the MDG indicators, as part of the UN mandate. Given that other better resourced agencies are making heavy inputs into data collection a reduced role in this area seemed appropriate. However, the exception would be the DHS’s to which UNFPA expertise could and should play a very useful role. A more significant financial contribution than was available in CP3 would also help UNFPA to maintain a higher profile in this area. Furthermore, UNFPA should consider assistance for censuses.

The Parliamentary project (PPAPD) has the potential to play a very useful role in educating decision makers on Pacific population issues. Some gains were made during CP3, especially through the regional meetings and the production of the advocacy kit. However, some refinements are required in the approach to make the project more effective and sustainable.

The Indicator project is helping to fill a significant data gap for UNFPA’s priority countries and will provide essential baseline data for assessing CP4 achievements. The Gender Based Violence (GBV) research is helping to place the subject on national agendas which is crucial if women’s rights are to be met, their reproductive health improved and their vulnerability to HIV infection reduced. Such research is a useful example of how data can define a problem and be used for advocating for attention to be paid to the subject and providing guidance on how the issues should be addressed.

Conclusions - Population and Development

The Population and Development sub-programme made a small but reasonably effective contribution to achieving its Sub-Programme outputs of improved national, sub-national and sectoral policies, plans and strategies that take into account population and development linkages. In turn, they contributed, to a certain extent, to achieving the outcome of national, sub-national and sectoral policies, plans and strategies that take into account population and development linkages. With some fine tuning and an adequate budget, Population and Development activities have the potential to contribute more substantively to this outcome in CP4.

5.3 COMPARISON WITH CP2 FINDINGS:

In summary, CP3 did address a number of the issues identified, especially the one related to monitoring and evaluation but also ensuring integration of projects into national efforts. Its niche role in RH continued to be recognized as was its effectiveness in promoting the subject. Its implementation rate was high and CST missions greatly increased. PICs did not expect funds for RH to decrease in order to support PD, and this issue did not occur. In regard to being responsive to requests for changes in activities UNFPA states that it was in fact quite flexible in accepting changes, despite project staff failing to adequately document their requests well, as is required to meet justification requirements.

However, under CP3, UNFPA was not able to effectively address issues relating to financial reporting under national execution (NEX); its support for dissemination of training to subnational level was not fully effective; the role of PD assistance was not fully clarified though it had increased; national counseling and other RH training still needed additional financial and technical support and the need to make services more youth friendly (and confidential) continued. Governments needed to take more responsibility for justifying requested changes and for accurate and timely financial reporting and for distributing commodities to outer areas.

These points are in line with some of the findings of this Composite Review.
CHAPTER 6
RECOMMENDATIONS

The following are the major common issues which were identified during this Composite Review and which need to be addressed during CP4, if not before. In addition, each project has some specific areas which need to be addressed which are covered in the Evaluation reports and/or in the project specific sections of this report.

MANAGEMENT

1. Issue: Take lessons learned from the past into account in CP4.
   
   Task: Each implementing agency and partners should meet together in-country to review evaluation and monitoring key issues (and UNFPA) to identify practical ways of avoiding or overcoming issues. There is need to monitor that issues are addressed.
   
   Responsibility: UNFPA

2. Issue: Ensure selection of qualified and (technically and management-sound) implementing agency related to ensuring that standards are maintained:
   
   Task: UNFPA should ensure selection of appropriate implementing agencies, by using criteria, including relevant capacity in management and technical issues taking into account past performance.
   
   Responsibility: UNFPA

3. Issue: Implementing agencies need to ensure they are fulfilling their responsibilities.
   
   Task: Implementing agencies need to ensure that they are following project documents, that any changes are well justified, that activities use educationally sound methodologies and quality technical inputs and that funds are properly accounted for in a timely manner.
   
   Responsibility: Implementing agencies.

4. Issue: Tighter monitoring of project activities:
   
   Task: Monitoring mission reports should be made more analytical. Supervisors should ensure adequate follow-up of mission issues. There is a need to undertake more than one mission a year to each country (budgetary implications for additional monitoring

PROGRAMMING

5. Issue: Ensure projects are more strategic and focussed, with more emphasis on quality (rather than quantity).
   
   Task: All partners should provide strategic inputs during design phase and implementation. It is important to ensure objectives are realistic, not too ambitious, limit area of focus (accept that it is impossible to cover all needs). Only expand when original objectives are met and developments are consolidated. This is especially important given the number of countries being covered which makes effective management and monitoring a real challenge.
   
   Responsibility: UNFPA and implementing agencies, in conjunction with national partners.

6. Issue: Be more realistic about local conditions and what can be achieved.
   
   Task: There is need to plan schedules/inputs to take into account recipient workloads/capacity/other responsibilities. UNFPA should provide in-country project staffing support if necessary to assist staff to implement (budgetary implications) even if not sustainable.
   
   Responsibility: UNFPA, implementing agencies and partners

7. Issue: More closely link related project/activities e.g. RH Services, RHCS, Adolescents and MIRH in one geographical area by ensuring balanced inputs to each aspect to enable synergies and leveraging of projects
   
   Task: It is important to ensure close linkages/communication between projects/programmes, regular meetings and oversite to ensure this happens at the country level. Programme staff to monitor inputs and ensure that they are “balanced”.
   
   Responsibility: Each country “team”, with implementing agency and UNFPA overseeing.

8. Issue: Ensure that other (non-UNFPA) enabling factors are in place so that UNFPA funded inputs provide leaving opportunities
Task: It is important to identify and determine local enabling factors in each implementation site (eg water at clinics, needs for refurbishing, communications, land or building for youth services, transport) and use existing evidence (or compile) to assist government to seek other funding.

Responsibility: UNFPA and governments and donors

9. Issue: Annual Regional Management meeting and regional technical training may have been of limited value if held frequently.

Task: Resources permitting, technical training in RH should be more at national level, include much more small group discussion of issues and have national staff lead sessions. There is need to put more effort into in-country annual programme meetings focused on discussing progress and issues and regional meetings need only occur at beginning and end of CP or 2 -3 yearly.

Responsibility: UNFPA and governments

10. Issue: National Execution financial reporting in some countries continues to be problematic for some countries

Task: UNFPA (or consultant) and relevant governments need to review the issues and address the problem. Increasing in-country UN presence may help somewhat in terms of monitoring.

Responsibility: UNFPA (for ensuring issue is resolved) and governments (for taking greater responsibility for donor funds)

TECHNICAL

11. Issue: Having to deal with so many countries, the pressures of results based management and addressing the MDG indicators presents an impossible additional workload for UNFPA advisors.

Task: Advisory team needs to be supported by a full time Monitoring and Evaluation advisor/manager in the Sub-regional office

Responsibility: UNFPA HQ

12. Issue: Lack of gender perspective inhibits effectiveness of inputs and opportunity for equality

Task: Advisory team needs to include a dedicated Gender Advisor to ensure gender equality is clearly included in programming and to ensure UNFPA can respond to country requests and build capacity in the region

13. Issue: Lack of addressing the socio-cultural aspects of RH and relying heavily on a health approach and neglecting the empowerment of communities to have a role in empowering communities in protecting maternal and adolescent health.

Task: It is important to ensure socio-cultural inputs (eg rapid operational research, BCC/ focus group discussions/ discussions with key informants), ie value local knowledge and get to understand beliefs and practices. There is need to support community empowerment activities to complement and reinforce the health services inputs (eg BCC programmes).

Responsibility: UNFPA

14. Issue: Increase technical inputs to ensure maintenance of technical standards and quality f services/programmes provided.

Task: It is important to ensure quality and appropriate technical inputs (either through UNFPA Advisors, consultants or local experts at all key stages of project development and implementation, including for manuals and educational approaches). This should be adequately budgeted for.

15. Issue: Low and even declining Contraceptive Prevalence Rate. This is alarming given high population growth rates in some countries, the number of young people coming into their sexually active years and the importance of family planning for all aspects of development and maternal and family well-being, including prevention of maternal deaths, HIV and STIs

Task: There is urgent need to reposition Family Planning through improved advocacy, education and services and make it a high priority in CP4

Responsibility: UNFPA and partners

16. Issue: Educational methodologies used are not always sufficiently effective e.g. programmes too short, too high level, very information dense and lack supportive supervision/technical post training support. As well, inappropriate people have been picked for trainings on some occasions.
Task: It is important to ensure appropriate educational inputs to technical trainings, and budget for adequate follow-up by implementing agencies. Governments need to select appropriate participants.

Responsibility: UNFPA and implementing agencies (training content), governments (re selection of participants)

17. Issue: Lack of appreciation of significance of STIs including HIV on good Reproductive Health. Limited knowledge and uptake of STI/HIV services, and lack of access to non-judgmental service providers.

Task: It is important to make the subject of STI prevention a priority focus, including condom promotion and availability. There is need to investigate local beliefs and practices and take them into account and address them if necessary.

Responsibility: UNFPA, implementing agencies and partners

CAPACITY BUILDING

18. Issue: Human resource shortages especially in health sector but also in PD, gender and youth sectors

Task: It is important to support governments (in collaboration with WHO) and HOPS to review the reasons for the shortages, develop human resource data bases and come up with creative solutions for overcoming the shortages (e.g. changing retirement age, topping up salaries, obtaining overseas or regional assistance (South-South, UNVs, AVAs, AYADs etc) and accessing help from NGOs/FBOs.

Responsibility: UNFPA and governments

19. Issue: Constant requests for training in same areas, despite large investment over many years

Task: It is important to help governments review situation, develop a human resource data base, examine placement of staff, effectiveness of training and alternative solutions to address the loss of trained staff to overseas

Responsibility: UNFPA with governments

20. Issue: Lack of some types of key expertise in the region: e.g. Gender, BCC, data analysis, M and E

Task: There is need to examine the possibility of supporting institutions to provide short-term training/courses

Responsibility: UNFPA with institutions

21. Issue: Cultural factors can inhibit learning and practising of new skills and knowledge and effectiveness of service delivery e.g. supervision, passing on of information, counselling, birthing and educating clients

Task: There is need to use applied socio-cultural research to explore relevant social and cultural factors and use local advice about the nuances of service delivery, health seeking behaviour, sexual behaviour and gender inequalities. This knowledge can be used to shape delivery of services that both builds on productive/positive cultural factors and counters/reduces community focus on negative or dangerous cultural practices.

Responsibility: UNFPA, implementing partners and governments/NGOs
CONCLUSIONS

UNFPA’s third country programme of assistance to the Pacific island region provided an integrated set of activities in areas appropriate to the prevailing needs and to UNFPA’s mandate, and complementary with those of other development partners. It is notable that UNFPA is the major contributor of Reproductive Health assistance in the region with most countries relying heavily on its support.

The Reproductive Health sub-programme provided extensive, high quality inputs during CP3, addressing the needs of health providers in the region for up-to-date, international standard information and skills and helping them to manage Reproductive Health programmes more effectively. It also provided adolescent and male oriented inputs which are clearly beginning to meet strongly felt needs. An array of operationally oriented research also provided valuable baseline data and information for current and future decision making and Reproductive Health Commodity Security was greatly improved.

However, the reality of the human resource situation, including loss of trained staff, means that there are still constant demands for more training. Financial and geographical constraints have hindered the full realization of the benefits of the inputs and the programme lacked socio-cultural inputs, including substantial gender analysis, which would have complemented and reinforced the benefits of the health focused inputs. All projects contributed in various ways to HIV education and prevention and the introduction of Behaviour Change strategies will contribute further to that, as well as to Reproductive Health in general.

The Population and Development sub-programme made a small but reasonably effective contribution to achieving its Sub-Programme outputs of improved national, sub-national and sectoral policies, plans and strategies that take into account population and development linkages. In turn, they contributed, to a certain extent, to achieving the outcome of national, sub-national and sectoral policies, plans and strategies that take into account population and development linkages. With some fine tuning and an adequate budget, Population and Development activities have the potential to contribute more substantively to this outcome in CP4.

The mixed start dates of projects makes it impossible to say that the Country Programme as a whole achieved particular outcomes but it is possible to say that particular project components contributed to varying extents to their desired outputs, and in turn to the outcomes. Since most, if not all, projects in CP4 will be continuations of those funded in CP3 there should be no delays and a much more cohesive implementation of the new country programme. In addition there will be comprehensive baseline data against which to monitor and judge performance. With closer attention paid to educational methodologies including a focus on quality, the taking into account of socio-cultural aspects, a more integrated technical/programmatic planning approach for the CP4 cycle, and the shaping of activities to mesh with the reality on the ground in the island countries, the same projects have the potential to make more effective and more measurable contributions to the objectives of CP4.