Desk Review of Programs for Most at Risk Young People in Six Pacific Countries –

Cook Islands, FSM, Marshall Islands, Tonga, Tuvalu & Samoa

A Collaboration between AHD Program SPC and UNICEF Asia-Pacific Shared Services Centre

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Acknowledgements

Table of Contents

Introduction

Across the Pacific region, youth population between 10-25 years of age represents about 56% of the pacific population of 9.5 million, with 37% under the age of 14 years. The region's median age is 21 years. UNICEF, UNFPA and SPC jointly support 10 countries across the Pacific to deliver programs targeting the sexual and reproductive health needs of young people. A 2007 Review of the Adolescent Health and Development (AHD) Program recommended specifically targeting vulnerable, marginalised and most at risk groups of young people. It also noted that specific interventions for this group were inadequate. As a result, the AHD Program is reviewing its strategies to assess the extent to which the MARYP approach has been used, with a view to strengthening program results and outcomes.

Purpose of the review

The purpose of the assignment, as stated in the Terms of Reference (TOR), was to collect information to identify the context, groups and location of Most at Risk Young People (MARYP) in the Pacific and determine the extent to which specific interventions have been implemented to reach this group of young people. The six countries of interest include Cook Islands, Federated States of Micronesia, Marshall Islands, Tonga, Tuvalu and Samoa.

Methods

Interviews

Alongside a desk review of appropriate literature, the consultancy team was tasked with conducting phone interviews with AHD Country Coordinators and other relevant stakeholders at the country level in order to gain a personal perspective of their understanding of the MARYP concept as well as to obtain additional information available in their respective countries.

The team developed a questionnaire to guide telephone interviews with respondents in the six countries. The questionnaire was tested informally within SPC's Public Health Department and confirmed with the AHD Advisor in Suva before being sent out prior to the scheduled phone interviews, so interviewees could choose to complete the questionnaire in writing to supplement the interviews. The questionnaire used a mix of open and specific questions to scope any additional sources of information that might inform:

- The identified issues young people face in each country – including the current perceptions and understanding (amongst young people, service deliverers, funders and others) of who constitutes most at risk young people and the relevant risk factors.
- The current strategies and program approaches (and tools) used at regional and country levels to map most at risk young people; and to develop and implement responses; and if possible, any evidence of their effectiveness.
- The services and programs available at country (national and sub-national levels, delivered through government and/or civil society agencies) targeting young people at risk in each country; and if possible, the scope of their usage by the target audience (and the extent of those

not accessing the services, if possible); and, the current resources committed (including staff and other resources) at either a country level, or at a regional level which impact on country level.

- Any coordination mechanisms or advocacy groups which focus on issues relevant to MARY
- Any literature or other data documenting the size/proportion of the population of youth at risk in each country and region.

In total, thirteen country phone interviews were conducted (see Annex J for a full list of interviewees).

Desk Review

The Team undertook a preliminary review of available known literature (including the 2007 AHD Program Review and UNICEF Baseline Study 2008) prior to being briefed by the AHD and UNICEF offices in Suva. The briefing provided an opportunity to:

- Confirm the purpose and approach to the review;
- Clarify the range and known sources of data likely to be available;
- Discuss the proposed approach including timeframes, including logistics relating to ascertaining contact points for the AHD Program and other relevant agencies in the six countries (Cook Islands, Federated States of Micronesia, Marshall Islands, Tonga, Tuvalu and Samoa).

The team reviewed known available literature and other data (qualitative and quantitative) sourced from the UNICEF and AHD offices in Suva to develop a database for categorisation and identification of potential sources of information prior to contacting each country office of the AHD program and UNICEF Programs to advise country officers of the Assignment, and request their assistance to source relevant literature and other data, and establish an interview time.

Data sought included: official Government reports and surveillance data about HIV, published and unpublished reports relating to HIV & MARYP in the Pacific; reports and findings from significant projects and programs implemented by national or sub-national agencies, government or civil society, which focusing on at-risk young people and/or risky behaviours for HIV; published and unpublished reports and data related to STIs, pregnancy, abortion, reproductive health problems and drug and alcohol abuse among young people. These will include a review of relevant Integrated Biologic and Behavioural Survey (IBBS), Multiple Indicator Cluster Survey (MICS) and Second Generation Surveillance (SGS) reports. A web-trawl of relevant sites was undertaken, iincluding: UNICEF, UNAIDS, WHO, UNFPA, UNDP and SPC. Burnet also reviewed its own extensive research network to ascertain any additional literature and data sources of interest, including the recent (and yet to be published) Situation Assessment of Drug and Alcohol use in the Pacific, undertaken by Burnet on behalf of the Pacific Drug and Alcohol Research Network. A bibliography of data collected was drafted.

The quality of the literature was then assessed for each country to generate an annotated bibliography (see Annex G). The following table summarises the number of documents reviewed, together with an assessment of the kind of data generated.

Table 1: Number and types of documents reviewed

Country	No. of Doc'ts	Kind of information available					
		Donor commissioned Qualitative evaluations & assessments	National Quantitative surveys inc SGS, KAPBs etc	Government population surveys eg DHS	Policy/ Strategy Documents	NGOs Program reports	Technical Papers & reports
Cook Islands	12	4	2	2	2	1	1
FSM	18	1	5	1	2	2	9
Marshalls	16	4	3	5	1		3
Tonga	10		2		3		5
Tuvalu	13	1	3		5		
Samoa	11	7	2	1	1		
International	18	1					17
Total	98	18	17	9	14	3	35

The Team then developed an analytical framework for assessing the literature.1 This scoped the following questions for exploration:

- What is the status of young people's health outcomes and access to services?
- What is the understanding of vulnerability and risk with regards to young people? What factors contribute to risk and vulnerability?
- What are the range of interventions to respond to adolescent health issues? And to specifically target vulnerable groups and most at risk young people
- Has 'the MARYP Approach' been used in these 6 countries in the Pacific?
  - What is the size of the youth population in each country?
  - Who are the most at risk or vulnerable young people in each country?
  - Are some groups of young people more at risk, or more vulnerable, in relation to their health outcomes and access to health services, than others across the six

[1] The Desk Review had intended to source the preliminary report of the three-country study of MARYP from the UNICEF Pacific office in order to harmonise, where possible, data collection methods, variables and indicators gathered, and report analysis and reporting. However, a copy of the preliminary report was not available at the time of analysis.

countries? What are the key indicators of biological, behavioural and socio-economic risk and vulnerability?

- What barriers do most at risk or vulnerable young people face in accessing health services/achieving good health outcomes in these six countries?
- What interventions, if any, target most at risk or vulnerable young people in these six countries?
- How successfully do these interventions respond to risk and vulnerability?
- What gaps are there in interventions to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?
- What are the research and/or programming priorities for the future

Presentation of preliminary findings

The literature and interview data was reviewed and analysed, to prepare a series of draft reports on the six countries. The Burnet Pacific office presented a review of the preliminary findings to the UNICEF and AHD MARYP meeting of AHD coordinators and country informants in Nadi in late November. Following feedback from the UNICEF and AHD Program Coordinators in Suva, Burnet's Pacific Program has reviewed the first draft of the Report for submission to UNICEF for their consideration in mid-December 2009.

Findings

Defining Young People

While several organisations use the United Nations' definition of young people being 15-24, Table 2 clearly shows a wide range of differences in how the parameters of this target population are defined, with different definitions of what age ranges constitute 'young people' as illustrated in the following table.

Table 2: Country/organisational definitions of 'young people'

Country	Organisation	Age range of young people (years)
Cook Islands	AHD/MOH	15 - 19
	Red Cross	15 - 30
FSM	AHD/MOH Pohnpei	**15 - 24**
	HIV Program Chuuk	**15 - 24**
	Red Cross	11 - 25
RMI	Youth to Youth in Health	0 - 25
Samoa	Samoa AIDS Foundation	15 - 29
	Samoa Family Health Association	**15 - 24**
	TALAVOU Program	12 - 29
Tonga	AHD/TFHA	10 - 24
	Tonga National Youth Congress	14 - 35
Tuvalu	AHD/MOH	**15 - 24**
	Tuvalu Family Health Association	14 - 25
	Tuvalu National Youth Policy	14 - 34

Who are the MARYP? Identifying risk and vulnerability

Interviewees generally did not differentiate between the terms 'at risk' and 'vulnerable' and used them interchangeably. Whilst 'vulnerability' generally refers to the larger context of an issue in terms of its social variables and environmental factors, e.g. being a woman; 'at risk' usually refers to individual behaviour, e.g. having unprotected sex. It would appear that this difference is not widely considered in terms of identifying MARYP populations.

In the course of the country phone interviews, it became very evident that while the term '*Most at Risk Young People*' (MARYP) is not widely used, every interviewee had an understanding of the concept and to varying degrees were already implementing programmes, services and activities that specifically targeted '*Most at Risk Young People*'.

No organisation interviewed had a formal definition of '*Most at Risk Young People*'. Furthermore, most interviewees shied away from actually offering a definition, choosing instead to attach the term to the members of certain social groups e.g. sex workers or school dropouts. On the other

hand, a few interviewees identified MARYP populations in terms of their individual behaviours as shown in the last three rows in Table 2 below.

Table 3: Identified Most at Risk Young People (MARYP) Populations

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
High school students	-	-	-	-	-	-	X	X	-	-	X	-	-	3
LGBT population	-	-	-	-	-	-	X	-	-	X	X	-	-	3
Marginalised YP groups	-	-	-	-	-	-	-	-	-	-	-	X	-	1
Mobile students	-	-	X	-	-	-	-	-	-	-	-	-	-	1
Mobile young sports people	-	X	-	-	-	-	-	-	-	-	-	-	-	1
MSM	X	X	-	-	X	-	-	-	-	-	-	-	X	4
Outer island YP	-	X	-	-	-	-	-	-	-	-	-	X	-	2
Prison inmates	-	-	X	-	-	X	-	X	X	-	-	-	-	4
School dropouts	X	-	X	-	-	X	X	X	X	X	X	X	-	9
School leavers	-	X	-	-	-	-	X	X	X	-	-	-	-	4
Seafarers	-	-	X	-	-	X	-	-	-	-	-	-	X	3
Sex workers	-	-	X	X	X	X	X	-	-	X	-	-	-	6
Taxi drivers	-	-	-	-	-	X	-	-	-	-	-	-	-	1
Teenage mothers	X	-	-	-	-	X	-	-	-	X	X	-	X	5
Unemployed YP	-	-	-	-	-	X	-	-	X	-	-	-	-	2
Young (XX-X3) adolescents	-	-	-	-	X	-	-	-	-	-	-	-	-	1
Young deportees	-	-	-	-	-	-	-	-	-	X	-	-	-	1
YP practising unprotected sex	-	-	-	X	-	-	-	-	-	X	-	-	-	2
YP who abuse alcohol/substance	-	X	-	X	-	X	-	-	X	-	-	-	-	4
YP with multiple partners	-	-	-	X	-	-	-	-	-	-	-	-	-	1
TOTALS:	3	5	5	4	3	8	5	4	5	6	4	3	3	58

According to Table 3, the most identified MARYP populations were school dropouts, sex workers and teenage mothers followed by men who have sex with men (MSM), prison inmates, school leavers, and young people who abuse substances such as alcohol.

It is important to note that this table illustrates all the MARYP populations that were identified by interviewees and that not all populations are specifically targeted by their respective programs.

How do you know they are MARYP?

The interviewees were asked what 'tools', or evidence, they used to identify who the MARYP populations were. As can be seen in the table below, there was significant variance in the tools and methodologies utilised in identifying MARYP populations, ranging from structured formal statistical

data such as census reports and second generation surveillance survey reports to informal sources such as anecdotal evidence and peer educator observations.

Table 4: Tools Used to Identify Most at Risk Young People (MARYP) Populations

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
Anecdotal evidence	-	-	X	-	X	X	-	-	-	-	X	X	X	6
Clinical data used to identify MARYP	X	-	X	-	-	-	-	-	-	-	-	-	-	2
In-house KAP Survey Report	-	-	-	-	X	-	-	-	-	-	-	X	-	2
MOE school attendance data	-	-	-	-	-	-	-	-	-	X	-	-	-	1
National HIV Plan of Action	-	-	-	-	-	-	X	-	-	-	-	-	-	1
Peer Education Outreach Reports	-	-	-	-	-	-	-	-	-	X	-	X	-	2
Peer Educator observations	-	X	-	-	-	-	-	-	-	-	-	-	-	1
Population Census Data	-	-	-	-	-	-	-	-	X	X	-	-	-	2
Regional Strategy on HIV/AIDS	-	-	-	-	-	-	X	-	-	-	-	-	-	1
Research literature & data	-	-	-	-	-	-	X	-	-	-	-	-	-	1
SGS Survey Reports	-	X	-	X	-	-	-	-	-	-	-	-	X	3
Youth Vulnerability Mapping Report	-	-	-	-	-	-	-	X	X	-	-	-	-	2
TOTALS:	**1**	**2**	**2**	**1**	**2**	**1**	**3**	**1**	**2**	**3**	**1**	**3**	**3**	**24**

Anecdotal evidence usually amounts to stories collected by peer educators in the communities they serve. In small island communities, it was common for interviewees to say “We just know who the high risk groups because this is a small place”. Thus, on the one hand, this process does involve youth participation; however, conversely, the approach is quite subjective and interventions could possibly be developed based on the perceived needs of a certain group by another.

Given the absence of reliable up-to-date research literature and disaggregated data on young people and sexual health in the Pacific, it is not surprising that service providers and others rely on anecdotal evidence to identify MARYP populations.

Risk and Vulnerability: Assessing the indicators

The data was reviewed to assess the known level of risk and vulnerability across a range of biological, behavioural and structural indices. The following tables outline the current data, please refer to the Annexes for further information.

Table 5: Biological Evidence of Risky Sexual Behaviour in Young people in 6 PICs

Country	Chlamydia Prevalence				Cumulative Number of HIV infections reported				Teen pregnancy % of births in teenagers (TFR)		Unsafe Abortion (is illegal)		Other SRH	
	<25		>25		<25		>25							
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Samoa	na	40.7% data from pregnant women – SGS Survey)		17.5%	1	1	10	4		11% (2003-04) TFR 54/1000		Nd - although anecdotal evidence		
Tuvalu	na	18.8%	na	16.0%						TFR 42/1000				
Tonga	na	21.2% (27.5% WHO - 2006 SGS)		9.2%						TFR 24/1000				
Marshall Islands										TFR 138/1000				
FSM	19%	35%	7.8%	12%	7	5	17	7		13-16% (2001-) TFR 48/1000	19%	35%		
Cooks Islands	na	38%	na	4%	0	0	0	1	na	33% (2006) TFR: 47/1000 (58/1000?)				

Table 6: Sexual and Reproductive Health and other Health Behaviour data in Young People from 6 PICs

Country	Mean age of 1st sex		Reported condom Use in last 12 months		Forced to have sex		Mean number of sexual partners in last 12 months	
	M	F	M	F	M	F	M	F
Samoa	17	17	14%					
Tuvalu	18	18	11.6%				1 (Range 0-10)	
	Females <25	Females >25				Females <25	Females >25	
	21.9%(median age under 18yrs)	78.1% (median age under 18yrs)				98.4% had 1 partners	1.6% had 2 or more partners	
Tonga	17.2	17.8	11.5%			3.1%	2.8	2.4
Marshalls				16% ever used a modern form of contraction – altho 37% were sexually active or married		8% (at sexual initiation)		
FSM	14.5	16.5	52%	28%			3.3	1.5 Range 1-17
Cooks	16	14.6	26.8%		0.4%	27%	5.3 (range 1-8)	3 (range 1-10)
	15 (median)		25%	9%				

Table 7: Sexual Behaviours among Young People in 6 PICs – Transactional Sex and Male-to-Male Sex

Country	Received Money or Goods for Sex (females only)	Paid Money for good for sex (Males only)	Male have sex with another male in last 12 months
	F	M	M
Samoa	8.7%	8.2%	14.7%
Tuvalu	100% - No	1.0%	8.0%
Tonga	0.7%	0.3%	15%
Marshalls			
FSM	1.2%	5.1%	
Cooks	0.4%	0.4%	2.4%

Table 8: Alcohol, Drug and Tobacco use among Young People in 6 PICs

Country	Drug & Alcohol use – % teenagers who drink		Tobacco % of 10-29 yrs who smoke		Suicide attempts	
	M	F	M	F	M	F
Samoa	50%	33%	43%			
Tuvalu	41.6% drink with 57% drinking once a week average of 4 cans and 63% consuming more than 5 cans per session		38%			
	81.9%	17.3%				
Tonga						
Marshalls						
FSM						
Pohnpei	28.6% binge drink	16.6% binge drink				
Yap	10% drink weekly	10 % drink weekly				
	31.8% drink 10 SDs when they drink					
Cooks	91%	85%	1:10 used in last 30 days			
	One third drank weekly; one third drank two or three times per week with those consume drink more than 5 SDs in a session					

Table 9: Social & Economic indicators of vulnerability

Country	Literacy				Unemployment				Convicted of Offences		Violence against women & girls	
	<25		>25		<25		>25					
Samoa	M	F	M	F	M	F	M	F	M	F	M	F
					58% (of total unemployed =5%)		62%	38%				37.6% (physical violence ever)
												19.6% (sexual violence ever)
Tuvalu												37.2% (physical violence ever)
												21.2% (sexual violence ever)
Tonga												
Marshalls												28.3% (physical violence ever)
												19.5% (sexual violence ever)
FSM												
Cooks	99%											

Strategies Currently Used to Reach People MARYP

Interviewees were asked about the strategies their organisations used to reach MARYP populations. Responses from interviewees included descriptions of fixed clinical services as well as mobile outreach activities and the inclusion of specific program under the banner of other activities, such as recreation and sports. In some cases, specific high risk groups were targeted and, in others, activities that targeted the general youth population also, sometimes inadvertently, targeted particular MARYP groups.

Table 10: Strategies Currently Used to Target Most at Risk Young People (MARYP)

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
Domestic Abuse Program for YP	-	-	-	-	-	-	X	-	-	-	-	-	-	1
Domestic Violence & HIV Program for YP	-	-	-	-	-	-	-	-	-	-	(X)	-	-	1
Expand clinic hours for SWs	-	-	X	-	-	X	-	-	-	-	-	-	-	2
MARYP involved in project mgmt	-	-	-	-	-	X	X	X	X	X	-	-	-	5
Mobile Clinical Outreach	-	-	X	-	-	-	-	X	-	-	-	-	-	2
Most at risk settings targeted	-	X	X	X	-	-	X	X	-	X	X	X	-	8
Peer Education for sex workers	-	-	-	X	-	-	-	-	-	-	-	-	-	1
Peer Education for seafarers	-	-	-	-	-	-	-	-	-	-	-	-	(X)	1
Program for young mothers	-	-	-	-	-	-	-	-	-	X	-	-	-	1
Program for school dropouts	X	-	-	X	-	-	-	-	-	-	-	X	-	3
Program for young women	-	X	-	-	-	-	-	-	-	-	-	-	-	1
Rehabilitation program for young prisoners	-	-	-	-	-	-	-	-	X	-	-	-	-	1
Sports programs for YP with special needs	-	-	-	-	-	-	-	-	X	-	-	-	-	1

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
Substance Abuse program for YP*	-	(X)	-	(X)	-	X	(X)	-	-	(X)	(X)	-	-	6
Youth Centre	-	-	X	X	-	-	-	X	-	X	-	-	-	4
Youth Clinic	X	-	X	X	-	X	-	X	-	X	-	X	-	7
TOTALS:	2	3	5	6	0	4	4	5	3	6	3	3	1	45

(X) = Program implemented by a different national organisation (not part of this study)

The FSM Red Cross interviewee stated that the organisation purposely does not target MARYP populations in order to avoid those groups getting stigmatised and facing possible discrimination by being seen to receive separate and different treatment. As can be seen from Table 3, FSMRCS do not implement any activities or strategies that specifically target MARYP. However, the interviewee revealed that the settings in which the general youth groups are reached are selected based on needs assessments and situational analysis. Thus, specific MARYP groups are indirectly targeted through the settings in which they congregate within the larger general youth population.

As can be seen in Table 3, the most common strategy for reaching MARY populations was to target the settings in which MARYP might congregate, such as nightclubs, bars, wharfs and the areas in which they live. The most common program strategies implemented in these settings were peer education outreach activities and condom distribution.

Two countries implemented a peer education model that trained members of the MARYP group as peer educators so they can inform and educate their own peers in the same social group. In FSM in the AHD Program in Pohnpei and the HIV Program in Chuuk, sex workers were trained as peer educators. In Tuvalu, the National Red Cross has a peer education program for seafarers whereby they work closely with the Seafarers Training School and the Tuvalu Overseas Seamen's Union (TOSU) to train young seafarers as peer educators.

This mobile targeted approach contrasts with the option of providing youth friendly clinical services at a fixed location identified in a number of countries. Seven of the organisations interviewed operate youth clinics that offer a range of ASRH services such as contraceptives, IEC materials, Voluntary Confidential Counselling and Testing (VCCT) for STIs and HIV, as well as family planning and in some cases, treatment. Several youth clinics are also attached to youth centres that provide other services such as libraries, internet access, media equipment and sports facilities.

While this study did not explore how these clinical services categorise themselves as 'youth friendly', the TFHA interviewee stated that their clinic uses the UNFPA Youth Friendly Services (YFS) Criteria Checklist to provide a Youth Friendly Clinic day every Friday. In Majuro (RMI), the clinic specifically targets MARYP populations through extending operating hours; the clinic remains open until 9:00pm in order to cater for the needs of young people, and especially young sex workers.

Peer education programs and clinical services naturally complement each other as it makes perfect sense for peer educators to target MARYP populations and refer them directly to youth friendly clinics. The success of this symbiotic relationship is certainly more likely when both services are implemented by a single organisation. In instances where this is not the case, and a peer education program is operating without an effective link to a youth clinic (or vice versa), there exists a large gap and a need to forge a strong working relationship with another organisation to fill it. If this does not occur and programs continue to work in isolation, neither will adequately serve MARYP populations efficiently.

In order to inform interventions, several interviewees emphasised the importance of consulting directly with their target audience by involving MARYP in planning, implementation and evaluation of programs. This process may take the form of focus group discussions to identify emerging issues and particular high risk groups or youth stakeholder meetings which bring together representatives of different youth groups to review and evaluate program activities. What remains unclear is how frequent these consultations take place, whether they are planned activities or undertaken on an ad hoc needs basis and what criteria and processes are used to select participants.

Another significant finding in Table 3 was the presence of substance abuse programs for young people in five of the six countries in this study. While Youth to Youth in Health (YTYIH) in RMI was the only organisation implementing their own program, other interviewees did point to the fact that they regularly collaborate with other lead organisations' programs, e.g. the Police Department in the Cook Islands and the Salvation Army in Tonga.

Gaps identified in Reaching MARYP

Given that the ambition of programs usually outweighs the resources available to achieve such success, it is not difficult for service providers to identify gaps in their programs in reaching MARYP populations.

Table 11: Gaps identified in Reaching Most at Risk Young People (MARYP)

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
Collaboration between service providers	-	X	X	-	-	-	-	-	X	-	-	-	-	3
Difficulty of identifying sex worker population	-	-	-	-	-	-	X	X	-	-	-	-	-	2
Lack of accessibility of YP to ASRH services	-	-	-	-	-	-	X	-	-	-	-	-	-	1
Insufficient human resources	-	X	-	X	X	-	-	-	-	-	-	-	-	3
Lack of availability of	-	-	-	-	-	-	X	X	-	X	-	-	-	3

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
YFS clinical services														
Lack of consultation	-	X	-	-	-	-	-	-	-	-	-	-	-	1
Lack of funds	-	-	-	-	-	-	X	-	-	-	-	-	-	1
Limited resources	-	-	-	X	-	-	-	-	-	-	-	-	-	1
Programs not reaching young sex workers	-	-	-	-	-	-	X	X	-	-	-	-	-	2
Programs not reaching outer island/rural YP	-	X	-	X	-	X	X	X	-	X	-	X	-	7
TOTALS:	-	4	1	3	1	1	6	4	1	2	-	1	-	24

The most common response was not surprising for the Pacific context. Seven interviewees outlined the situation whereby most program activities are concentrated in the capital (or main island). Whilst these urban areas usually have the highest number of young people, it seems quite common that resources and funds are allocated disproportionately in their favour to the detriment of young people in rural or outer island communities. Interviewees explained that limited funds and irregular and often unreliable transportation options prevented their organisations' programs from extending their reach to these rural / outer island communities. It seems reasonably common for outer island young people to receive training outreach activities only once a year with little support and follow-up thereafter.

Another group that doesn't often access youth clinics are young sex workers. Two interviewees from Samoa expressed the difficulty of identifying this social group given the non-commercial transactional nature of their work and the fact that as a social group, they are fairly hidden and not yet fully identifiable.

Limited funding obviously has multiple implications for programs including having inadequate numbers of staff on the payroll and often insufficient capacity within organisations to produce expected outputs. Insufficient capacity of human resources can also refer to the lack of Youth Friendly Services (YFS) training for health service providers.

Another significant gap highlighted by interviewees was the lack of YFS clinics, in particular the lack of availability outside of urban areas. There was also concern raised as to the need for commonly used criteria so that standards of YFS clinics are consistent and can be maintained.

Lastly, while there are many commendable examples of tangible collaboration between national organisations, several interviewees felt there remains much work to be done in terms of stakeholders working and planning together for both their programs' mutual benefit and that of the target audience. In some instances, interviewees expressed that personal issues and personality clashes were preventing certain organisations from collaborating effectively.

Suggested Options to Fill Gaps in Reaching MARYP

Once interviewees had identified gaps within their programs, they were asked for suggestions of how to fill them in terms of reaching MARYP populations more effectively. Naturally, many suggestions rely implicitly on the availability of increased funding and the table below may appear somewhat of a 'wish-list', but it is a useful exercise nevertheless and could be used as a tool for additional fundraising or advocacy.

As can be seen in the table below, the most common suggestions for reaching out to MARYP populations included 'increasing outreach and services to rural / outer island youth' as well as 'increasing the number of YFS clinics'. While both suggestions are practically synonymous with 'expanding coverage', the focus is clearly on increasing availability and accessibility of ASRH programs and services. Evidently, such up-scaling of programs and services are inherently linked to 'increasing human resources' and is therefore particularly cost intensive.

National Red Cross peer education programs have a policy of training young peer educators from rural and outer island communities so as to facilitate outreach within those communities, but admit there exist many un-served communities due to limited funding.

Of course, there are suggestions that do not necessarily require additional funding such as involving MARYP groups in project management and using more creative ways to engage and reach MARYP populations. Such suggestions would simply involve more consultation with target audiences and slight adjustments to existing processes.

The need for 'increasing visibility of programs', 'more open discussion of sensitive topics' and 'increasing the use of media' all point to the need for more activities that contribute to creating an enabling environment, whether they be focussed on advocacy, policy development or public events.

Table 12: Suggested Options to Fill Gaps in Reaching Most at Risk Young People (MARYP)

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
Develop IEC materials for less literate YP	-	-	-	-	-	-	-	-	-	X	-	-	-	1
Expand clinic hours to target SWs	-	-	X	-	-	-	-	-	-	-	-	-	-	1
Expand coverage	-	-	-	-	X	X	X	-	-	-	-	-	-	3
Increase frequency of outreach to rural/outer	-	X	X	X	-	X	-	-	-	-	-	-	-	4

	CI AHD MOH	CIRC	FSM AHD Pohnpei	FSM Chuuk HIV	FSM RCS	RMI AHD YTYIH	SAF	SFHA	Samoa TALAVOU	TFHA AHD	TNYC	TuFHA	Tuvalu AHD MOH	TOTALS:
island areas														
Increase no. of YP accessing YFS	-	-	-	-	-	-	-	-	-	X	-	-	-	1
Increase use of media	-	-	X	-	-	-	-	-	-	X	-	-	X	3
Increase mobile clinical outreach	-	-	X	-	-	-	-	-	-	-	-	-	-	1
Involve MARYP in project management	-	-	-	-	-	-	X	-	X	-	-	-	-	2
More creative ways to reach MARYP	-	X	X	-	-	-	-	X	-	-	-	-	-	3
More focus on BCC strategies	-	-	-	-	-	-	X	-	-	-	-	-	-	1
More sustainable funding	-	-	-	-	-	-	X	-	-	-	-	-	-	1
More open discussion of sensitive topics	-	-	-	-	-	-	X	-	-	-	X	-	-	2
Need more analysis of root cause of problems	-	-	-	-	-	-	-	-	-	-	-	X	-	1
Need more focus on specific target groups	-	-	-	-	-	-	-	-	-	-	-	X	-	1
Need more visibility of programs	-	-	-	-	-	-	-	X	-	-	-	X	-	2
Need to increase human resources	X	-	-	X	X	-	-	-	-	-	-	-	-	3
Need to increase YFS	X	-	-	X	-	X	-	-	-	X	-	-	-	4
Need to target YP under 15 yrs	-	-	-	X	-	-	-	-	-	-	-	-	-	1
TOTALS:	2	2	5	4	2	3	5	2	1	4	1	3	1	35

Comparing Table 3 and Table 5, it can be clearly seen that many suggestions involve simply increasing current strategies for reaching MARYP populations. Evidently, interviewees believe that their organisations are targeting MARYP populations to a certain degree, however limited. It is therefore encouraging that so many suggestions were forthcoming in terms of up-scaling such interventions.

Conclusions

This section has detailed a fairly small scale survey of thirteen national organisations with programs in six countries. Phone interviews were carried out in a limited amount of time and thus may not convey the entire picture of their organisations' interventions or approaches taken.

However, the responses from interviewees have provided a useful insight into their understanding and conceptualisation of the Most at Risk Young People (MARYP) approach. What is clear is that there is no single common understanding of what the term implies in terms of its practical application.

Whilst every interviewee could identify populations they believed to be MARYP within their countries, there was great variance in the kind of tools that were used to assist this process. Informal methodologies are widely relied upon, usually in the absence of skills and confidence to generate up-to-date and disaggregated research data.

There was a wide range of strategies used to target MARYP populations. The process of targeting requires a contextualised approach, however, there is much to be gained also from creating opportunities to share best practices and lessons learnt within the region as well as within countries. Comprehensive monitoring and evaluation tools and techniques that measure the efficacy and efficiency of interventions in reaching MARYP populations are required.

This raises the need for research to determine baseline indicators but also, and just as importantly, capacity building of national service providers to translate the theory into practice in order to inform appropriate responses. The operational research funded through UNFPA, for example, in FSM, is an excellent example of how research and analytical capacity can be built at the operational levels.

Finally, the gaps identified within programs and suggestions to fill them in terms of better targeting MARYP populations provide a useful list of potential strategies to further explore. Acknowledging shortfalls in current programs and services also provide the scope for seeking increased funding and areas for up-scaling activities.

Country Annexes: Annexes A to G

Other Annexes: Annexes H to K

Annex A: Cook Islands

1. Quality of the Data

Identify the quality of literature or other data documenting the population of youth 'at risk' in each country and the kind of information on risk and vulnerability available

Table 1: Quality of Data by Country

Country	No. of Documents		Kind of information available				
Cook Islands		Donor commissioned Qualitative evaluations & assessments	National Quantitative surveys inc SGS, KAPBs etc	Government surveys	Policy/Strategy Documents	NGOs Program reports	Technical Papers & reports
	12	4	2	2	2	1	1

2. Target/Audience Population Size

Identify and describe:

- perceptions of who constitutes 'most at risk young people' - amongst young people, service deliverers, funders, government and others;
- numbers of young people, male and female and other genders
- numbers of young people considered to be at risk as a proportion of each country's youth population

Table 2: Size of the population, and youth as a proportion

Country	*Cook Islands*			
Total population				
As % of total population	*30%*			
	<25		*>25*	
	M	*F*	*M*	*F*

2.1 The evidence of risk and vulnerability:

Indices of risk and vulnerability:

Relevant known data in relation to risk factors and conditions conducive to vulnerability.

Biological measures of risk:

Table 3.1 SRH biological data on young people

Country	*STIs*				*Cumulative Number of HIV infections reported*				*Teen pregnancy % of births in teenagers*		*Unsafe Abortion*		*Other SRH*	
Cook Islands	*Chlamydia prevalence (data from pregnant women)*													
	<25 yrs		*>25 yrs*		*<25yrs*		*>25yrs*							
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	na	*38%*	*na*	*4%*	*0*	*0*	*0*	*1*	*na*	*33% (2006)*				
										47/1000				

										(58/1000?)				

Indicators of at-risk behaviours:

Table 3.2 SRH & Other health behavioural risk data

Country	*Mean age of 1st sex*		*Reported condom Use in last 12 months (where more than one partners)*		*Forced to have sex*		*Mean number of sexual partners in last 12 months*		*Other*	
Cook Islands	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	16	*14.6*	*26.8%*		*0.4%*	*27%*	*5.3 (range 1-8)*	*3 (range 1-10)*		
	15 (median)		*25%*	*9%*						

Country	*Received Money or Goods for Sex (females only)*	*Paid Money for good for sex (Males only)*	*Male have sex with another male in last 12 months*
Cook Islands	*F*	*M*	*M*
	0.4%	*0.4%*	*2.4%*

Drug & Alcohol use – % teenagers who drink (starting before age 16)		*Tobacco % of 10-29 yrs who smoke*		*Suicide attempts*	
M	*F*	*M*	*F*	*M*	*F*
91%	*85%*	*1:10 used in last 30 days*			
One third drank weekly; one third drank two or three times per week with those consume drink more than 5 SDs in a session					

Social & Economic indicators of vulnerability

Table 3.3 Socio-economic data on vulnerability

Country	*Literacy*				*Unemployment*				*Convicted of offences*		*Other*	
	<25		*>25*		*<25*		*>25*					
Cook Islands	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	99%											

Analysis:

The health of young people in the Cook Islands is marked by:

- High rate of teenage pregnancies, with factors suggesting this has been a trend since 1991 to 2006 (at least) – but contradictory claims of whether the rate of 47/1000 represents the highest teenage fertility rate in the region. It is claimed that most births are to single women, with the implication that the births were not intended and there is an unmet need for family planning amongst adolescents and low utilisation of planning services by adolescents aged less thank 20 years. However, a small survey of young people and health care providers in 2007 found that a higher percentage of students were knowledgeable about family planning and where to go to for services, and the factors associated with teenage pregnancy. However, fewer used contraception. (Note: overall maternal mortality and morbidity indicators are good in the Cook Islands.)
- Between 1998-2000, female and male youth between 15-24 and 25-35 accounted for the largest proportion of hospital admissions, with injuries being the main cause of youth death and illness, particularly for young men, and largely because of motorcycles – we do not have age-specific data for the years since, although 2004 figures indicates high numbers of motor cycle accidents for men (91), associated with alcohol, as a cause of hospital admission, with alcohol related in over half (58)[1].
- Young people between 15-19 demonstrated very high rates of Chlamydia (higher than comparative rates identified in total population in the same survey) with 45% of those tested showing infections

Some of the known indicators of risk and/or vulnerability include:

- Young people are mobile - most people who leave the Cook Islands are under 35 years of age, with a similar rural drift to Raratonga (15-24 age rate not known)
- A third of respondents to the 2006 SGS indicated they had had sex before 15 years of age, with a high prevalence of two or more partners in the previous 12 months.
- Although 75% reported ever having used a condom, a third reported using a condom the first time they ever had sex and one quarter had used a condom at least sex with any partner they did not live within in the last 12 months.
- condom use was irregular in those who had sex off-island with someone other than their partner
- Roughly a third of young people surveyed did not drink; another third drank weekly; and another third drank two or there times a week – 80% of those who consumed alcohol reported they consumed more than 5 standards drink in a session.
- There are claims that there is an increase in 'underage' drinking (PDARN network representation); a 1999 source indicated that 91% of males and 85% of females respondents (secondary school students) started drinking before the age of 16; with females drinking more than males. The 2006 SGS showed that over two thirds of the youth surveyed were drinking, with 80% of the third who drank weekly drinking more than 5 standards drinks. The Drug and Alcohol situation assessment[2] refers to the 2002 survey of children and youth which found that alcohol was one of the most important issues they face. It also notes that alcohol use is associated with prevalence of motor vehicle accidents, particularly involving young men in Raratonga on motor cycles.

However, young people's literacy rates are high, at 99%

There are some claims which have not been substantiated by data:

- Youth suicide rates are claimed to be high

There is sufficient evidence to justify the need for programs specifically addressing the prevention of teenage pregnancy and STIs & HIV, and to reduce alcohol and substance abuse.

4. The interventions: Services and Programs

- *levels of operation – regional, national and/or sub-national?*
- *delivery agency - government and/or civil society organisations*

[1] P56 Drug and Alcohol Sit Assessment

[2] P56/244, Small Island Voices Survey of children 5-14, youth 15-21 and adults 21+foussing on the environment, tourism dn development

- *access and coverage - scope of their usage by the target audience, and the extent of those in the target audience not accessing the services*
- *resources - including staff, infrastructure, and other resources*
- *coordination mechanisms or advocacy groups which focus on issues relevant to most at risk young people.*
- *strategies, approaches and tools used to 'map' most at risk young people;*
- *evidence of effectiveness: how successfully do the interventions respond to risk and vulnerability? What gaps are there in interventions, or knowledge, to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?*

Table 4.1 List of Agencies in each country providing services for this group

Table 4.2 Quant Data on the kinds of services and programs for youth – and Most at Risk as a subset – and how many MARYP are accessing which services (TBC)

Analysis:
A number of interventions operate to respond to young people's sexual and reproductive health, with information, education and services on sexual and reproductive health: including knowledge and skills in relation to prevention of STIS and HIV (condom and other information on HIV transmission); and to assist young people to reduce risk and vulnerability factors through education and awareness on alcohol and drug use- these operate primarily through the schools (secondary) or through the YPE operated by Red Cross.

It is not clear where the youth friendly health service will operate; but it is not likely it can meet the needs of the broad youth population of the outer islands as well as urban settings.

All the interventions focus on youth; reports do not indicate that programs specifically focus on those 'at risk' groups

There do not seem to be specific services focusing on Alcohol use – these are integrated into the peer education and behavior change communications noted as part of the broader peer education and school curriculum.

There are other service providers in community mental health and alcohol education and awareness. It is not clear whether these services focus on youth, or MARYP.

Analysis:
There is limited evaluation information available on the effectiveness of programs. A recent external evaluation of the YPE program suggested that it has some elements that constitute best practice and should be shared with others in the region, although its focus on a broader age group can tends to blur the effectiveness of its peer education strategy. Overall, the evaluation recommended the program continue. YPE is expanding reach to outer islands, and across diverse populations of youth. There was no evaluative data available on the AHD program in the Cook Islands.

5. Barriers and Gaps:

5.1 Barriers

What barriers prevent most at risk of vulnerable young people from accessing health services/achieving good health outcomes in each country.

5.2 Gaps:

What gaps are there in interventions to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?

6. Future directions for Research or Programming

- All youth area considered at risk or vulnerable – how can we target better – some data (2002 and 2007) suggests that the differences across age range 13-14 15-16, 16-18, can be significant for sexual and reproductive health knowledge and access to services
- Although the YPE program identified some best practice issues – do we know how the program is contribution to changes in reducing risk or vulnerability PRHP qualitative survey is 2008 indicated signs of 'improvement' in some factors (tho not same measures exactly – would lit be a long bow) – would SGS or? help?

- The 2007 teen pregnancy surveys identify useful data – is the youth friendly service really happening? Can we do more with teen pregnancy? To do that, we need to know how effective YPE is in reducing risk and vulnerability – not just how well they operate and who they reach
- Can we do more around alcohol? especially with rates of motor cycle injury and young men?
- And possible suicide? Should we explore suicide claims?

Annex 2 FSM

1. Quality of the Data

Identify the quality of literature or other data documenting the population of youth 'at risk' in each country and the kind of information on risk and vulnerability available

Table 1: Quality of Data Table by Country

Country	No. of Documents	Kind of information available					
FSM		Donor commissioned Qualitative evaluations & assessments	National Quantitative surveys inc SGS, KAPBs. etc	Government surveys	Policy/Strategy Documents	NGOs Program reports	Technical Papers & reports
	18	1	5	1	2	2	9

2. Target/Audience Population Size

Identify and describe:

- perceptions of who constitutes 'most at risk young people' - amongst young people, service deliverers, funders, government and others;
- numbers of young people, male and female and other genders
- numbers of young people considered to be at risk as a proportion of each country's youth population

Table 2: Size of the population, and youth as a proportion

Country	*FSM*			
Total population	*110,899*			
Youth % of total population	*60% >24 yrs*			
	<25		*>25*	
	M	*F*	*M*	*F*

3. The evidence of risk and vulnerability:

Indices of risk and vulnerability:

Relevant known data in relation to risk factors and conditions conducive to vulnerability.

Biological measures of risk:

Table 3.1 SRH biological data on young people

Country	*STIs*				*Cumulative Number of HIV infections reported*				*Teen pregnancy % of births in teenagers (TFR)*		*Unsafe Abortion (illegal in all states except Yap)*		*Other SRH*	
FSM	*Chlamydia prevalence*													
	<25		*>25*		*<25*		*>25*							
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	19%	*35%*	*7.8%*	*12%*	*7*	*5*	*17*	*7*		*13-16% (2001-)*				
										48/1000				

Indicators of at-risk behaviours:

Table 3.2 SRH & other health behavioural risk data

Country	Mean age of 1st sex (years)		Reported condom Use in last 12 months (last time had sex)		Forced to have sex		Mean number of sexual partners in last 12 months		Other	
FSM	M	F	M	F	M	F	M	F	M	F
	14.5	16.5	52%	28%			3.3	1.5 Range 1-17		
Yap	>15	>15	30%							

Country	Received Money or Goods for Sex (females only)	Paid Money for good for sex (Males only)	Male have sex with another male in last 12 months
FSM	F	M	M
	1.2%	5.1%	

Country	Drug & Alcohol use – % teenagers who drink		Tobacco % of 10-29 yrs who smoke		Suicide attempts	
FSM	M	F	M	F	M	F
Pohnpei	28.6% binge drink	16.6% binge drink				
Yap	10% drink weekly	10 % drink weekly				
	31.8% drink 10 SDs when they drink					

Social & Economic indicators of vulnerability

Table 3.3 Socio-economic data on vulnerability

Country	Literacy				Unemployment				Convicted of offences		Violence against women & girls	
	<25		>25		<25		>25					
FSM	M	F	M	F	M	F	M	F	M	F	M	F

Analysis:

There is data from FSM which identifies the health outcomes and access to services for young people. The most common causes of mortality in FSM according to 2003 data (from Kosrae HIV situation analysis, 2007, J Gold) are:

- Disease of the circulatory systems
- Endocrine, nutritional and metabolic disease
- Neoplasm or cancer
- Infectious and parasitic disease

With evidence of

- 2 deaths attributed to pregnancy, childbirth and puerperium
- 13 deaths registered to intentional self harm (2005 figures indicate 39 suicides)

There is considerable data on the factors that promote or prevent good health outcomes, including effective programming: barriers to access to health/coverage of services / risks, protections & vulnerabilities but need more specific data which identifies the context, groups and location of most at risk young people. There is strong evidence of the extent of 'most at risk or vulnerable' groups in FSM, with information from the SGS surveys in Yap and Pohnpei and the UNFPA sponsored operational research in Pohnpei and Chuuk

- There is a higher rate than other countries in the Pacific of teenage pregnancies.
- Young males in Yap are engaging in risky sexual behaviors (multiple sexual partners, first sex before age 15 years, infrequent condom use) – and in Pohnpei, this is particularly so for young teenagers.
- In both Yap and Pohnpei, Females are at risk because of male behaviors, and low condom use; Pohnpei is considered to have the highest rate of teenage pregnancy in the Pacific. Although social stigma arising from this is limited, there is acknowledgement that early pregnancy can interrupt education and other life plans.
- Knowledge on HIV prevention and misconceptions varies (only 15% of males and 8% of females correctly answered all five questions)
- High levels of alcohol consumption is of concern for a significant proportion of both males and females – both in terms of influence on inhibitions and likelihood of risky sexual behaviours; and possible relationship (no known evidence generated in relation to health status in FSM yet, although possible relationship to high rates of NCDs) of negative physical, social and mental health and well-being – with mention of related suicide events.

So youth are in a situation of high risk of STIs, and unwanted pregnancies. Therefore, we need to know more about:

- the circumstances for female youth and build skills in negotiation of condom use
- understand more about how drug and alcohol consumption is related to high risk sexual activity
- evaluate existing prevention messages and means to assess effectiveness in targeting Or find new ways of communicating the message
- stigma needs to be targeted better

MSR's recent KAP survey is of interest too. It suggests that the MIRC HIV prevention and education programs are having quite mixed results in terms of overall accurate knowledge of transmission and prevention of HIV and STIs.

4. The interventions: Services and Programs

- *levels of operation – regional, national and/or sub-national?*
- *delivery agency - government and/or civil society organisations*
- *access and coverage - scope of their usage by the target audience, and the extent of those in the target audience not accessing the services*
- *resources - including staff, infrastructure, and other resources*
- *coordination mechanisms or advocacy groups which focus on issues relevant to most at risk young people.*
- *strategies, approaches and tools used to 'map' most at risk young people;*
- *evidence of effectiveness: how successfully do the interventions respond to risk and vulnerability? What gaps are there in interventions, or knowledge, to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?*

Table 4.1 List of Agencies in each country providing services for this group

Table 4.2 Quant Data on the kinds of services and programs for youth – and Most at Risk as a subset – and how many MARYP are accessing which services (TBC)

There is data reporting on a number of interventions, although the extent of data varies across the four states:

Pohnpei seems comparatively well placed in terms of services, policy and infrastructure, with an integrated AHD program in addition to various HIV-focused activities. All interventions seem to offer services to all young people, with no records of specific definitions of 'at risk' young people. Whilst Chuuk has some services in operation – including those HIV services offered by the Dept of Health, and the Chuuk Youth Resource Centre – it does not offer the same level of integrated AHD services that Pohnpei does.

Even so, both states need to substantially improve the level of AHD services they offer. Kosrae offers some education activities in relation to HIV and STIs.There is only limited information available on HIV and STI services in Yap.

There was limited evidence of sex work and male to male sex in relation to young people. Kosrae provided some disputed evidence of transactional sex, although young women were considered to feature, even if it was limited; and one reference in Chuuk indicated that 'all their HIV vulnerable groups' ie MSM, sex workers and travellers, were youth under 30 years of age.

There is evidence of the effectiveness (and efficiency) of these interventions in:

- Reaching most at risk or vulnerable people
- Responding to most at risk or vulnerable people
- Reducing the risk, harm or vulnerability of these young people
- Improving the health outcomes and access to services for young people, particularly most at risk or vulnerable groups

AHD services

There are two excellent operational research studies conducted by AHD with support from UNFPA which have assessed the effectiveness of the AHD programs in Pohnpei and Chuuk in

- The quality of the delivery of integrated ASRH services to young people
- Young people's access to ASRH services

Overall the Pohnpei AHD services, particularly the Youth-Friendly school clinic, operate to improve access for young people to family planning and other sexual and reproductive health services. The school clinic is cited as a potential model for encouraging the expansion of such clinics throughout the country. Whilst there have been improvements with the community health clinics in the way they are more youth-oriented, there remains need for improvement.

However, whilst the AHD program may be delivering a quality service that demonstrates evidence of moving towards integration with broader primary health care, it is worth noting that teenage pregnancies have not decreased since 2001 and the concern is that they are increasing. The AHD program began in 2005. The 2006 SGS surveys also note significant cause for concern is relation to the extent of risky behaviours. Of concern also is the Utilisation study's findings that many young people (females) default and do not return for follow up appointments in relation to family planning advice.

Supports the WHO framework for Youth Friendly Services:

The expansion of the model requires

- Policy development to support the approach
- Legislative changes to promote youth access to contraception (without the need for parental consent)
- Resources
- Refresher skills training for staff
- Education and awareness/advocacy with the broader community, including teachers and parents

HIV Prevention Services

There is a third evaluation of the Chuuk resources centre's operations in prevention of HIV in young people, primarily through its peer education program.

- Presents evidence of the effectiveness of the youth peer education program which seems to be supported by the findings of the Utilisation Study (though need to check Lambert's peer education review)

- FSM had no information available in UNGASS country report to report on programs in HIV and STIs – and at risk groups were limited to sex workers (although few exist) MSM (although no data was available) and seafarers (although no one talked about them really) – youth were a key focus, with much information – but no evidence of targeted programs, no evidence of analysis of the data by program deliverers except MRC's 2008 report which was intended to find out what was working, although some doubts about some of the results/interpretation..

5. The Barriers and Gaps:

5.1 Barriers

What barriers prevent most at risk of vulnerable young people from accessing health services/achieving good health outcomes in each country.

5.2 Gaps:

What gaps are there in interventions to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?

6. Future directions for Research or Programming

- Need to expand the AHD youth friendly model in Pohnpei as per the recommendations – are there resources?
- No services seem to focus on suicides/mental health and only limited attention to alcohol – what are the consequence for health outcomes for adolescents? And what programs would best suit?
- Need to think more about out of school programs?
- Yap and Kosrae? limited programs, information and resources

- The UNPFA operational research provide for excellent examples of local staff, with support, finding out information on knowledge, behaviours and access to/use of services – can we promote more of this – do we know what has happened in those countries since? Has this research been integrated into programs?

Annex 3 Marshall Islands

1. Quality of the Data

Identify the quality of literature or other data documenting the population of youth 'at risk' in each country and the kind of information on risk and vulnerability available

Table 1: Quality of Data Table by Country

Country	No. of Documents	Kind of information available					
Marshalls		Donor commissioned Qualitative evaluations & assessments	National Quantitative surveys inc SGS, KAPBs. etc	Government surveys DHS etc	Policy/Strategy Documents	NGOs Program reports	Technical Papers & reports
	16						

2. Target/Audience Population Size

Identify and describe:

- perceptions of who constitutes 'most at risk young people' - amongst young people, service deliverers, funders, government and others;
- numbers of young people, male and female and other genders
- numbers of young people considered to be at risk as a proportion of each country's youth population

Table 2: Size of the population, and youth as a proportion

Country	*Marshall Islands*			
Total population				
	<25		*>25*	
	M	*F*	*M*	*F*

3. The evidence of risk and vulnerability:

Indices of risk and vulnerability:

Relevant known data in relation to risk factors and conditions conducive to vulnerability.

Biological measures of risk:

Table 3.1 SRH biological data on young people

Country	*STIs*				*Cumulative Number of HIV infections reported*				*Teen pregnancy % of births in teenagers (TFR)*		*Unsafe Abortion*		*Other SRH*	
Marshall Islands	*Chlamydia prevalence*													
	<25		*>25*		*<25*		*>25*							
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F (15-19 yrs)*	*M*	*F*	*M*	*F*
										138/1000				

Indicators of at-risk behaviours:

Table 3.2 SRH & other Health behavioural risk data

Country	*Mean age of 1st sex*	*Reported condom Use in last 12 months (ever)*	*Forced to have sex*	*Mean number of*	*Other*

									sexual partners in last 12 months			
Marshall Islands	M	F	M	F (15-19 yrs)	M	F	M	F	M	F	M	F
				16% ever used a modern form of contraction – altho 37% were sexually active or married				8% (at sexual initiation)				

Country	Received Money or Goods for Sex (females only)				Paid Money for good for sex (Males only)				Male have sex with another male in last 12 months		Other	
Marshall Islands		F		F	M		M		M		M	F

Drug & Alcohol use – % teenagers who drink		Tobacco % of 10-29 yrs who smoke		Suicide attempts	
M	F	M	F	M	F

Social & Economic indicators of vulnerability

Table 3.3 Socio-economic data on vulnerability

Country	Literacy				Unemployment				Convicted of Offences		Experience of violence against women & girls	
	<25		>25		<25		>25					
Marshall Islands	M	F	M	F	M	F	M	F	M	F	M	F
												28.3% (physical violence ever)
												19.5% (sexual violence ever)

4. The interventions: Services and Programs

- *levels of operation – regional, national and/or sub-national?*
- *delivery agency - government and/or civil society organisations*
- *access and coverage - scope of their usage by the target audience, and the extent of those in the target audience not accessing the services*
- *resources - including staff, infrastructure, and other resources*
- *coordination mechanisms or advocacy groups which focus on issues relevant to most at risk young people.*

- *strategies, approaches and tools used to 'map' most at risk young people;*
- *evidence of effectiveness: how successfully do the interventions respond to risk and vulnerability? What gaps are there in interventions, or knowledge, to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?*

Table 4.1 List of Agencies in each country providing services for this group

Table 4.2 Quant Data on the kinds of services and programs for youth – and Most at Risk as a subset – and how many MARYP are accessing which services (TBC)

5. The Barriers and Gaps:

5.1 Barriers

What barriers prevent most at risk of vulnerable young people from accessing health services/achieving good health outcomes in each country.

5.2 Gaps:

What gaps are there in interventions to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?

6. Future directions for Research or Programming

Annex 4 Tonga

1. Quality of the Data

Identify the quality of literature or other data documenting the population of youth 'at risk' in each country and the kind of information on risk and vulnerability available

Table 1: Quality of Data Table by Country

Country	No. of Documents	Kind of information available					
Tonga		Donor commissioned Qualitative evaluations & assessments	National Quantitative surveys inc SGS, KAPBs. etc	Government surveys DHS etc	Policy/Strategy Documents	NGOs Program reports	Technical Papers & reports
	12						

2. Target/Audience Population Size

Identify and describe:

- perceptions of who constitutes 'most at risk young people' - amongst young people, service deliverers, funders, government and others;
- numbers of young people, male and female and other genders
- numbers of young people considered to be at risk as a proportion of each country's youth population

Table 2: Size of the population, and youth as a proportion

Country	*Tonga*			
Total population				
	<25		*>25*	
	M	*F*	*M*	*F*

3. The evidence of risk and vulnerability:

Indices of risk and vulnerability:

Relevant known data in relation to risk factors and conditions conducive to vulnerability.

Biological measures of risk:

Table 3.1 SRH biological data on young people

Country	*STIs*				*Cumulative Number of HIV infections reported*				*Teen pregnancy % of births in teenagers (TFR)*		*Abortion*		*Other*	
Tonga	*Chlamydia prevalence*													
	<25		*>25*		*<25*		*>25*							
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	na	*21.2%* *(27.5% WHO - 2006 SGS)*		*9.2%*										
										24/1000				

Indicators of at-risk behaviours:

Table 3.2 SRH & other health behavioural risk data

Country	*Mean age of 1st sex (years)*		*Reported condom Use in last 12 months*		*Forced to have sex*		*Mean number of sexual partners in last 12 months*		*Other*	
Tonga	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	17.2	*17.8*	*11.5%*			*3.1%*	*2.8*	*2.4*		

Country	*Received Money or Goods for Sex (females only)*	*Paid Money for good for sex (Males only)*	*Male have sex with another male in last 12 months*
Tonga	*F*	*M*	*M*
	0.7%	*0.3%*	*15%*

Drug & Alcohol use – % teenagers who drink		*Tobacco % of 10-29 yrs who smoke*		*Suicide attempts*	
M	*F*	*M*	*F*	*M*	*F*

Social & Economic indicators of vulnerability

Table 3.3 Socio-economic data on vulnerability

Country	*Literacy*				*Unemployment*				*Convicted of Offence*		*Other*	
	<25		*>25*		*<25*		*>25*					
Tonga	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*

4. The interventions: Services and Programs

- *levels of operation – regional, national and/or sub-national?*
- *delivery agency - government and/or civil society organisations*
- *access and coverage - scope of their usage by the target audience, and the extent of those in the target audience not accessing the services*
- *resources - including staff, infrastructure, and other resources*
- *coordination mechanisms or advocacy groups which focus on issues relevant to most at risk young people.*
- *strategies, approaches and tools used to 'map' most at risk young people;*
- *evidence of effectiveness: how successfully do the interventions respond to risk and vulnerability? What gaps are there in interventions, or knowledge, to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?*

Table 4.1 List of Agencies in each country providing services for this group

Table 4.2 Quant Data on the kinds of services and programs for youth – and Most at Risk as a subset – and how many MARYP are accessing which services (TBC)

5. Barriers and Gaps:

5.1 Barriers

What barriers prevent most at risk of vulnerable young people from accessing health services/achieving good health outcomes in each country.

5.2 Gaps:

What gaps are there in interventions to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?

6. Future directions for Research or Programming

Annex 5 Tuvalu

1. Quality of the Data

Identify the quality of literature or other data documenting the population of youth 'at risk' in each country and the kind of information on risk and vulnerability available

Table 1: Quality of Data Table by Country

Country	No. of Documents	Kind of information available					
Tuvalu		Donor commissioned Qualitative evaluations & assessments	National Quantitative surveys inc SGS, KAPBs. etc	Government surveys DHS etc	Policy/Strategy Documents	NGOs Program reports	Technical Papers & reports
	13						

2. Target/Audience Population Size

Identify and describe:

- perceptions of who constitutes 'most at risk young people' - amongst young people, service deliverers, funders, government and others;
- numbers of young people, male and female and other genders
- numbers of young people considered to be at risk as a proportion of each country's youth population

Table 2: Size of the population, and youth as a proportion

Country	*Tuvalu*			
Total population				
	<25		*>25*	
	M	*F*	*M*	*F*

3. The evidence of risk and vulnerability:

Indices of risk and vulnerability:

Relevant known data in relation to risk factors and conditions conducive to vulnerability – specifically in relation to

Biological measures of risk:

Table 3.1 SRH biological data on young people

Country	*STIs*				*Cumulative Number of HIV infections reported*				*Teen pregnancy % of births in teenagers (TFR)*		*Abortion*		*Other SRH*	
Tuvalu	*Chlamydia prevalence*													
	<25		*>25*		*<25*		*>25*							
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	na	*18.8%*	*na*	*16.0%*										
										42/1000				

Indicators of at-risk behaviours:

Table 3.2 SRH & other health behavioural risk data

Country	*Mean age of 1st sex (Years)*		*Reported condom Use in last 12 months*		*Forced to have sex*		*Mean number of sexual partners in last 12 months*		*Other*	
Tuvalu	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*

	18	*18*	*11.6%*				*1 (Range 0-10)*		
	Females <25	*Females >25*				*Females <25*	*Females >25*		
	21.9%(median age under 18yrs)	*78.1% (median age under 18yrs)*				*98.4% had 1 partners*	*1.6% had 2 or more partners*		
	Youth								

Country	*Received Money or Goods for Sex (females only)*	*Paid Money for good for sex (Males only)*	*Male have sex with another male in last 12 months*
Tuvalu	*F*	*M*	*M*
	100% - No	*1.0%*	*8.0%*

Drug & Alcohol use – % teenagers who drink		*Tobacco % of 10-29 yrs who smoke*		*Suicide attempts*	
41.6% drink with 57% drinking once a week average of 4 cans and 63% consuming more than 5 cans per session		*38%*			
M	*F*	*M*	*F*	*M*	*F*
81.9%	*17.3%*				

Social & Economic indicators of vulnerability

Table 3.3 Socio-economic data on vulnerability

Country	*Literacy*				*Unemployment*				*Convicted of Offences*		*Violence against women & girls*	
	<25		*>25*		*<25*		*>25*					
Tuvalu	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
												37.2% (physical violence ever)
												21.2% (sexual violence ever)

4. **The interventions: Services and Programs**

- *levels of operation – regional, national and/or sub-national?*
- *delivery agency - government and/or civil society organisations*

- *access and coverage - scope of their usage by the target audience, and the extent of those in the target audience not accessing the services*
- *resources - including staff, infrastructure, and other resources*
- *coordination mechanisms or advocacy groups which focus on issues relevant to most at risk young people.*
- *strategies, approaches and tools used to 'map' most at risk young people;*
- *evidence of effectiveness: how successfully do the interventions respond to risk and vulnerability? What gaps are there in interventions, or knowledge, to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?*

Table 4.1 List of Agencies in each country providing services for this group

Table 4.2 Quant Data on the kinds of services and programs for youth – and Most at Risk as a subset – and how many MARYP are accessing which services (TBC)

5. Barriers and Gaps:

5.1 Barriers

What barriers prevent most at risk of vulnerable young people from accessing health services/achieving good health outcomes in each country.

5.2 Gaps:

What gaps are there in interventions to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?

- Need to expand the AHD youth friendly model in Pohnpei as per the recommendations – are there resources?
- No services seem to focus on suicides/mental health and only limited attention to alcohol – what are the consequence for health outcomes for adolescents? And what programs would best suit?
- Need to think more about out of school programs?
- Yap and Kosrae? limited programs, information and resources
- The UNPFA operational research provide for excellent examples of local staff, with support, finding out information on knowledge, behaviours and access to/use of services – can we promote more of this – do we know what has happened in those countries since? Has this research been integrated into programs?

6. Future directions for Research or Programming

Annex 6 Samoa

1. Quality of the Data

Identify the quality of literature or other data documenting the population of youth 'at risk' in each country and the kind of information on risk and vulnerability available

Table 1: Quality of Data Table by Country

Country	No. of Documents	Kind of information available					
Samoa		Donor commissioned Qualitative evaluations & assessments	National Quantitative surveys inc SGS, KAPBs. etc	Government surveys DHS etc	Policy/Strategy Documents	NGOs Program reports	Technical Papers & reports
	11	7	2	1	1		

Samoa is of interest in the kind of comparative data that is available in the series of studies commissioned by UNFPA, UNCIEF and SPC over the last decade: apart from a surprisingly large amount of information from a range of Ministries, there are four specific desk reviews or studies that provide useful comparative data for analysis. These include the following:

UNFPA has commissioned three substantial studies of reproductive health knowledge, practices and services in Samoa since 1998:

- Seniloli's reproductive health, knowledge and services in Samoa, focusing on a multi-staged sample of the Samoan population, and including specific data on 15-19 and 20-24 and 25-29 age groups (and up to 54 in most instances). Although published 2002, with data collected over December 1998 from across the four provinces;
- Seniloli's sexual knowledge and attitudes of Adolescents in Samoa, focusing a multistage sample of the Samoa adolescent population between the ages of 13-19; again although published in 2002, the data was collected in 1998, at the same time as the previous study;
- In addition, in 2006 UNFPA commissioned a desk study of literature and projects between 1995-2005, (Adolescent sexual and reproductive health Situational Analysis for Samoa, 2006, UNFPA by Andrea Irvin (who also did the recent 2007 AHD review); and lastly,
- The 2005-2006 SGS study undertaken by SPC on HIV and STIs in six pacific countries. The focus in Samoa was on ante-natal women attending STI clinics and BSS of youth.

2. Target/Audience Population Size

Identify and describe:

- perceptions of who constitutes 'most at risk young people' - amongst young people, service deliverers, funders, government and others;
- numbers of young people, male and female and other genders
- numbers of young people considered to be at risk as a proportion of each country's youth population

Table 2: Size of the population, and youth as a proportion

Country	*Samoa*			
Total population				
	<29		*>30*	
% of Total Pop	*50%*			
	M	*F*	*M*	*F*

The National Youth Policy of the Government of Samoa defines young people as those between 12-29 years of age – with young people accounting for 50% of the overall population.

3. The evidence of risk and vulnerability:
The National Youth Policy refers to the term vulnerable rather than young people at risk. It defines vulnerable as youth with the following characteristics:

- Do not complete basic education or meet standards for entry into secondary or tertiary level studies
- No access to non-formal & community education services thru traditional settings or church based services
- Influenced by crime alcohol and drug abuse
- No knowledge of the impact of HIV & AIDS and STIs
- No access to health services and information
- Limited access to job opportunities
- Have special needs
- Limited access to economic diversification (even if self employed thru traditional means)
- Do not receive financial support form the family

Indices of risk and vulnerability:
Relevant known data in relation to risk factors and conditions conducive to vulnerability – specifically in relation to

Biological measures of risk:

Table 3.1 SRH biological data on young people

Country	*STIs*				*Cumulative Number of HIV infections reported*				*Teen pregnancy % of births in teenagers (TFR)*		*Abortion (is illegal)*		*Other SRH*	
Samoa	*Chlamydia prevalence (data from pregnant women – SGS Survey)*													
	<25		*>25*		*<25*		*>25*							
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	na	*40.7%*		*17.5%*	*1*	*1*	*10*	*4*		*11% (2003-04)*		*Nd - although anecdotal evidence*		
										54/1000				

Indicators of at-risk behaviours:

Table 3.2 SRH & other health behavioural risk data

Country	*Mean age of 1st sex*		*Reported condom Use in last 12 months*		*Forced to have sex*		*Mean number of sexual partners in last 12 months*	
Samoa	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
	17	*17*	*14%*					

Country	*Received Money or Goods for Sex (females only)*	*Paid Money for good for sex (Males only)*	*Male have sex with another male in last 12 months*
Samoa	*F*	*M*	*M*
	8.7%	*8.2%*	*14.7%*

Drug & Alcohol use – % teenagers who	*Tobacco % of 10-29 yrs*	*Suicide attempts*

drink		who smoke			
M	F	M	F	M	F
50%	33%	43%			

Social & Economic indicators of vulnerability

Table 3.3 Socio-economic data on vulnerability

Country	Literacy				Unemployment				Convicted of Offences		Violence against women & girls	
	<25		>25		<25		>25					
Samoa	M	F	M	F	M	F	M	F	M	F	M	F
					58% (of total unemployed =5%)		62%	38%				37.6% (physical violence ever)
												19.6% (sexual violence ever)

Analysis:

The leading cause of disease or ill health among the young is injuries, poisoning associated with risk-taking behavior like cigarette smoking and alcohol consumption; followed by diseases of the circulatory system, infectious diseases and cancer. The main cause of morbidity amongst youth is related to reproductive health, risk taking behaviors and infectious diseases. The majority of suicide attempts between 2002-2006 were made by young people, with males between 20-29 most vulnerable, particularly in rural areas; and 50% of injuries occur in children up the age of 19 years, with most around the home and more likely to involve males than females; and young people between 20-29 were more likely to die from motor vehicle accidents.

The available data suggests that youth are engaged in at risk behaviours relating to their sexual and reproductive health, and/or are vulnerable to the adoption of at risk behaviours arising from environmental and other challenges.

The 2006 SGS survey shows that Samoa whilst a low prevalence environment, demonstrates biomedical and behavioural indicators of risk of HIV and other sexual and reproductive health issues. Youth demonstrated a low level of condom use and low level of knowledge of HIV & AIDS, especially among females. Few youth had undergone an HIV test and knew the results. The survey found an association between correct knowledge of HIV transmission and gender – females were less likely to have both correct knowledge of HIV transmission routes and prevention methods. There was also a relationship between gender and sexual behaviors: females were less likely to have had sex in the last twelve months and less likely to have had sex with a casual partner.

The literature shows that a reduction in environmental (protective factors, such as family support, parental guidance etc...) can leave a young person vulnerable to the adoption of high risk behaviors. The Tavalou project identifies vulnerable youth in relation to regions/geography, with the analysis indicating, for different reasons, that various categories of youth are identified as vulnerable:

- In the Rest of Upolu youth are particularly vulnerable to likelihood of teenage pregnancies, unemployment, criminal offences resulting in incarceration and suicide
- youth from the North-West Upolo (highest % of youth amongst youth population 32%) and Savaii (highest migration rate of youth) are two most vulnerable regions of Samoa – Apia Urban Area has highest y% of youth as proportion of the population and is most vulnerable for male age group 15-24 years in relation to economic activities
- Apia is also most vulnerable in terms of education in relation to opportunities for school leavers
- Rest of Upolu and NWU have highest vulnerability to suicide
- Females looking to the private sector are vulnerable to unemployment; with males more likely to gain employment in private sector than public sector
- 16-29 female age group are vulnerable to school drop out – with a third dropping out at the end of year 8

- 16-29 males are most vulnerable to criminal activity – youth make up 90% of persons on probation and 59% of persons sentenced to prison
- 16-29 females and males are vulnerable to unemployment - especially males

4. The interventions: Services and Programs

- *levels of operation – regional, national and/or sub-national ?*
- *delivery agency - government and/or civil society organisations*
- *access and coverage - scope of their usage by the target audience, and the extent of those in the target audience not accessing the services*
- *resources - including staff, infrastructure, and other resources*
- *coordination mechanisms or advocacy groups which focus on issues relevant to most at risk young people.*
- *strategies, approaches and tools used to 'map' most at risk young people;*
- *evidence of effectiveness: how successfully do the interventions respond to risk and vulnerability? What gaps are there in interventions, or knowledge, to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?*

Table 4.1 List of Agencies in each country providing services for this group

Table 4.2 Quant Data on the kinds of services and programs for youth – and Most at Risk as a subset – and how many MARYP are accessing which services (TBC)

Analysis:

Main policies: **Samoan National Youth Policy 2001-2010** – prioritises youth aged 12-29 years through the Strategy for the Development of Samoa. There are also a number of plans showing government intentions in relation to ARH.

Youth policy identifies intention to: strengthen family and chiefly system; youth participation; youth and gender; youth counseling; suicide; health; education and training; youth income generation. The program for addressing key areas of policy is TLAVOU program (Towards a legacy of achievement versatility and opportunity through unity) with four components:

- Enabling youth to improve their self worth
- Skills formation and human development
- Income generation and livelihoods initiatives
- Program management and coordination

Health sector strategic Plan 1998-2003 (and next?)

- Institutional strengthening at the health sector level
- Primary health care and health promotion focusing on non-communicable disease, children women's health, and communicable disease surveillance
- Improving public health facilities including information and data systems

2000 Strategic plan for responding to Impact of HIV on Women in Samoa 2001-2005

- Care and support of people living with HIV
- Reducing vulnerability of specific groups and promoting safer sexual behaviors
- Prevention and control of STIs
- HIV and Human rights
- Coordination the multisectoral response to HIV

Young women are identified as a priority vulnerable group for promoting safer sexual behaviours

Education Policy and Strategic plan 2006-2014

- Ensuring that the learning needs of all young people are met through equitable access to appropriate learning ad life skills programs;
- Although girls used to be expected to leave school if they become pregnant, this is no longer required. However, thre is no evidence to suggest they do come back to school.

(Draft) National Policy for Women of Samoa 2001-2004

Tabled in parliament but not endorsed.

Overall, a supportive policy environment, for youth and ASRH issues including: support for life skills training programs, sexual health education in curriculum; addressing gender in-school curriculum; ensuring provision of relevant information on HIV and AIDS,; access to condoms. However, challenge in implementation: no funds or resources committed. Dependent on donor funds for any resources to support ASRH programs.

Existing programs:

Information, education and communication intervention:

- Only limited use of mass media intervention = although all youth cited this as primary sources of information on reproductive health
- Some IEC brochures and pamphlets developed(produced in FIJI)
- ARH Training manual and flipchart (produced in FIJI)
- No evaluations of any materials
- Materials for program implementers seem limited.
- Need materials to support curriculum.

In-school education intervention

- Some groups, including ASRH project, go to schools at their invitation to conducted awareness raining activities (as they do in communities)
- A new health and physical education curriculum is being developed for secondary schools (yrs 9-12)
- Teacher training for in-services and pre-service has been undertaken, although its not clear if any follow up in schools has happened – it would be useful to know the effectiveness of this training in preparing teachers for , and its impact on secondary school students, knowledge, attitudes and behaviours.

Community based awareness programs

- Many programs, through ASRH Project, the Samoa Family health Association, the Red Cross, The Faataua-Le-Ola or lifeline, Matuaileoo Environment trust METI.
- Samoa AIDS Foundation peer education (planned, at time of review but eventuated through PRHP support)
- Focus of programs:
    - relationships and communication between parents and adolescents, teen pregnancy, drinking and substance abuse, family violence, immoral and hypocritical behaviors;
    - teen pregnancy, communication and relationships between mothers and daughters;
    - ASRH, men's roles and responsibilities in teen pregnancy
    - Life skills
    - Men's roles, HIV & AIDs, family planning , overpopulations teen pregnancy; sexuality, anatomy, physiology, values,
    - HIV & AIDS (while recruiting for blood donors) stigma and discrimination, immune systems, modes of transmission, risk behaviors, prevention and the window period.
    - Suicide prevention
    - Life skills – focusing on problem solving skills to address family, community, career and leisure (creative problem solving, communication, goal setting, self esteem, conflict resolution, managing change and handling stress)

- Target audiences:
    - church, community groups, parents, elders , church leaders.
    - After school youth,
    - Community and church based youth
    - Out of school men
    - Youth in schools
    - Village youth groups
    - Trainees in ministry of justice, police, education, women community and social development, youth, curriculum development unit, education , polytechnics, theological colleges and churches and FLO
    - Youth offenders
    -

- Means
    - Drama groups
    - Community seminars
    - After school group sessions
    - Workshops
    - Presentations
    - Discussion groups
    - Inspirational speeches
    - Action songs
    - Puppetry drama and skits
    - Dialogue based critical consciousness (Friere's pedagogy of the oppressed)
    - Capacity building (life skills training of trainers)

Gender /Girls Programs
The review did not find any programs specifically for girls on challenging gender stereotyping or empowerment. Some programs appear to reinforce stereotypes instead. Current strategies may not be addressing special needs of adolescent girls.

Livelihood skills
ASRH, with Division of Youth, SFHA and Red Cross s have integrated SARH topics into livelihood skills training for girls.

Programmes for special sub-populations:

High-risk youth:
- FLO and Lifeline Samoa –provide crisis intervention and suidice prevention
    - Face to face Counseling
    - 24 hour hotline
    - 60 counselors trained majority in villages and some teachers

- METI/Dept of Youth about to start a pilot adult education program targeting premature school leavers (drop outs) to re-enter education with view to engaging in future tertiary studies – not sure whether targets adolescents per se

Health Care Services Interventions:
Youth friendly clinics
- No community based clinics only for youth
- No programs with youth specific hours established
- SFHA and government services are aiming to establish youth friendly services
- Youth division/MWCSD and ASRH project are discussion options for youth drop in centre /clinic

Youth Friendly training for services Providers
- ASRH Project training of services providers (nurses fro national and community health centers so far) on integrating of youth friendly services into government services
- Follow up unclear – not sure if program implemented of systems established to monitor extent of 'youth friendly ' services
- SFHA developed curriculum in advanced reproductive and sexual health for undergraduate program at nursing schools and training lecturers to deliver the curriculum which includes research topics on RH

Access to contraception
- Condoms are free from the SFHA, ASRH Project, STI clinic – all in Apia
- SAF provides dispensary boxes and condoms to nightclubs

Pregnancy services for Youth
- No special programs targeting pregnant adolescents at time of review
- Pregnant teens go to the Family Welfare clinic in Apia for antenatal (<20yrs = 9% of antenates)

- Although RH services in Samoa are trying to be youth friendly, none had implemented strategies eg hours of operations to target youth, nor had any introduced ways of targeting boys better
- There was no data available to assess the impact of efforts to be youth friendly, such as rates of usage by adolescents, etc
- Need to formally assess the extent to which youth are using existing services, particularly for family planning, and their impressions of those services, so can develop strategies to better meet needs of adolescents.
- Little in known about current attitudes of providers to adolescents, esp. those who are sexually active, or about the quality of care they provide. This would be useful for training and future strategy development

Advocacy & Policy work

The review did not uncover projects specifically working to advocate for improved policies laws, or governmental strategies related to youth or ASRH. This is not seen as priority given positive policy environment overall, and pressing needs in other areas

5. The Barriers and Gaps:

5.1 Barriers

What barriers prevent most at risk of vulnerable young people from accessing health services/achieving good health outcomes in each country.

5.2 Gaps:

What gaps are there in interventions to ensure that those most at risk and vulnerable access appropriate and effective health services/achieve good health outcomes?

Key gaps in the information available include:

Appropriate disaggregation of data by sex and age
There is not a good understanding of the underlying causes of the issues
Insufficient information on
- Street children
- Sex work and transactional sex among youth
- Male to male sex

Research and Data collection.

- Little research done in Samoa on ASRH or RH between 2000-2005, esp. baseline or evaluation research
- Much is not known about ASRH
- Information on these issues would help program developers, implementers to have better understanding of the issues that area needed for effective programming
- It would also be useful for advocacy programs with decision makers, opinion leaders, and policy makers

Programming:

Since the 2006 UNFPA sit analysis, it would seem (from our information collected) that the only programs since supported have been those in HIV through PRHP or Response Fund.

6. Future directions for Research or Programming

Priority: evaluate existing programs to ascertain how to build on gaps identified in 2006 sit analysis by UNFPA.

Annexes H to K

Annex H: Summary of Interviews with Individual Country-based Organisations

Cook Islands AHD Program

The Cook Islands AHD Program is based in the Ministry of Health and primarily focuses on young people aged 15-19 years. Since June 2--9, the program has operated a Youth Drop-in Clinic in Rarotonga that provides youth friendly services, family planning, contraceptives, IEC materials, counselling and referrals.

The program does not specifically target at risk groups but does receive clients that include teenage mothers and school dropouts. The program also provides in-school education as requested but also approaches schools where there have been cases of teenage pregnancies.

The AHD Program also works in collaboration with the Cook Islands Red Cross and the Cook Islands Family Welfare Association providing technical assistance for training workshops in the community. The interviewee pointed out government-run programs such as a sports program for young male school dropouts as well as a vocational skills training program for young people.

However, these programs are mostly centred on the main island of Rarotonga due to the cost and logistics of travel and youth on the distant outer islands often do not have any access to these programs and services making them less informed and accordingly at higher risk.

The program is mostly monitored and evaluated using clinical records which are reported to the Ministry of Health and SPC on a quarterly basis. The interviewee pointed out that given the Youth Clinic is still in its early stages, its services have not been widely publicised which has meant very low numbers of youth clients in its first six months of operation.

Currently, the program has no peer education activities and thus no link to the youth population. However there are plans to recruit and train eight peer educators in 2010 to be based at the Youth Clinic in order to conduct community outreach and make referrals.

Cook Islands Red Cross (CIRC)

The Cook Islands Red Cross Youth Peer Education (YPE) Program targets young people aged 15-30 years and seeks to help educate young people and increase their awareness of HIV/AIDS and STIs through active participation of youth.

Focussing on educational activities, youth advocacy and condom distribution, the program targets marginalised young people, those attending school, school leavers, young mobile sports people, transgender groups and MSM. The organisation works closely with the Te Tiare Association, founded in 2008, to reach out to transgender groups and MSM.

CIRC peer educators specifically target nightclubs for condom distribution and regularly stock freely accessible condom dispensers. They also conduct activities for schools, church groups, sports groups as well as workplaces.

The interviewee highlighted the emerging issue of alcohol abuse facing young people in the Cook Islands. As such, CIRC works with the Cook Islands Police Department's newly established 'Blue Light' programme targeted at young people who abuse alcohol in an effort to reduce the high number of alcohol related road accidents. The interviewee stressed that the lack of road safety programs for young people is a big gap in addressing this issue.

Monitoring and evaluation of peer education activities is principally through written pre and post test evaluations of knowledge. Peer educators maintain diaries of all consultations, which are submitted to the Coordinators on a monthly basis, who compile quarterly reports for the Red Cross and other donor agencies but not go to the government. A monthly newsletter is circulated throughout a wide network, highlighting particular successful activities and profiling YPE.

Success is measured with respect to completion of tasks indicated in the Work Plan. Indicators measured are the numbers of people reached and the changes in pre and post test knowledge. The Coordinator reports that the project is doing well. Measurement of this success is determined by the public attention attracted through the media and the credibility it has established in the community.

In order to identify MARYP groups, CIRC relies on peer educator observations but also makes reference to the 2005-2006 STI SGS Report for Youth. The Program officers (all young people) decide the type of programs delivered based on the availability of volunteers. The YPE advises on the format and content, the alumni educators provide guidance but the Program Officers have the final say. Young people are involved in project design through the YPE.

The YPE Program collaborates with other NGOs such as the Pacific Islands AIDS Foundation (PIAF), with whom they coordinate their 'Faces and Voices' program whereby young people are referred to CIRC for their counselling service. CIRC also conducts joint activities with the National Youth Council, a body which has only recently been re-established to act as a national coordinating mechanism for youth.

Referral systems are in place whereby there is direct referral and communication between the YPE and the hospital laboratory where persons are referred for testing. Clients are referred to the Red Cross counsellor for VCT. However there is no follow-up of these referrals due to confidentiality reasons and there is no measure of the success of the referral unless the person returns to the YPE.

A significant gap identified by the interviewee is the unavailability of ASRH services, especially clinical services) on the outer islands. In addition, there are currently three islands that do not have YPE peer educators.

Federated States of Micronesia AHD Program (Pohnpei)

The Adolescent Health & Development (AHD) program in Pohnpei started in 2004 to specifically address ASRH issues. The program runs three in-school clinics, a Multipurpose Youth centre and a peer education programme.

The program targets marginalised young people, young people attending school, women, sex workers, police personnel, victims of rape and sexual coercion, migrants and displaced persons, people living in rural communities, partners of seafarers, school drop outs and young prison inmates.

The program's peer education activities are mostly focussed on in-school delivery but also target high risk settings which include the wharf as well as hotels in the urban area of the island. The program also has plans to extend opening hours of clinics to target sex workers.

MARYP groups and high risk settings are mostly identified using anecdotal evidence but clinical data is also used a reference.

The project is also involved in fund generating activities within the Multipurpose Youth centre and in the community. In addition, education and clinical services are integrated as part of a monthly mobile clinic which also targets sex workers. The program has also provided monthly training to eight sex workers.

The interviewee stressed a lack of communication between peer education programs in FSM, and very little collaborative work with other Public Health programs. There is a strong need for a uniform and collaborative network with standardised guidelines. The newly established Youth Development Association of Pohnpei is being viewed to assume this role.

The interviewee estimated that the program has reached between 1000-2000 young people in the last year with 5-% considered in the MARYP category. However, there still remains a great need to expand mobile clinical outreach to rural areas on a more frequent basis as well as greater use of the media.

Federated States of Micronesia HIV Program (Chuuk)

The Youth Development & Health Resource Centre was established in 2007 in Chuuk. The primary target of the program is young people aged between 15 to 24 years, but a range of other vulnerable groups are covered. While the program does not have a specific definition for MARYP they target sex workers, MSM, victims of rape and sexual coercion, seafarers, those with traditional tattoos, out of school youth, police, and young woman. Peer educators conduct outreach to the youth populations whilst the centre integrates HIV/STI screening, counselling, as well as RH services as part of its operation.

Sex workers have been trained as peer educators and operate from the youth centre; however these workers are not commercial, not identified as a group and form a hidden network. Contact was established with this network through some key sex worker contacts that were recruited as peer educators. In this way, sex workers have received training in health self management and decision making skills. Similarly, contact was established with MSM through the use of key informants.

Questionnaires and MSC stories are the primary tools for monitoring and evaluation. Pre and post session surveys are used to test for knowledge. Peer educators are trained in M&E, and collect data on their activities. The youth centre combines its education services with clinical and family planning delivery, houses a wide range of IEC materials and operates a room for clinical screening and sexual assault.

In order to identify MARYP groups, the program relies on the 2006 Chuuk HIV SGS Report as well as its own clinical data. The interviewee estimated that the program with its range of services and activities has reached around X--- young people in the last year with 35% considered in the MARYP category.

Young people are involved in the planning and implementation of the program, especially resourcing the Youth Centres. The program also collaborates with other youth-oriented programs of other organisations such as the Chuuk Women's Council and the government-run Substance and Mental Health Program and also works with the education department and church groups.

A significant gap in the targeting of MARYP groups has been the youth populations on the outer islands who until now, have not been accessed due to a lack of resources. The scattered populations of FSM results in many communities only receiving annual education with insufficient time for follow up. Despite not having enough peer educator trainers, the program plans to train peer educators in the outer islands to serve at risk young people there.

Federated States of Micronesia Red Cross Society (Pohnpei & Kosrae)

The FSM Red Cross currently operates HIV peer education initiatives in the states of Pohnpei and Kosrae. These target young people aged 15 – 25. The main aims of this project, consistent with universal Red Cross objectives, are to 'prevent further HIV infection', 'reduce HIV stigma and discrimination' and 'capacity building'.

The Red Cross interviewee, whilst acknowledging who the MARYP groups are, stressed that their policy involved not specifically targeting these groups so as to avoid further stigmatising them in their communities. Thus, their program targets all young people aged from 11-25. This includes both those who are marginalised (e.g. those who have dropped out of school) and those who are in school. Other vulnerable populations access these initiatives incidentally. These include, women, transgenders, those in the hospitality industries, and those in remote areas.

However, the findings of a recent Red Cross KAP Study of 11-14 year olds highlighted significantly high risk behaviour which has led to the specific targeting of this age group as an evidence-based intervention. In addition, whilst the Red Cross maintains a generalist approach to the youth population, the interviewee acknowledged that the choice of communities targeted for outreach is often informed by informal risk assessment.

The project is continually monitored and evaluated using tools such as KAP Surveys, MSC stories, individual peer-to-peer evaluation forms and feedback is used to update the initiatives undertaken in this project.

Members of the target population are not involved in the design and delivery of the project but the RC peer educators are involved in every stage of project management.

FSM Red Cross collaborates with the AHD Program and a new NGO called Youth for Change, who educates children with their parents, by providing capacity building assistance to members of their staff.

The interviewee estimated that the program has reached around X8-- young people in Pohnpei and Kosrae in the last year with 2--3-% considered in the MARYP category.

Marshall Islands AHD Program (Youth to Youth in Health) – AHD Program

Youth to Youth in Health (YTYIH) was founded in 1986 to address SRH issues and employs 32 staff and 50 volunteers. YTYIH is a youth centre that provides recreational, library, computer lab, media, and tutorial services, art studio, as well as clinical services. The clinic is open Monday to Saturday from morning until 9:00 pm. It is the only clinic that provides evening and weekend RH services for the most vulnerable population groups, free of charge. YTYIH has wide range of programs including:

- Youth Smart Program: providing basic education to young kids not going to school
- SAPT – Substance Abuse Prevention Training
- After Dark Program – outreach for MARYP
- Cancer Program – supporting youth with cancer
- Small Arts Program
- Media Program
- AHD Program
- Act Natural – using drama for outreach
- Condom Social Marketing

Despite not having a specific definition for MARYP, YTYIH programs target marginalised young people, young people in school, women, sex workers, transgenders, victims of rape and sexual coercion, people living in outer island communities, seafarers, and partners of seafarers. Additional groups were identified as young people affected by substance abuse, taxi drivers and students going abroad for education.

The project targets young people from 0 to 25 years and seeks to empower young people with information, knowledge, and skills so they can make better life choices for a better quality of life.

Success is measured by collating indicators such as number of users of services, MSC stories collected from focus group discussions and pre and post test results.

The interviewee estimated that the program has reached around X--- young people in Majuro and Ebeye in the last year with approximately 8% considered in the MARYP category.

While YTYIH stakeholder meetings effectively act as a national coordinating group on youth, the organisation is also a member of the Majuro Youth Council, which itself assumes this role for the capital island. The NGO Women United in the Marshall Islands (WUNIMI), a support group for teenage mothers, provides referrals to its clients for YTYIH clinical and counselling services as well as to access media facilities. YTYIH Peer Educators also collaborate with WAM, a NGO that teaches traditional canoe building skills to young former prison inmates; and, Women in Health which is a NGO that provides holistic health education in the community.

Gaps include vulnerable groups currently not being adequately targeted such as high school students, sex workers, transgenders, seafarers/sailors, juveniles or young prisoners under the age of 25 years. For high school students, the Peer Educators' time in schools is limited by the school schedule and in some private schools there are limitations on the information they will allow to be presented.

Another significant gap is the lack of outreach to the outer islands of the country due to limited funding and transportation options. As such young people in the outer islands have limited access to youth friendly ASRH services and information and may consequently fit into the MARYP category as their only option currently is to travel to Majuro.

Samoa AIDS Foundation

The Samoa AIDS Foundation was founded in 2005 to specifically address HIV and sexual health issues and employs ten staff members. The SAF program includes peer education, in-school education, theatrical productions for educational institutions, condom distribution and capacity building of peer educators. The program works with young people from 15-29 and targets marginalised young people, young people attending school, out of school young people, young sportspeople, the 'faafafine' transgender community, personnel working in the hospitality industry, MSM, rural youth and the general youth population.

The program targets areas and settings where MARYP groups are known to congregate, such as nightclubs and bars. SAF works at a national level and implements activities in urban and rural areas, including the outer islands.

The SAF program is informed by national and regional research literature on STIs and HIV as well as the National HIV Plan of Action and the Regional Strategy on HIV/AIDS to effectively identify and target MARYP groups.

Project activities are predominantly decided by the donors in consultation with the Peer Educators. SAF uses pre/post tests to evaluate programs. In other projects, donors direct the use of appropriate M&E tools to use such as Most Significant Change stories to review the success of programs.

Members of the target population are involved in the design, implementation and evaluation of the project through monitoring and evaluation questionnaires and interviews requesting feedback on best approaches.

SAF is a member of the national TALAVOU youth program's Steering Committee and also collaborates with the Samoa Family Health Association and the Samoa Red Cross for joint activities related to STIs and HIV.

The interviewee stressed that HIV stigma and discrimination are still considerable challenges in Samoa and gaps in funding make it difficult to reach out sustainably to certain MARYP groups such as young sex workers and make an impact.

Samoa Family Health Association (SFHA)

The Samoa Family Health Association delivers family planning, counselling and reproductive health services through its Youth Friendly Clinic and Study Centre in Apia and a mobile clinic which visits rural areas and the outer islands. It also acts as an advocate for family planning and education in human sexuality, targeting its efforts to the general population as well as special groups such as young people aged from 15-24. SFHA has an active peer education program with peer educators and youth volunteers receiving training and conducting community outreach to their peers.

SFHA does not have a specific organisational definition of MARYP and has a general youth population approach preferring to view all young people in Samoa as at risk, including young people in school, out of school, church youth, juvenile offenders and inmates.

However, SFHA does use situation analysis reports, needs assessments, and risk mapping to identify the MARYP groups and determine what settings and areas to reach them. Success is measured by collating indicators such as number of users of services, MSC stories collected from focus group discussions and pre and post test results.

The SAF program has reached more than 18,000 young people nationally in the last five years. The interviewee estimated that 50% of Samoa's young people would fit into the MARYP category.

Young people are involved in the planning and implementation of the program through the SFHA Peer Education Program, the Annual General Meeting and monthly capacity building meetings as well as when conducting research.

SFHA is a member of the TALAVOU Steering Committee and National Youth Forum as well as an active contributor to the Samoa Youth Parliament. SFHA has a wide network of partners and collaborates with government ministries, especially the Ministry of Health, other NGOs and educational institutions.

The interviewee highlighted the fact that sex workers were very difficult to identify but also that SFHA do conduct outreach and distribute IEC materials and condoms in settings where they are known to congregate.

Samoa TALAVOU Program

The TALAVOU Programme was born out of the National Youth Policy (2001-2010) as a mechanism for its implementation and based in the Ministry of Women, Community & Social Development's Division for Youth.

The TALAVOU Program works with a definition of young people being those between 12–29 years of age and specifically targets marginalised young people, young people attending school, young prison inmates sand young people living in rural communities.

The TALAVOU Program also acts as an umbrella organisation for government departments and NGOs, who have youth programs, bring them together to coordinate an effective framework for youth development. As a coordinating mechanism, the TALAVOU Program has standardised M&E templates for all its members in an effort to develop a centralised database of all youth programs. The program has also developed a directory of youth service providers.

The Samoa National Peer Education program targets young people both in and out of school, unemployed, and employed persons aged 12–29 years of age. The program was initially monitored using questionnaires documenting feedback from peer educators. A plenary group reflection and evaluation was utilised at the end of the activities to reflect on achievements and map the way forward.

In 2007, a Youth Vulnerability Mapping Report was commissioned with the aim of identifying MARYP groups and their situation in order to inform appropriate evidence-based interventions. As a result, young prison inmates were identified as a particularly high risk group and a rehabilitation program was developed with the aim of including spiritual guidance as well as income generation activities.

In 2008, a special sub-committee was endorsed by the Steering Committee of the TALAVOU Program to coordinate and monitor the implementation of Peer education programs; hence a close partnership has developed in terms of implementation with the Samoa Family Health Association, Samoa AIDS Foundation and the Samoa Red Cross.

The program is a collaborative effort of a number of NGOs i.e. Samoa Red Cross, Samoa Family Health Association, Samoa AIDS Foundation and Young Women Christian Association (YWCA) and Adolescent Health Development Program (Samoa).

The interviewee estimated that in the last year the program has reached around 50% of the total Samoan youth population with approximately 30-40% considered in the MARYP category.

Young people are constantly involved in the planning, implementation and evaluation of the program through extensive consultation at the community level, including with church youth groups, cultural youth groups and young women's groups. TALAVOU's young peer educators also sit on the TALAVOU Steering Committee.

Tonga Family Health Association (TFHA) / AHD Program

The Tonga Family Health Association is an IPPF-affiliated NGO established in 1975 that specifically addresses HIV and sexual health issues and targets young people between 10–24years. While TFHA's primarily targets are school dropouts and deportees, there is acknowledgement of other MARYP groups, such as teenage mothers, young sex workers, transgenders and sexual minorities.

The TFHA runs a RH clinic on Tonga's main island of Nuku'alofa attached to a youth centre which offers a library and sports facilities. The clinic is open to the general public but provides Youth Friendly Services (YFS) every Friday. There are TFHA-run centres on Vava'u and a newly opened one in Ha'api.

The TFHA Peer Education Project developed through the AHD Program targets young people both in-school and school drop outs. The project has been operating for 6 years and aims at empowering youth with accurate information, equipping them with life skills, encouraging them to access YFS and referring their peers who need further counselling.

TFHA also have other projects including:

- Filitonu Drama Group who use music and drama for community education
- Youth Empowerment and Development Project: targets MARYP and settings such as unemployed youth. Every Tuesday runs a Young Mothers Programme.
- Livelihood Skills Program: every Friday in collaboration with Ministry of Youth

MARYP areas and settings are identified in collaboration with counterpart programs such as MORDI (Mainstreaming of Rural Development Initiatives) and the District Report of Health Nurses. Tools used to specifically identify MARYP groups include:

- Peer Educators Outreach Reports
- National RH Review Report/MOH Annual Report
- Demographic Profile of Adolescents in Tonga (Census Report 2006)
- School attendance records from the Ministry of Education

Monitoring and evaluation is conducted on a daily basis as well as through quarterly reporting of activities to both TFHA and SPC. Evaluative activities include frequent Focus Group Discussions with youth, the annual AHD Stakeholder Meeting and exit interviews of young clients accessing the YFS. Indicators used to measure the success of the project include:

- Number of referral clients by peer educators
- Number of youth participating in the youth meeting and peer education outreach
- Number of well defined vulnerable at risk groups reached/identified by peer educators

The interviewee estimated that in the last year the program has reached around 300 young people with approximately 70% considered in the MARYP category.

Activities are selected in consultation with TFHA, youth stakeholders and the donor. The target population are the potential stakeholders of this project and they participate, through a series of

ongoing meetings and needs assessments, in the design of the program in consultation with the Youth Advisory Group.

TFHA is a member of several coordinating groups such as the Tonga Country Coordinating Mechanism for HIV/AIDS, the National AHD Project Task Force and the Tonga Youth Stakeholders (coordinated by the Ministry of Youth). TFAH also collaborates with multiple government departments and NGO partners in joint activities that target young people.

The interviewee noted that gaps in Tonga include a lack of ASRH information and services in the outer islands, a lack of credible YFS providers and insufficient use of Behaviour Change Communication (BCC) strategies and the media as well as a need for IEC materials for less literate young people.

Tonga National Youth Congress

Tonga National Youth Congress is a NGO founded in the 1980s that works with young people aged between 14-35 years. While they do not have an organisation definition of MARYP, they do target marginalised young people, hut dwellers, in-school youth, school dropouts, teenage mothers, sex workers, transgenders, MSM and rural/outer island youth.

TNYC has an active Peer Education Program with 40 volunteer peer educators spread across three island groups (Tongatapu, Ha'api and Eu'a). The have an in-school program and also work directly with a teacher training college. TNYC also have a media program that includes a regular radio program and newsletter.

MARYP groups and settings are identified through regular consultations with youth and Peer Educator reports.

M&E of this project is through peer education reports during regular peer meetings and post-session testing at every outreach to test newly gained knowledge. The interviewee also stated that TNYC conduct quarterly KAP studies of high school students.

Indicators used to measure the success of the project include:

- The number of outreach sessions requested from communities/schools
- Frequency of youth drop in for information
- Number of condoms distributed
- Referrals as a result of the peer education

Activities are determined by the executives of the organisation and the health department including the coordinator and the assistant. Surveys of the target group are conducted before the assigning of projects and they serve as a focus group for the purposes of evaluation.

The interviewee estimated that in the last year the program has reached between X5---2--- young people with approximately 25% considered in the MARYP category.

TNYC regularly collaborates with Tonga Family Health Association, the Ministry of Health and the Salvation Army in peer education activities.

Interestingly, the interviewee identified teenagers who still live at home with parents as a high risk group given their reluctance to access ASRH clinical services.

Tuvalu Family Health Association (TuFHA)

The Tuvalu Family Health Association is an IPPF-affiliated NGO that started in X989 to address SRH issues. TuFHA's Youth Program includes peer education, community outreach, condom distribution, drama education and livelihood skills training. TuFHA also runs a Youth Clinic and Youth Centre for the general youth population.

TuFHA works with young people between X4-25 years (IPPF focus) but also targets young people up to the age of 34, as is consistent with the Tuvalu National Youth Policy. Whilst TuFHA does not have a formal definition of MARYP, it does target school dropouts, marginalised youth groups, outer island youth groups and seafarers.

Given the small population of Tuvalu, the tools used to identify MARYP and settings mainly include peer educator observations and reports as well as anecdotal evidence.

M&E of this project is through peer education reports during regular peer meetings and post-session testing at every outreach to test newly gained knowledge. The interviewee also referred to a TuFHA SRH KAP Study (2--6-2--7) that was used to evaluate the Youth Program.

The interviewee estimated that in the last year the program has reached around 3-% of Tuvalu's youth population (albeit mostly on the main island of Funafuti) with approximately X-% considered in the MARYP category.

In terms of involvement of young people, the TuFHA volunteers and peer educators are heavily involved with the implementation of the program and two young people sit on the TuFHA Executive Board, but there is no mechanism for involvement of the target audience.

TuFHA is a member of the Tuvalu National Youth Council and the AHD Project Coordinating Committee. The program also collaborates with the Red Cross and MOH in the delivery of services. They refer the target population to the TuFHA clinic or MOH, and attempts to follow up these referrals through condom distribution.

The interviewee stated that a gap in the program is reaching out to outer island youth which is hampered by limited funding and transportation issues.

Tuvalu AHD Program (Ministry of Health)

The Tuvalu AHD Program is based in the Ministry of Health and primarily focuses on young people aged X5-24 years. Program activities include community education, in-school education and YFS at the MOH SRH Clinic, including IEC materials and contraceptives.

The interview expressed the difficulty of defining MARYP groups in Tuvalu but highlighted that the 2--7 HIV/STI SGS Survey Report and the National Strategic Plan have identified that young seafarers are a particularly high risk group.

Currently, the Tuvalu Red Cross run a Peer Education program for seafarers and work closely with the Tuvalu Overseas Seamen's Union, The program also targets seafarers' wives by providing free internet services and support.

The MOH has a close working relationship with TuFHA and provides technical assistance to enable the TuFHA Youth Clinic to provide STI testing and treatment for the young people of Tuvalu.

The interviewee stated that a gap in the program is reaching out to outer island youth which is hampered by limited funding and transportation issues

Annex I: MARYP Questionnaire Template

MARYP Questionnaire

for the

Most at Risk Young People (MARYP) Desk Review of Six Countries

[Cook Islands, Federated States of Micronesia, Marshall Islands, Samoa, Tonga, Tuvalu]

Issued by the Adolescent Health and Development Programme

- A joint initiative of UNFPA, UNICEF and the Secretariat of the Pacific Community (SPC)

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Background

The 2007 Review of the Adolescent Health and Development (AHD) Programme recommended specifically targeting vulnerable, marginalised and most at risk groups of young people.

The AHD Programme is reviewing the existing status of the 'most at risk young people (or MARYP) approach in selected countries. The rationale for the review is to understand the profile of MARYP in countries in order to ensure effective interventions, despite limited resources.

As a process of the review, the program seeks to collect available information to identify the context, groups and locations of MARYP in the Pacific and determine the extent to which specific interventions have been implemented to reach this group of young people.

This MARYP Questionnaire is to be used as a basis for phone interviews which will record your actual country experiences. Your feedback will be recorded and analysed to form part of the MARYP Review Report.

These findings will be fed back to the AHD Programme and will also be presented in the SPC-hosted Meeting to Improve Strategic Information and Programming for Most at Risk Young People (MARYP) from 26-28th November 2009 in Nadi, Fiji.

As such, time is very short so we would be very grateful for your assistance to help us collect the most relevant and effective information for this exercise.

Return of the Questionnaire

We would like you to complete this questionnaire through a phone interview

Please send an email to the consultant (georgetavola@gmail.com) to let him know what would be the best time to call you to carry out the phone interview (before 5th November).

Also, please send in an email if you have any questions or difficulties answering the MARYP Questionnaire.

Time Allocation

Completion of this questionnaire through a phone interview should take approximately 30 minutes.

Section One: You and Your Organisation

1.1 What is your name?_____

1.2 What is the name of your organisation?_____

1.3 How would you describe your organisation?

☐ NGO ☐ Private ☐ Faith-based ☐ CBO ☐ Govt

1.4 What is your position in the organisation?_____

1.5 Is your organisation involved in working with young people?

☐ Yes ☐ No

1.6 How does your organisation work with young people?

_____

_____

_____

1.7 What is the age range of these young people?

☐ 10-14 ☐ 15-19 ☐ 20-24 ☐ 25+

1.8 In your programs, would you describe any of the young people targeted as 'most at risk'? Does your organisation have a formal definition in its policies or plans for 'Most at Risk Young People'?

_____

_____

_____

_____

Section Two: MARYP Programs

2.1 What programs are there in your country for 'most at risk young people'?

_____

_____

_____

_____

_____

_____

2.1 What programs does your organisation deliver to 'most at risk young people'? What do these programs hope to achieve?

2.2 In what settings or locations does your organisation target 'most at risk young people'? For example: across the whole country, in urban settings, in the community or at other locations?

Please provide as much detail as you can about these locations and settings.

2.3 What information or tools has your organisation used to identify which young people are 'most at risk' in your country?

2.4 How would you describe the effectiveness of this program in responding to the needs of 'most at risk young people'?

2.5 Do you measure the programs' success in achieving its aims?

☐ Yes ☐ No

If yes, how do you monitor and evaluate the program? Do you use any tools to help you monitor and evaluate the program?

2.1 In the last year, how many 'most at risk young people' would you say have been reached by your organisation's programs?

2.2 What percentage of the total number of young people reached by your programs would you estimate are 'most at risk young people'?

2.3 How are young people, including 'most at risk young people', involved in the design, implementation and evaluation of the program?

Section Three: Partnerships

3.1 Is your organisation a member of any national coordinating group on youth?

☐ Yes ☐ No

If yes, please specify:

3.2 Does your organisation deliver programs in collaboration with other partners?

☐ Yes ☐ No

If yes, please specify:

3.3 What are the benefits of collaborating with these partners?

3.4 What are the challenges of collaborating with these partners?

Section Four: Identifying Gaps

4.1 In your country, at there any 'most as risk young people' who have difficulties accessing available services?

4.2 Are there any gaps that you can identify in the programs and services offered to young people, including those most at risk?

Section Five: 'At Risk' or 'Vulnerable'?

5.1 Some people see a difference between (i) an 'at risk' young person, and (ii) a 'vulnerable' young person. What do you think is the difference?

5.2 What do you think are the factors that lead to a young person being vulnerable in your country or community?

Is there more that could be done to address these factors in your country or community?

Section Six: Other Information?

6.1 Would you like to tell us anything else about young people's access to available programs and services in your country?

6.2 In your opinion, what else could be done for 'most as risk young people'?

Section Seven: Supporting Information

7.1 Is there any other information about young people's needs, and/or the programs and services in your country that you think the Review Team should consider? Can you send us any useful reports?

Thank you for your time and attention.

Annex J: List of MARYP Phone Interviewees

NAME	ORGANISATION	POSITION TITLE
COOK ISLANDS		
Maine Beniamina	AHD / MOH	AHD Coordinator
Patience Vainerere	Cook Islands Red Cross	HIV Program Officer
FSM		
Pertina Albert	AHD Pohnpei / MOH	AHD Coordinator
Eleanor Sos	Chuuk HIV Programme	HIV Coordinator
Morgan David	FSM Red Cross (Pohnpei)	Youth / HIV Officer
RMI		
AlicethaTata Kalles	AHD / Youth to Youth in Health	AHD Coordinator
SAMOA		
Sydney Faasau	TALAVOU Programme	Programme Coordinator
Manu Samuelu	Samoa Family Health Association	Services Manager
Peone Fuimaono	Samoa AIDS Foundation	Acting Director
TONGA		
Katherine Mafi	AHD / TFHA	AHD Coordinator
Polikalepo M Kefu	Tonga National Youth Congress	HIV Coordinator
TUVALU		
Tekafa Neemia	AHD / MOH	AHD Coordinator
Savali Kelese Matio	Tuvalu Family Health Association	Youth Officer
Annie Homasi	Tuvalu Association of NGOs	Executive Director
Stephen Homasi	MOH	Permanent Secretary
REQUESTED INTERVIEWS THAT DID NOT EVENTUATE		
Tevaerangi Tatuava	Cook Islands Family Welfare Association	
Goretti Wulf	Samoa Red Cross	
Iemaima Havea	Former AHD / Tonga FHA	
Fepuale Kitiseni	Tuvalu Overseas Seamen's Union	

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2009	*Responding to the sexual and r*	Sex Workers	Asia	Family Health International (FHI) (Graham Nielson)						
2004	*Cook Islands: A Situation Analysis of Children, Youth and Women*	Situation Analysis	Cook Islands	Cook Islands Government / UNICEF	Donor program assessment/evaluation report	yes	yes	No	Yes	Good qualitative overview
2000	*STD, HIV & AIDS A Situationa*	STIs, HIV & AIDS	Cook Islands	Government of Cook Islands (Fanaura K. Kingstone)	Donor program assessment/Evaluation report	No				
2007	*Draft Strategy on the Response*	STIs, HIV & AIDS	Cook Islands	Government of Cook Islands	Donor Program Assessment/Evaluation Report	No				
2006	*Cook Islands Millennium Devel*	MDG Progress Report	Cook Islands	Government of Cook Islands, CIANGO, UNs	Donor Program Assessment/Evaluation Report	yes	No	no	yes	good, data not representative of the population of interest
2009	*Evaluation of the Cook Islands*	Evaluation Report	Cook Islands	Cook Islands Red Cross Society (James Puati)	NGO report	No	Yes	Youth identified as 'at risk'	Yes	limited evidence for conclusions
2008	*Evaluation of Chlamydia Testing and Treatment Pilot*	STIs	Cook Islands	Government of Cook Islands / SPC	Other MOH Survey	No	Yes - identifies youth 15-30 years	No	Yes	Reasonable - some data not available to survey team
2007	*Factors Contributing to Teenage Pregnancies in Rarotonga, Cook Islands*	Teenage Pregnancy AHD Research Report	Cook Islands	Government of Cook Islands (Rufina Tutai) / UNFPA / SPC	Other MOH Surveys	yes	Yes	No	yes	Good - interviews both youth and services providers but not a large sample
2002	*Sexual Knowledge and Attitudes of Adolescents in the Cook Islands*	Adolescent Reproductive Health KAP Study Report	Cook Islands	UNFPA / University of the South Pacific (Kesaia Seniloli)	Other Quantitative survey eg SGS/BSS/KABP	yes	yes	no	yes	good - be useful to compare with more recent data in 2006 SGS
2005-2006	*Second generation surveillance surveys of antenatal women and youth, Cook Islands*	HIV/STIs Surveillance Reports	Cook Islands	Government of Cook Islands / SPC	Other Quantitative survey eg SGS/BSS/KABP	yes	yes - BSS - 15-24 years	no	yes	good - uses methods common to other SGS in Pacific so can facilitate comparative analysis
2007	*National Strategy on the Response to HIV, AIDS and STI 2008-2013, Cook Islands*	STIs, HIV & AIDS	Cook Islands	Government of Cook Islands	Policy /Strategy Document	Yes	Yes - youth aged 10-24	Identifies youth as 'at risk'	Activities planned to gather specific information	Good
2003	*Strategic Plan for Responding t*	STIs, HIV & AIDS	Cook Islands	Government of Cook Islands	Policy /Strategy Document	No				
2007	*PRHP Grant Program Evaluati*	Evaluation Report	Cook Islands	Pacific Regional HIV/AIDS Project (PRHP)	Technical Agency Report	no	No	No	yes	good - although focus is on the effectiveness of PRHP Grant rather than programs. Data no representative of the population of interest
2009	*Peer Education and Support Program Mapping Report*	Peer Education	Cooks, FSM, Kiribati, Nauru, RMI, Samoa, Solomon's, Tonga, Tuvalu, Vanuatu	Secretariat of the Pacific Community (SPC)	Technical Agency Report	yes	yes	??	yes	Excellent overview of peer education across the region, together with excellent country level interviews and analysis although focused on peer education programs

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2008	*Pre-Intervention Study in Implementation of School Based Family Life Education*	FLE KAP Study	Fiji	SPC / Fiji School of Medicine (Eleanoa Seru-Puamau & Graham Roberts						
2008	*Final Report: UNFPA Supported Sex Worker Initiatives in Six Pacific Island Countries 2007-2008*	Sex Workers	Fiji, FSM, Kiribati, Marshall Islands, Solomon Islands, Vanuatu	UNFPA (Tim Sladden)						
2008	*Commercial Sexual Exploitation of Children & Child Sexual Abuse in the Pacific*	Child Sexual Abuse	Fiji, Kiribati, PNG, Solomon's, Vanuatu	UNICEF						
2006	*Second generation surveillance surveys of HIV, other STIs & Risk Behaviours in 6 PICs (2004-2005)*	HIV/STIs Surveillance Reports	Fiji, Kiribati, **Samoa**, Solomon Islands, **Tonga**, Vanuatu	Secretariat of the Pacific Community (SPC)	Other Quantitative survey eg SGS/BSS/KABP	yes	Yes - in	Yes, BSS in Samoa (but not in Tonga)	yes	Excellent report - provides comparative framework for indicators across 14 Pacific coutnries, with number of follow up SGS since completed and published (anor ?5 to be completed)
2008	*Analysis of Poverty - the 2005 Household Income And Expenditure Survey*	HIES Report	FSM	Government of Federated States of Micronesia	Demographic & Health Surveys	yes	Yes - youth	young males in rural drift to the urban areas leads to unemployment & poor living conditions	yes	good overview of general population and determinants of wellbeing
2008	*UNGASS 2008 Country Progress Report*	UNGASS Report	FSM	Government of Federated States of Micronesia	Donor Assessment /Evaluation Report	NO	yes - age specific data 15-24 for some key indicators & best practice programming	no	yes	Most data not available for most key indicators esp age-specific indicators of risk
2004	*HIV and AIDS Situation and Services in Chuuk State, FSM (PPT)T*	Situation Analysis	FSM	Department of Health, Chuuk State (Eleanor Sos)	NGO report	no	yes - 15-30 years	yes - all those 15-30 in various categories	yes	useful
2009	*HIV/AIDS Knowledge, Attitude and Practices (KAP) Survey*	KAP Study	FSM	Micronesia Red Cross Society	NGO report	no	yes - elementary school students in 7th & 8th grade b/n ages of 11-23 years in Kosrae and Pohnpei	no	yes	aimed to provide information to identify gaps in information assist in re-design of program - some of that analysis is dodgy, with responses poorly categorised and not providing a clear response.
2007	*Utilization of Adolescent Health and Development Clinical Services in Pohnpei State*	Clinical Services AHD Research Report	FSM	Government of Federated States of Micronesia (Pertina Albert)	Other Quantitative survey eg SGS/BSS/KABP	yes	yes	yes - teen pregnancies particularly	yes	Good data with indicators for teen sexual & reproductive health, and access to services. These UNFPA surveys are good - focused on each countries issues, conducted by each country, useful recommendations - THEY SHOULD DO MORE OF THEM!
2007	*Qualitative Adolescent Health & Development Study in Pohnpei and Chuuk States*	AHD Research Report	FSM	Government of Federated States of Micronesia	Other Quantitative survey eg SGS/BSS/KABP	yes	yes		yes	Excellent report - also identifies what is working in two states, and

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2007	*Collection of Indicators in FSM*	Indicators	FSM	PRHP/Burnet (Judy Gold)	Other Quantitative survey eg SGS/BSS/KABP	no				proposes likely indicators for M&E (HIV & STI)
2009	*Second generation surveillance*	HIV/STIs Surveillance Reports	FSM	Government of Federated States of Micronesia / SPC	Other Quantitative survey eg SGS/BSS/KABP	No	yes - 15-24 yrs		yes	good data
2009	*Yap Youth Second Generation S*	HIV/STIs Surveillance Reports	FSM	Government of Federated States of Micronesia / SPC	Other Quantitative survey eg SGS/BSS/KABP	no	yes 15-24 yrs		yes	good data
2008	*Chuuk Peer Education Evaluation Report*	Evaluation Report	FSM	PRHP/Burnet (Marion Brown)	Technical Agency Report	no	yes		yes	good - especially advise on effectiveness of programs
2008	*Chuuk Youth Resource Centre Evaluation Report*	Evaluation Report	FSM	PRHP/Burnet (Marion Brown)	Technical Agency Report	no	yes		yes	good - especially advise on effectiveness of programs
2006	*DRAFT Chuuk HIV and AIDS Situation and Response Analysis*	Situation Analysis	FSM	PRHP/Burnet (Judy Gold)	Technical Agency Report	No	no	no	some information tho advise to treat with caution	reasonable although report advises to treat some information with caution
2008	*PRHP Grants Program in FSM - Evaluation Report*	Evaluation Report	FSM	Pacific Regional HIV/AIDS Project (PRHP)	Technical Agency Report	no	yes	?	yes	good - especially advise on effectiveness of programs
2009	*PRHP Pohnpei Competitors Association - Evaluation Report*	Evaluation Report	FSM	SPC (Kellie Woiwood)	Technical Agency Report	no	yes	?	yes	good - especially advise on effectiveness of programs
2003	*HIV/AIDS Situation Analysis - Pohnpei, FSM*	Situation Analysis	FSM	Government of Federated States of Micronesia	Technical Agency Report	no	yes	yes	yes	useful
2006	*DRAFT Kosrae Situation and Response Analysis Report*	Situation Analysis	FSM	PRHP/Burnet (Judy Gold)	Technical Agency Report	no	yes 15-26 years	yes - teen pregnancies particularly although treat data with caution	yes although advises to treat data with caution	good although reviewer advises to treat data with caution.
2006	*Yap HIV and AIDS Situation and Response Analysis*	Situation Analysis	FSM	PRHP/Burnet (Judy Gold)	Technical Agency Report	no	no	no	some information tho advise to treat with caution	reasonable although report advises to treat some information with caution
2006	*Annex 2.3 Federated States of Micronesia Analysis*	Country profile	FSM	Pacific Regional HIV/AIDS Project (PRHP)	Technical Agency Report					
2001	*Access to Health Services for Young People for Preventing HIV and Improving Sexual and Reproductive Health*	HIV / SRH	International	World Health Organisation (WHO)						
2007	*Practical Guidelines for Intensifying HIV Prevention Towards Universal Access*	HIV Prevention	International	UNAIDS						
2005	*Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries*	Adolescent Reproductive Health	International	World Health Organisation (WHO)						

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2009	*Inter-Agency Task Team on HIV and Young People: Guidance Brief*	HIV / MARYP	International	UNFPA / UN IATT						
2006	*Investing in our Future: A Framework for Accelerating Action for Sexual and Reproductive Health of Young People*	Adolescent Reproductive Health	International	UNFPA / WHO / UNICEF	Technical Agency Report	yes	yes	yers	yes	excellent guidance document
1998	*Expanding the global response to HIV/AIDS through focused action*	HIV & AIDS	International	UNAIDS						
2006	*Preventing HIV/AIDS in Young People: A Systematic Review of Evidence from Developing Countries*	HIV Prevention	International	World Health Organisation (WHO)						
2009	*The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities (SOGI)*	Sexual Minorities & G	International	The Global Fund						
2009	*UNAIDS Guidance Note on HIV and Sex Work*	Sex Workers	International	UNAIDS						
2002	*Broadening the Horizon: Balancing protection and risk for adolescents*	Adolescent Reproductive Health	International	World Health Organisation (WHO)	Technical Agency Report					useful guidance document
2004	*Key Issues in the Implementation of Programmes for Adolescent Sexual and Reproductive Health*	Adolescent Reproductive Health	International	World Health Organisation (WHO)	Technical Agency Report	Yes	yes	yes	yes	excellent guidance document
2008	*Youth Participation Guide: Assessment, Planning, and Implementation*	Youth Participation	International	Family Health International (FHI)						
2003	*Estimating the Size of Populations at Risk for HIV*	MARPs	International	UNAIDS						
2008	*Framework for M&E HIV Prevention Programmes for MARPs*	MARPs	International	UNAIDS						
2009	*"The Bridge for Prevention": G*	HIV Prevention	International	UNICEF (Rick Olsen)						
2009	*Primary Prevention Policies (PPT)*	HIV Prevention	International	UNICEF						
2009	*The Global Fund Strategy in Re*	Sexual Minorities & G	International	The Global Fund						
	Sexual and reproductive health & HIV &AIDS, A framework for priority linkages	Linkage between ASRH & HIV	international	WHO, UNFPA, IPPF, UNAIDS	technical Agency Report	yes	yes y	yes	yes	useful overivew of the linkages
2006	*Factors Associated with the Reproductive Health Risk Behaviour of High School Students in the Republic of the Marshall Islands*	KAP Study	Marshall Islands	Journal of School Health d April 2006, Vol. 76, No. 4 (Keiko Suzuki, Yutaka Motohashi, Yoshihiro Kaneko)	Other Quantitative survey eg SGS/BSS/KABP	yes	yes		yes	Good points for basis of future sexual and reproductive health strategies targeting young people in Marshalls
2006	*Annex 2.8 Republic of Marshall Islands Analysis*	Country profile	Marshall Islands	Pacific Regional HIV/AIDS Project (PRHP)	Technical Agency Report	no	yes	no	yes	Good overview of HIV related programming

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2004	*Second Generation Surveillanc*	HIV/STIs Surveillance Reports	Marshall Islands	SPC (Tim Sladden)	Technical Agency Report	no	yes - identifies females as risk group	yes - females involved in commercial sex		good - identifies strategies for getting data rather than presents data - query currency given date
2005	*Draft Situational Analysis of H*	Situation Analysis	Marshall Islands	PRHP (Kamma Blair)	Technical Agency Report	no	yes	yes - programs operate for at risk young people (men) - with also priority to young	yes	good overview of situation including programs
2006	*Republic of the Marshall Island*	National Strategic Plan	Marshall Islands	Government of the Republic of the Marshall Islands	Policy /Strategy Document	no	yes - those under 30 and those aged 15-24	yes - re teen pregnancies	Yes	
2008	*SWIP (Sex Worker Intervention*	Evaluation Report	Marshall Islands	Youth to Youth in Health / Government of the Republic of the Marshall Islands	Other Quantitative survey eg SGS/BSS/KABP	no	yes - although no explicitly stated, seems that the SWrkrs are young women	yes - although no explicitly stated, seems that the SWrkrs are young women	yes	
2003	*2002 Statistical Yearbook*	Development Indicators	Marshall Islands	Economic Policy, Planning and Statistics Office (EPPSO), Ministry of Health, RMI						
2009	*Teenage Pregnancy Statistics in*	Teenage Pregnancy Statistics spreadsheet	Marshall Islands	Economic Policy, Planning and Statistics Office (EPPSO), Ministry of Health, RMI						
2006	*The Truth on Our Youth: A Market Based Assessment of the Youth Population and its Major Issues*	Situation Analysis	Marshall Islands	Benjamin Graham & Youth to Youth in Health (YTYIH)	Other national survey	no	yes	yes	yes	good
2003	*Republic of the Marshall Islands: A Situation Analysis of Children, Youth and Women*	Situation Analysis	Marshall Islands	Government of the Republic of the Marshall Islands / UNICEF	Donor program Assessment/ Evaluation report	Yes	yes - 13-35 ages	yes	yes	good - query currency given date (but suggest remains valid)
2007	*Understanding Teenage Pregnancy in the Republic of the Marshall Islands*	Teenage Pregnancy AHD Research Report	Marshall Islands	Government of the Republic of the Marshall Islands (Tauki Reimers) / Youth to Youth in Health / UNFPA / SPC	Donor program Assessment/ Evaluation report	yes	yes	yes - youth identified as risk or high risk	yes	good mix of qualitative and quantitative - also includes information on sexual abuse (suggests more research)
2008	*Responding to the Youth Crisis*	Youth Research Report	Marshall Islands	Benjamin Graham & Asian Development Bank	Donor Program Assessment /Evaluation Report	Yes	yes	youth described as falling through the cracks	Yes	Good qualitative overview of situation for young Marshallese
2009	*Draft Millennium Development Goals (MDGs) Report*	MDG Progress Report	Marshall Islands	Government of the Republic of the Marshall Islands (Ben Graham) / UNDP	Donor program Assessment/ Evaluation report	yes	no	no	yes - age specific literacy rates & HIV related indicators	good overview, very little age specific data

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2008	*Republic of the Marshall Islands: Demographic and Health Survey (DHS) 2007*	DHS Report	Marshall Islands	Government of the Republic of the Marshall Islands / ADB / SPC	Demographic & Health Surveys	yes	no , youth included in general populations - some breakdown of some determinant s by age specific info but mostly 15-49 year breakdown	young people's sexual behaviour described as high risk	does identify age specific fertility rates	good on broader populations based overview with some key determinants identified
2008	*Republic of the Marshall Islands 2007 DHS Fact Sheets*	DHS Fact Sheets	Marshall Islands	Government of the Republic of the Marshall Islands / ADB / SPC						
2006	*Adolescent Reproductive Health in the Pacific: Marshall Islands*	Adolescent Reproductive Health Monograph	Marshall Islands	De La Salle University (Trinidad Osteria) / UNESCO / UNFPA	Other Quantitative survey eg SGS/BSS/KABP	Yes	Yes - specific data on 15-19 years	identifies adolescents as vulnerable group	yes	good - mix of quantitative and qualitative data
2006	*Cultures and Contexts Matter: Understanding and Preventing HIV in the Pacific*	Youth Vulnerability to HIV	PNG & Regional	Carol Jenkins & Holly Buchanan-Aruwafu, Asia Development Bank (ADB)	Technical Agency Report	no	yes	yes	yes	Good analyis of Pacific culture and context in relation to HIV - specific chapter on youth in the Solomon Islands as case study
2007	*An Integrated Picture:HIV Risk and Vulnerability in the Pacific. Research Gaps, Priorities and Approaches.*	HIV	Regional	Holly Buchanan-Aruwafu / SPC	Technical Agency Report	no	yes	yes	yes	Comprehensive analysis of vulneraiblity and risk re HIV across the Pacific, with reference to a number of focus countries
2007	*Adolescent Reproductive Health in Asia and Pacific Region*	UNFPA Country Programmes	Regional	UNFPA	Donor Assessment /Evaluation Report	yes	yes	yes	yes	generic review of lessons learnt without specific information on Pacific
2009	*Mapping the youth challenge*	Youth	Regional	Secretariat of the Pacific Community (SPC)	Technical Agency Report	no	yes	yes	yes	Good qualitative overview of youth issues across the pacific commissioned by HDP
2005	*HIV and AIDS in the Pacific*	Regional Response to HIV	Regional	Carol Jenkins, Asia Development Bank (ADB)	Donor Assessment /Evaluation Report	no	yes	yes	yes	good overview of HIV in the Pacific - basis for ADB grant
2009	*SPC-ADP PIC Populations Data Sheet 2009*	Disaggregated PIC Population data	Regional	Secretariat of the Pacific Community (SPC)	?					not sighted
2002-2004	*Youth Alcohol & Tobacco Risk Factors*	Youth Tobacco and Alcohol data	Regional	Secretariat of the Pacific Community (SPC)	?					not sighted
2001	*Adolescent Reproductive Health Annual Report 2001*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2002	*Adolescent Reproductive Health Annual Report 2002*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2003	*Adolescent Reproductive Health Annual Report 2003*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2004	*Adolescent Reproductive Health Annual Report 2004*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2005	*Adolescent Health and Development Annual Report 2005*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program

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2006	*Adolescent Health and Development Annual Report 2006*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2007	*Adolescent Health and Development Annual Report 2007*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2008	*Adolescent Health and Development Annual Report 2008*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2005	*Adolescent Health and Development Regional Review & Planning Meeting Report 2005*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2007	*Adolescent Health and Development Regional Review & Planning Meeting Report 2007*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2007	*Adolescent Health and Development Regional Review & Planning Meeting Report 2007 (2)*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2007	*Adolescent Health Development Project Review*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2009	*Adolescent Health Development Project Strategic Plan 2009–2012*	AHD	Regional	SPC / UNICEF / UNFPA	Policy /Strategy Document	no	yes	yes	yes	good overview of the Program
2008	*Framework of Priorities for Youth in the Pacific Concept Paper*	Youth Framework	Regional	SPC (Tangata Vainerere & Rose Maebiru)						
2008	*Assessment of HIV Counselling and Testing Services in Pacific Island Countries*	HIV Counselling and Testing	Regional	ASHM / NCHSR (Jacinta Ankus, Alistair Mac Donald, Heather Worth, Edward Reis)	Technical Agency Report	no	no	No	yes	good overview of program activities to end 2008 in VCCT across the region
2008	*Gender Review & Evaluation of PRHP*	Evaluation Report	Regional	Jeffrey Buchanan	Technical Agency Report	no	yes	yes	y es	Good assessment of progress under PRHP on gender integration - most tools handed over to SPC
2009	*Update on Second Generation Surveillance (PPT)*	Surveillance	Regional	SPC (Gillian Duffy)	Powerpoint presentation					Update on Status of SPC approach to surveillance in the region
2008-09	*Situational analysis of Drug & Alchol Issues & Responses in the Pacific*	Situation Assessment	Regional	The Burnet Institute	Technical Agency Report	Draft - to be published	yes	yes	yes	Good comprehensive overview of what is known about drugs and alcohol use and responses across the Pacific
2005	*HIV and AIDS in the Pacific Annex A - Country Profiles*	Regional Response to HIV	Regional incl. **Cooks**, **RMI, Samoa, Tonga, Tuvalu**	Carol Jenkins, Asia Development Bank (ADB)	Donor Assessment /Evaluation Report	no	yes	yes	yes	good qualitative overview - check currency of views, given date (2005)
2006	*Adolescent Sexual & Reproductive Health Situation Analysis: Samoa*	Adolescent Reproductive Health Situation Analysis (1995 - 2005)	Samoa	UNFPA	Donor program assessment/evaluation report	yes	yes	?	yes	good overview of determinants

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2006	*Samoa: A Situation Analysis of Children, Youth and Women*	Situation Analysis	Samoa	Government of Samoa & UNICEF	Donor program assessment/evaluation report	yes	yes	Yes, identifies youth at risk	Yes	Good
2006	*Adolescent Reproductive Health in the Pacific: Samoa*	Adolescent Reproductive Health Monograph	Samoa	De La Salle University (Trinidad Osteria) / UNESCO / UNFPA	Donor program assessment/evaluation report	yes	yes	yes - identifies high risk youth	Yes	good
2006	*Annex 2.9 Samoa Analysis*	Country profile	Samoa	Pacific Regional HIV/AIDS Project (PRHP)	Donor program assessment/Evaluation report	no	no - youth are noted but not as key focus	no	yes	good overview of HIV activities in Samoa
2009	*Evaluation of the Samoa AIDS Foundation*	Evaluation Report	Samoa	SPC / Kellie Woiwood	Donor program assessment/Evaluation report	no	no - youth are noted but not as key focus	No	yes	Good - evaluation of HIV activities in Samoa
2004	*UNICEF Review and Development of Policy and Practices for the Prevention of Mother-to-child Transmission of HIV in Samoa*	Evaluation Report	Samoa	UNICEF / Rob Condon	Donor program assessment/Evaluation report	no	no	yes identifies Teen pregnancies	yes	good brief
2005	*Youth and the Millennium Development Goals in Samoa*	MDG Progress Report	Samoa	Government of Samoa	Donor program assessment/Evaluation report	Yes	yes	yes	yes	NO sure we have the right document - the closest version I have is the general - Final report of the Ad hoc working group for youth and the MDGs
2007	*Mapping of Vulnerable Youths*	Youth Vulnerability D	Samoa	Small Business Enterprise Centre / Government of Samoa	Other national survey	No	Yes	Yes - identifies vulnerable youth	Yes	Good qualitative overview of economic opportunities from national perspective
2002	*Sexual Knowledge and Attitudes of Adolescents in Samoa*	Adolescent Reproductive Health KAP Study Report	Samoa	UNFPA / University of the South Pacific (Kesaia Seniloli)	Other Quantitative survey eg SGS/BSS/KABP	yes	yes	yes - identifies youth at risk	yes	Interesting - some inconsistencies in some data need clarification
2002	*Reproductive Health Knowledge and Services in Samoa*	Reproductive Health KAP Study Report	Samoa	UNFPA / University of the South Pacific (Kesaia Seniloli)	Other Quantitative survey eg SGS/BSS/KABP	yes	no - defines information by women and men by 15-49 or 20-54 age groups	yes	for broader populations	useful for comparative data at broader population levels.
2000	*Strategic Plan for Responding to the Impact of HIV/AIDS in Women in Samoa (2001-2005)*	National Strategic Plan	Samoa	Ministry of Women, Government of Samoa	Policy /Strategy Document	no	no	yes	yes	dated
2006	*Tonga: A Situation Analysis of Children, Youth and Women*	Situation Analysis	Tonga	Government of Tonga & UNICEF	Donor Assessment /Evaluation Report	yes	yes	yes	yes	good qualitative overview
2008	*Second generation surveillance in antenatal clinic attendees and Youth,*	HIV/STIs Surveillance Reports	Tonga	Government of Tonga & SPC	Other Quantitative survey eg SGS/BSS/KABP	yes	yes	yes	yes	good - provides comparative indicators with region and over time in key areas
2004	*Teenage Pregnancy in Tonga*	Teenage Pregnancy Research Report	Tonga	UNFPA / SPC	Donor Assessment /Evaluation Report	Yes	Yes	yes	y es	Excellent qualitative discussion with teenage parents, supplemented by review of hospital data
2006	*Annex 2.12 Tonga Country Analysis*	Country profile	Tonga	Pacific Regional HIV/AIDS Project (PRHP)	Technical Agency Report	Yes	no	yes	yes	Good overview of program activities to end 2008

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2009	*Adolescent Health and Development Database*	AHD Statistics	Tonga	Tonga Family Health Association (TFHA)	cant access the file					
2007	*Review of the HIV & AIDS Strategic Plan (2000-2005) for Tonga*	Evaluation Report	Tonga	Dr Sr Keiti Ann Kanongata'a	Policy /Strategy Document	no	yes	yes	yes	Lists concerns in relation to implementation of the HIV & STI strategy
2000	*Situational Analysis of STIs HIV AIDS in Tonga*	Situation Analysis	Tonga	Ministry of Health, Government of Tonga	Technical Agency Report	no	yes	yes	yes	Detailed documentaiton of issues, opinions and plans to address HIV & STI related risks and vulnerabilities - superseded by most recent plan
2008	*Evaluation of PRHP Grant Program in Tonga*	Evaluation Report	Tonga	SPC / Kellie Woiwood	Technical Agency Report	no	yes	No	yes	Provides a solid evaluation of the HIV &S TI program in tonga to end 2008 - with focus on yougn peolpel and changes in at risk behaviours identified
2000	*Strategic Plan for Responding to HIV/AIDS and STIs in the Kingdom of Tonga 2001-2005*	National Strategic Plan	Tonga	Government of Tonga	Policy /Strategy Document	no	yes	yes	yes	Useful planning framework
2007	*Government of Tonga & UNFPA: DRAFT Country Programme Action Plan 2008-2012*	Country Programme Action Plan	Tonga	Government of Tonga / UNFPA	Policy /Strategy Document	no	yes	yes	yes	solid
2009	*AHD In country Network Members*	AHD Network	Tonga	Tonga Family Health Association (TFHA)	list	no	yes - Tonga Natinoal Youth Congress a key stakeholder	n/a	n/a	n/a
2008	*Reproductive Health Section Data 2008*	RH Data	Tonga	Government of Tonga / Ministry of Health	Other Quantitative survey eg SGS/BSS/KABP	no	yes	yes	y es	good - 2008 TFR with age specific data
2008	*Update on HIV - Tonga*	HIV Statistics	Tonga	Dr. Fenua	?					
2008	*Access to Condoms and their Use Among Young People in Tonga and Vanuatu*	Condoms Research Report	Tonga & Vanuatu	Karen McMillin / National Centre in HIV Social Research	Technical Agency Report	Yes	yes	yes	yes	Excellent overview of qualitative and quantitaive data
2006	*Tuvalu: A Situation Analysis of Children, Youth and Women*	Situation Analysis	Tuvalu	Government of Tuvalu & UNICEF	Donor program assessment/Evaluation report	yes	Yes - youth defined age 15-34 (although traditionally, can be up to 49, in certain context)	yes identifies youth as at risk group	yes	Good qualitative overview with some quantitative data
2007	*HIV and other STIs in Tuvalu South Pacific*	HIV/STIs Surveillance Reports	Tuvalu	Government of Tuvalu (Stephen Homasi) / World Health Organisation (WHO)	Academic Report (Treatise Submitted as part of Masters Of Medicine, Sydney Australia)	NO	yes - BSS survey analyses of youth 15-24	identifies youth as at risk group	yes	Good Analysis of Second generation surveillance surveys on HIV & STIs
2007	*Adolescent Sexual Reproductive Health in Tuvalu, A report of the second Knowledge Attitude and Practice (KAPII) on Sexual Reproductive Health in Tuvalu 2007*	Adolescent Reproductive Health KAP Study Report	Tuvalu	Tuvalu Family Health Association (TuFHA)	Other Quantitative survey eg SGS/BSS/KABP	no	Yes - youth defined as age 14-25	no	yes	good - identifies some sampling issues however

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2007	*IPPF - Vision 2000 Fund Coordination , 2007 Half Yearly Report for EC-Funded V2F Projects*	TuFHA Report	Tuvalu	Tuvalu Family Health Association (TuFHA)	Donor program Assessment/ Evaluation report	NO	yes	No	yes	Good program report
2006	*Tuvalu Millennium Development Goals (MDGs) Report*	MDG Progress Report	Tuvalu	Government of Tuvalu / UNDP		yes	no	no	yes	Good overview of social and demographic data, some age specific commentary and indicators
2000	*Strategic Plan for Responding to HIV/AIDS and STIs in Tuvalu 2001-2005*	National Strategic Plan	Tuvalu	Government of Tuvalu	Policy /Strategy Document	no	yes	no	yes	
2005	*DRAFT Strategic Plan for Responding to HIV/AIDS and STIs in Tuvalu 2006-2010*	National Strategic Plan	Tuvalu	Government of Tuvalu	Policy /Strategy Document	no	yes - age 15-24	yes - youth identified at risk or high risk	yes	good overview of planned approach- now replaced by next strategy
2007	*DRAFT Strategic Plan for Responding to HIV/AIDS and STIs in Tuvalu 2008-2012*	National Strategic Plan	Tuvalu	Government of Tuvalu	Policy /Strategy Document	no	yes	yes - youth identified as risk or high risk	yes	good
2005	*Review of the Strategic Plan for Responding to HIV/AIDS and STIs in Tuvalu 2001-2005*	Evaluation Report	Tuvalu	Tuvalu National AIDS Committee (Stephen Homasi)	Policy /Strategy Document	no	es	yes	yes	good
2008	*Status of HIV Situation & Responses in Tuvalu*	Situation Analysis	Tuvalu	PRHP (Tamara Kwarteng)	Policy /Strategy Document	no	yes	yes - youth at high risk	yes	good - check currency given date
2008	*Tuvalu HIV AIDS AIDS Deaths -1980-2006*	HIV Statistics	Tuvalu	SPC	Other Quantitative survey eg SGS/BSS/KABP					couldn't print document
2006	*Tuvalu Situation Analysis and Response Review*	Situation Analysis	Tuvalu	Tuvalu National AIDS Committee (Cathy Vaughn)	Other National survey & assessments	no	yes	yes - youth a high-risk group	yes	good
2007	*A Study of Teenage Pregnancy in Tuvalu*	Operational research Study	Tuvalu	Government of Tuvalu /UNFPA	Other Quantitative survey eg SGS/BSS/KABP	yes	yes	Yes	Yes	Good - reports on both teenagers and health care providers
2007	*Vanuatu Female Sex Workers Survey*	Sex Workers	Vanuatu	Judy Gold & Siula Bulu, et al						
2005	*Health behaviour and lifestyle of Pacific youth surveys: a resource for capacity building*	Youth / Health	Vanuatu, Tonga, FSM	Health Promotion International	Technical Agency Report	yes				
	Investing in our Future: A Framework for Accelerating Action for Sexual and Reproductive Health of Young People									
2004	*Guide to Indicators for M&E National HIV/AIDS Prevention Programmes for Young People*	HIV Indicators for Young People								
					World Health report	none sourced				
					Academic report	none sourced				
					Demographic & Health Surveys	none sourced				