

ADDRESSING BARRIERS TO INTER-SECTORAL COLLABORATION BETWEEN HEALTH, EDUCATION AND WELFARE SECTORS IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH SERVICE DELIVERY IN THE SOLOMON ISLANDS

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Solomon Islands

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CONTENTS

2	Acronyms
3	Executive summary
4	Study aim
4	Background and literature review
14	Study methods
19	Survey findings
47	Summary of results
48	Conclusions
49	Recommendations
51	References
54	Annexes

LIST OF FIGURES

5	Figure 1. Map of the Solomon Islands
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LIST OF TABLES

17	Table 1. Summary of interviews, focus group discussions & survey conducted in the provinces of Honiara and Malaita
17	Table 2. Education, youth and health sector participant roles
18	Table 3. Participants' places of work
21	Table 4. Surveyed health workers' facility, location, and the number working in each facility
23	Table 5. Contraception method and number of children a client must have before respondents will prescribe contraception
24	Table 6. What method would you NOT recommend for youth clients with an STI?

ACRONYMS

ADH	Adolescent health	NYP	National Youth Policy
ADRA	Adventist Development & Relief Agency	OC	Oral contraceptive
ASRH	Adolescent sexual and reproductive health	OPD	Outpatient department
AusAID	Australian Agency for International Development	PDMC	Pacific Developing Member Country
CBO	Community-based organisation	PICT	Pacific Island countries and territories
DHS	Demographic and Health Survey	PTA	Parent Teacher Association
FBO	Faith-based organisation	RH	Reproductive health
FLE	Family Life Education	RN	Registered Nurse
HIV	Human immunodeficiency virus	SCA	Save the Children Australia
ICD	Intrauterine contraceptive device	SI	Solomon Islands
IEC	Information, education & communication	SIPPA	Solomon Islands Planned Parenthood Association
IPAM	Institute of Public Administration and Management	SPC	Secretariat of the Pacific Community
IPPF	International Planned Parenthood Federation	SICHE	Solomon Islands College of Higher Education
ISC	Inter-sectoral collaboration	SIDT	Solomon Islands Development Trust
MCHN	maternal and child health nurse	SRH	Sexual and reproductive health
MEHRD	Ministry of Education and Human Resource Development	STI	Sexually transmitted infection
MHMS	Ministry of Health and Medical Services	SWAps	Sector-Wide Approaches
MWYCA	Ministry of Women, Youth and Children's Affairs	UNDP	United Nations Development Programme
NA	Nurse Aide	UNFPA	United Nations Population Fund
NGO	Non-government organisation	UNICEF	United Nations Children's Fund
NHSP	National Health Strategic Plan	VCCT	Voluntary Confidential Counselling and Testing
NHPMSP	National HIV Policy & Multi-Sectoral Strategic Plan	WHO	World Health Organization
NSV	Non-scalpel vasectomy		
NYC	National Youth Council		

A note about the use of acronyms in this publication

Acronyms are used in both the singular and the plural, e.g. NGO (singular) and NGOs (plural).

Acronyms are also used throughout the references and citations to shorten some organisations with long names.

EXECUTIVE SUMMARY

“I really appreciate this survey and I hope that through this survey it will give us some way out to provide some improvement to the current activities we carry out, and I see the need, there is a big need. We must build on more, because our needs are plenty and currently we have limited resources, limited manpower, and if we trained the people in the community to take the lead in advocacy of information, I think we should have a good impact on our future especially for our youths”

(Study participant)

This study gathered information on adolescent sexual and reproductive (ASRH) services and education provision in Honiara Town and Malaita province in the Solomon Islands and explored ways in which collaboration between the health, education and youth sectors could be feasibly enhanced.

Focus group discussions, interviews and surveys were held, involving 147 teachers, principals, youth workers and health workers. Two stakeholder meetings were held in Honiara in September 2012 to provide feedback on the findings and to generate stakeholders’ suggestions on policy recommendations. Stakeholders meetings were attended by high level staff from various Ministries.

This report explores barriers to the provision of ASRH services and the current perceived roles and functions of health, education and youth workers in responding to ASRH needs. The findings identify barriers to young people accessing advice and help, an uninformed group of early school leavers, gaps in contraceptive service provision, uncertainty about professional roles and advice, and a poor understanding of policy related to ASRH among health, education and youth sector workers.

Advising adolescents in this sensitive area presents challenges to professionals attempting to work within community norms. We explore examples of inter-sectoral collaboration currently being undertaken to face these challenges and propose ways in which collaborative action could improve ASRH service delivery.

STUDY AIM

1. To conduct an in-depth study in Honiara Town Council and Malaita province, Solomon Islands, to identify from the perspective of providers, the real and perceived gaps in adolescent sexual and reproductive education and service delivery.
2. To explore the feasibility of inter-sectoral collaboration between the education, health and youth welfare sectors in optimising health outcomes for adolescents in the Solomon Islands.

BACKGROUND AND LITERATURE REVIEW

Introduction

This report focuses on adolescents, defined by the World Health Organisation (WHO) as those aged between 10-19 years, but also encompasses youth, those aged 15-24. The term 'young people' encompasses both age groups (10-24 years) [WHO 2009].

The *Solomon Islands Youth Policy* defines youth as young men and women aged 14-29, but also acknowledges that this is a dynamic definition that can change depending on cultural beliefs and context [Ministry of Women, Youth & Children's Affairs 2012].

A benchmark global definition of sexual and reproductive health (SRH) was developed at the International Conference on Population and Development (ICPD) in 1994, which the Solomon Islands government ratified. The ICPD definition of reproductive health (including sexual health) is:

"... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes....people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so... the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" [UNFPA, 1995].

Country context

The Solomon Islands is a vast archipelago in Melanesia which stretches from Papua New Guinea toward Vanuatu in the South West Pacific.

The country is divided into nine administrative provinces, and the Capital Territory Honiara [Government of Solomon Islands & SINAC 2012].

The total population of the Solomon Islands is estimated as 552,000 [Population Reference Bureau 2012].

Ninety-three percent of its people are Melanesian in origin – comprising of a diverse people with over 80 different language and ethnic groups [Martiniuk et al. 2008]. Christianity has a large influence on Solomon Islands society [Weir 2000].

Most of the population live in rural areas (85%), although the majority of wage employment, facilities, transport and communication services, are found in the urban areas of Honiara and northern Guadalcanal [Allen 2012].

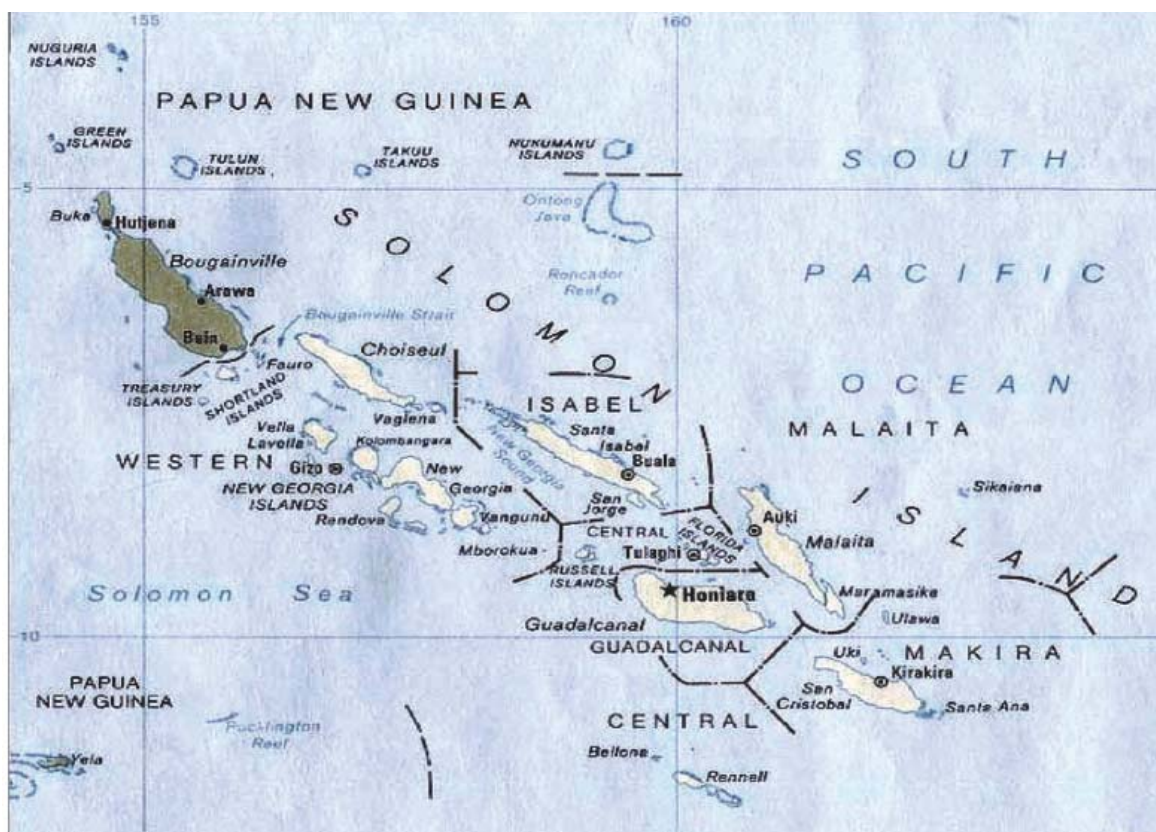
Islanders outside these provinces often lack basic services and usually rely on subsistence cultivation to survive [UNICEF 2005b].

The Solomon Islands is classified by the United Nations as a low-income (1,320 USD per capita in 2011) country and is one of the least developed among Pacific Developing Member Countries (PDMCs) [Asian Development Bank 2004].

Poverty worsened with the near collapse of the economy due to internal conflict in 1998-2003 and political rioting in 2006, and the majority of Solomon Islanders living in rural areas can be considered poor, although poverty is the deepest and most severe in Honiara [Asian Development Bank 2004; Clarke 2007; UNDP 2011].

The conflicts and recent natural disasters severely disrupted health services in the country, and as a result health status and social indicators also deteriorated [UNICEF 2005b].

FIGURE 1. MAP OF SOLOMON ISLANDS



Adolescent vulnerability

Young people are regarded as one of the most vulnerable groups in the Solomon Islands because early school leaving, high levels of unemployment and limited opportunities for education have created large numbers of disaffected youth [UNFPA 2006].

The National Census of 1999 recorded that youth employment was as high as 61 percent and in 2000, the Ministry of Education and Human Resources Development (MEHRD) estimated that 44,000 young people had not been in paid employment since 1986 [UNFPA 2006].

Substance abuse, sexual health problems and prostitution are increasing among young people as they relocate to urban areas in search of employment [Noble et al. 2011].

Only half of all primary school aged children were attending school in 2007, and only half again are able to attend high school due to limited places. According to reports, as many as 65 to 85% of students are excluded from high school due to failing compulsory examinations or an inability to pay school fees [UNICEF 2005b].

Improving adolescent sexual and reproductive health (ASRH) and rights is critical to the wider development agenda of the Solomon Islands, particularly as more than half the population is under 20 years [UNICEF 2010].

The Solomon Islands has one of the highest population growth rates in the Pacific and its young age structure has created a demographic momentum that means the population will continue to grow rapidly and is expected to more than double by 2050 [Population Reference Bureau 2012].

Future social and economic development depends upon a healthy, productive population, but there are significant challenges that need to be addressed. Major sexual and reproductive health issues facing young people are: high levels of teenage pregnancies; sexually transmitted infections (STIs); and sexual violence [UNFPA & USP 2009].

The legal age of consent for marriage and sex is 15 years of age, but custom marriage can be used as an excuse for sexual relations with girls under 15 years [Holmes & Slater 2012; Solomon Islands Law Reform Commission 2010]. In the Solomon Islands 'sexual

Sexuality topics are generally taboo in the Solomon Islands according to custom, tradition and religion ...

touching of a child' is currently not an offense, nor is sexual abuse of those aged 16-18 years by a person in a position of "trust, authority or guardianship". Child prostitution offences are very low [Solomon Islands Law Reform Commission 2010].

Early and frequent sexual relations and repeated childbirth in children, before they are sexually mature or psychologically ready, places children and adolescent girls at a higher risk of pregnancy related death, violence, and poor health.

All these factors perpetuate poverty and are a great obstacle to education [UNICEF 2005a].

Knowledge of sexual and reproductive health is generally very poor and sexual and reproductive health services are often inadequate and inaccessible for adolescents [Ben & Siama 2007; SPC 2011].

Sexuality topics are generally taboo in the Solomon Islands according to custom, tradition and religion. This, combined with a perceived lack of power over health decisions means that it is very difficult for adolescents to make informed decisions about their sexual and reproductive life [Ben & Siama 2007; SPC 2011].

Although the United Nations considers that there is a growing acceptance of family planning among community and traditional leaders, some influential religious leaders and groups continue to remain opposed. According to a 2006 UNFPA situational analysis, many parents, teachers and health educators are concerned that sexuality education leads to greater promiscuity and sexual experimentation. Cultural practices and beliefs and a lack of knowledge and confidence about sexual health means that it is not usual for parents to discuss SRH issues with their children or amongst themselves [Buchanan-Aruwafu et al. 2003; UNFPA 2006].

Ongoing opposition within sections of the community to prescribing contraception for adolescents and misconceptions among health staff in the provision of family planning services for adolescents have contributed to low condom and contraception use. Combined with a high level of sexual activity amongst adolescents, this has ensured relatively high levels of STIs and teenage pregnancies [Ben & Siama 2007].

Steadily increasing STI rates (between 4-8/1000 notifications since 2004, and rising to 13/1000 post 2004) have been reported [Foster et al. 2009]. The government has concerns about the vulnerability of youth to HIV infection because of high proportions of unprotected sexual encounters (67%); early age of sexual debut (15% of all 15-19 year olds sampled); high numbers of forced sex (45.9% of Choiseul province sampled); and a low knowledge of HIV/AIDs (32%) [Government of Solomon Islands & SINAC 2012].

Amongst 15-19 year old girls, the adolescent fertility rate is very high (67/1000 women aged 15-19 years) [The World Bank 2012]. Approximately 12% of women aged 15-19 and 9% of 15-year-olds already had a child at the time of the Demographic and Health Survey (DHS) [National Statistics Office et al. 2009; Pego 2012]. More than half of young women in the 2006-2007 Solomon Islands Demographic and Health Survey (SI DHS) reported that their last pregnancy was unintended, indicating a considerable unmet demand for family planning.

Although knowledge of modern contraception methods is almost universal amongst women in the Solomon Islands, only 27.3% of married women and 16.2% of unmarried sexually active women were using contraception at the time of the SI DHS survey. Most women in the Solomon Islands do not begin to use contraception until they have had at least one child [National Statistics Office et al. 2009].

Authors of a UNFPA report noted that it is not uncommon for young women to present at the National Referral Hospital with complications from attempted abortions, although it is illegal, except to save the life of a pregnant woman [Ben & Siama 2007].

Mortality and morbidity related to unintended pregnancy and child birth, including unsafe abortions

... there is evidence that **many health workers still require parental consent before prescribing contraception and other SRH services for adolescents or 'do what they think is best'**

remain a significant health risk for young women [WHO 2008].

Recent studies on violence against women in the Solomon Islands indicate that more than 60% of women were severely abused physically and sexually at some time during their lifetime; more than 30% of them were sexually abused below 15 years of age and about 40% of young women's first sexual experience was forced. Many of the perpetrators are also adolescents [UNDP 2011].

Government ASRH plans, policy and strategy

Efforts have been made by the Solomon Islands (SI) government to address the reproductive needs of adolescents since they endorsed the IPCD in 1994.

The Population and Reproductive Health Plan (2011-2013) addresses adolescent health issues such as youth friendly services, prevention of unplanned pregnancy, STIs/HIV and high risk sexual behaviour. Targets include:

- providing life-skills education to at least 75% of high school students by 2013;
- at least 50% of adolescents and young people to receive comprehensive SRH information;
- at least 75% of men, women and adolescents to be aware of common STIs and HIV/AIDs prevention.

According to the UNFPA, policy has been developed supporting the provision of reproductive health services for children 12 years and over without parental consent [UNFPA 2006], however, there is evidence that many health workers still require parental consent before prescribing contraception

The Ministry of Health and Medical Services (MHMS) has been responsible for implementing a number of plans and policies that are concerned with adolescent/youth issues.

and other SRH services for adolescents or ‘do what they think is best’ [SPC 2011].

The government is currently working with the UNFPA, UNICEF and SPC to implement the Adolescent Health and Development Program (ADH) [Pego 2012] to address the needs of young people, which has four key components:

1. Enhance a supportive policy environment and enabling community environment
2. Strengthen gender sensitive and life-skills based SRH education for young people
3. Strengthen youth friendly services
4. Enhanced program management and delivery

The Ministry of Women, Youth, Child and Family Affairs (MWYCFA) is the lead ministry responsible for youth issues and coordinating and implementing youth policy:

- A National Youth Policy 2010-2015 (NYP) provides programmes and strategies to address the needs of youth aged between 14-29 [Ministry of Women, Youth & Children’s Affairs 2012]. Priority outcome 3 states: *“youth and health improved through equitable access to health services for young women and men”*. Under this policy the youth budget allocation has increased; youth officers have been recruited for national and provincial offices; and youth policies and action plans have been formulated for each province [UNFPA 2006]. However, the government acknowledges that implementation of this policy has been “weak” with “no real sense of ownership” [Ministry of Women, Youth & Children’s Affairs 2012].

- The National Youth Congress (a quasi-governmental organisation, affiliated with MWYCFA Youth Development Division) advocates to government on behalf of youth and monitors the implementation of the NYP [Ministry of Women, Youth & Children’s Affairs 2012]. The Congress has been successful in launching provincial youth policies and action plans in recent years, but has struggled because of capacity constraints.
- The National Steering Committee is the highest decision-making body regarding the implementation of youth policy – it is planned that this committee will meet annually to assess youth development [Ministry of Women, Youth & Children’s Affairs 2012].
- The National Youth Stakeholders Committee meets quarterly to coordinate cross-sector policies and programs related to youth development and receives feedback from the government regarding implementation of the NYP. The Committee is comprised of public and private sector organisations which implement youth programs and activities.
- A national policy on the Elimination of Violence against Women (EVAW), and a 10-year National Action Plan to guide its implementation has been developed [Ministry of Women, Youth & Children’s Affairs]. Young people are mentioned specifically in strategic area 3 – *“eliminate violence against women through programs in schools”*.

The Ministry of Health and Medical Services (MHMS) has been responsible for implementing a number of plans and policies that are concerned with adolescent/youth issues:

- The National Health Strategic Plan 2011-2015 (NHSP). The number one priority outlined in this plan is that *“The health sector and some health-related sectors, especially education, will reduce the most important individual and family behaviour-related risk factors through health promotion and some prevention services”* [The Ministry of Health & Medical Services SI Government 2011].
- A joint development strategy action plan developed between SPC, UNFPA and UNICEF,

with the support of the SI government, outlines strategies to prevent HIV/AIDS and other sexually transmitted infections (Strategic Area 6), and Strategic Area 7 aims to improve RH services and uptake of family planning methods with more of a focus on the sexual and reproductive health of young people [Chen 2012].

- The National HIV Policy and Multi-sectoral Strategic Plan (NHPMSP) has a section devoted to youth and children which focuses specifically on the risk factors for young people in the Solomons, including unsafe sex, multiple partners and low condom use. The importance of sex education and appropriate awareness, especially for girls, is highlighted and non-formal education is a priority [Solomon Islands Government, Solomon Islands National AIDS Council & NGOs 2005].

ASRH services in the education sector

Health topics are currently being offered to students in primary and secondary schools (and tertiary institutions) as part of the general curriculum [SPC 2010]. Topics such as basic human reproduction, sexual development and HIV/AIDS prevention are taught as part of science and home economics subjects.

A 'fully fledged' life skills and gender sensitive based SRH/HIV national curriculum is currently being planned and developed with the support of the UNFPA. The government aims to promote sexuality education (family life education), through the formal education curricula [SPC 2010]. Piloting in some primary schools is currently underway.

Available evidence suggests that what is currently offered is often poorly delivered or not at all. Many teachers lack understanding about fundamental SRH information; can be resistant to teaching it; and lack support for its delivery. In addition, they often face disapproval and resistance from parents [SPC 2010].

The education system faces a chronic shortage of trained teachers – in 2005, 20% of all secondary teachers were reported as unqualified – as well as a chronic shortage of classrooms and basic materials [The Ministry of Education & Human Resources Development 2007].

A 2002 development report noted that there is no school-based quality assurance mechanism

The government and donor partners are seeking to **address the lack of teacher capacity and exposure in life skills pedagogies.**

to evaluate performance of teachers and the school. Government school inspectors carry out quality assurance visits, once a year or not at all [Government of Solomon Islands 2002].

The government and donor partners are seeking to address the lack of teacher capacity and exposure in life skills pedagogies. Family Life Education (FLE) is now taught in pre-service teacher training colleges (SPC), and a UNFPA-supported intervention has accredited over 500 teachers with life skills and gender sensitive based pedagogical competencies.

But the education sector faces an urgent demand for trained teachers and school infrastructure which may delay progress [Government of Solomon Islands 2002]. In 2005 there were about 17,000 places available for secondary form 1-3 students, but it was predicted by 2009 that to educate all the students coming through there would be a need for over 40,000 places for students [The Ministry of Education & Human Resources Development 2007].

Syllabi, teachers' handbooks and curriculum review are undertaken or developed by curriculum panels in the Curriculum Development Centre, Ministry of Education and Human Resource Development.

ASRH services in the health sector

Judgemental attitudes by many health workers are still a significant barrier for youth accessing health services for SRH advice and/or contraception in the Solomon Islands.

Many health workers do not receive adequate training, or have inadequate support [SPC 2011]. There remains a serious shortage of health workers [WHO 2006], and a shortage of condoms, drugs and equipment and medical supplies [Foster et al. 2009; Government of Solomon Islands 2002].

A lack of staff incentives and knowledge about relevant adolescent policy also complicates the provision of services for young people.

There are a number of 'youth friendly' clinics in the Solomon Islands, some run by the government and others by NGOs [Pego 2012]:

Government adolescent youth friendly health services:

- Rove clinic (Honiara City Council)
- Kukum clinic (Honiara City Council)
- Lata hospital clinic (Temotu Province) – opened in 2011
- Vonunu (Western Province) – a youth centre integrated with HIV/STI VCCT services
- SICHE (MEHRD)

NGO & faith-based youth friendly adolescent health services:

- SIPPA (Honiara)
- SIPPA Auki (Malaita province)
- SIPPA Gizo (Western province)
- SIPPA Taro (Choiseul province)
- Helena Goldie Hospital clinic (Western province) – run by Wesley United Church

Other private church-run and public provincial hospitals and primary health clinics also provide SRH services for adolescents, but these services are integrated with adult services (often maternal and child clinics) and do not set aside waiting areas or clinic hours for young people.

An *ad-hoc* referral system exists between the health providers so that a more complete range of services are offered (though this also creates problems with absentee referrals)[SPC 2011].

Primary care for adolescents is also served through Area Health Centres (AHCs), Rural Health Clinics (RHCs) and Nurse Aid Posts (NAPs).

The majority of trained doctors work in the National Referral hospital (the only tertiary hospital in the country), while nurses, nurse aides and village health workers staff rural provincial services [Government of Solomon Islands & SINAC 2012].

Routine screening for HIV occurs in many antenatal clinics and Voluntary Confidential Counselling and Testing (VCCT) clinics have been established in recent years.

Many young people do not access these services because they are unaware of the services available; they are not accessible; or there is a lack of privacy. Those that do access health services for contraception usually attend government clinics, where contraception is free, or NGO clinics which charge a small fee [SPC 2011].

Young people often resort to accessing *kastom* treatment for STIs and abortion because they are able to avoid the judgemental attitudes of clinic staff [UNFPA 2006].

Routine screening for HIV occurs in many antenatal clinics and Voluntary Confidential Counselling and Testing (VCCT) clinics have been established in recent years. There is a lack of support or counselling services available for pregnant teenagers because of societal attitudes [UNFPA 2006].

Although many health workers have been trained in providing VCCT for HIV, they are not provided with 'broad counselling training' aimed at emotional, social and or physical development of young people [SPC 2011].

There are also a number of school and community peer outreach programs which are run by the Ministry of Health and Medical Services under the Adolescent Health and Development Program [SPC 2011]. Parents are usually not included in peer outreach activities, and there is limited support amongst parents in the provision of SR health services [SPC 2011].

ASRH services in the youth welfare sector

Most young people leave school early and they are therefore not able to access formal SRH education. NGOs, faith-based organisations (FBOs) and other

community-based organisations (CBOs) therefore play a very important role in the provision of non-formal education and health promotion programs.

However, most health promotion and education services are centrally located and therefore NGOs usually deliver community-based SRH peer education to out-of-school adolescents primarily in the urban centers of Honiara, Gizo and Auki. In the villages there has been some effort to provide mobile trainers delivering short courses, drama and workshops. Many peer educators who deliver information are volunteers [UNFPA 2006].

Key NGOs and FBOs working to improve ASRH in the Solomon Islands include: SIPPA, ADRA, Save the Children, World Vision and the Red Cross. All of these agencies work in loose or formal collaborations with private and/or public organisations to fund, develop and/or implement their adolescent programs. Some examples of SRH programs follow:

- In 2004, UNFPA, UNICEF and the Secretariat of the Pacific Community (SPC) implemented the *Adolescent Reproductive Health and Development Program* (AHD) to improve ASRH in the Solomons through the development of reproductive health protocols, IEC materials, outreach programs, health worker training and the upgrading of knowledge and skills [Chen 2012].
- *The Solomon Islands Planned Parenthood Association* (SIPPA), (under the International Planned Parenthood Federation umbrella), an NGO based in Honiara, has a leading role with the Ministry of Health in the provision of sexual and reproductive clinical, education and promotion services for adolescents [IPPF 2012]. One of the SRH programs they currently offer is the SISTA SAVE program which offers life skills programs for single mothers in partnership with the Young Women's Christian Association (YWCA-SI) and Family Planning International New Zealand. They also focus on training community peer educators to deliver information in schools [FPI 2008-2012].
- *The Adventist Development and Relief Agency* (ADRA) is a faith-based relief agency involved in youth projects such as the Youth Engagement and Livelihood Project [ADRA 2009]. This project provides livelihood training and educates young people and others in their community on the

Key NGOs and FBOs working to improve ASRH in the Solomon Islands include: SIPPA, ADRA, Save the Children, World Vision and the Red Cross.

consequences of destructive behaviours such as substance abuse and risky sexual behaviours. In 2003, ADRA established a reproductive health church committee comprising of eight Christian denominations to engage churches in providing SRH IEC materials to their communities [Family Planning International 2010]

- *Save the Children* also conduct youth outreach life skills and health education projects, and currently has an *HIV and STI prevention project* which is helping to build the capacity of government clinics to provide better quality and youth-friendly HIV related services [Save the Children 2012]
- *World Vision* relief agency currently uses the Channels of Hope approach – which uses a biblical perspective to train faith leaders to initiate activities concerning topics such as HIV and AIDS, maternal and child health and gender-based violence in their communities [World Vision].
- *The Church of Melanesia* undertakes peer education activities and use of the Stepping Stones program in collaboration with *ADRA*, *Oxfam* and *World Vision*. The Stepping Stones program targets community members and engages them in a series of weekly workshops on sexuality, HIV/AIDS, gender violence and relationship skills [SPC 2009].
- *Solomon Islands Development Trust* (SIDT) is a local NGO undertaking community-level development. SIDT works with villages across the Solomon Islands to promote community empowerment in education, health and other areas. The SIDT's Sei Theatre Group involves youth in HIV preventions plays [SPC 2009].

Churches have also started to incorporate reproductive health into their youth programs, focusing on bible scriptures and an 'abstinence and be faithful' approach to health and family issues.

Condom promotion is usually not supported [UNFPA 2006].

The UN reports that although many church programs engage young people in youth programs, many young people are excluded if they are found to have engaged in out-of-wedlock sexual activity [Noble et al. 2011]. However, the support and involvement of some religious and traditional leaders in ASRH programs has enhanced community awareness and acceptance of services and information [UNFPA 2006].

Inter-sectoral collaboration to improve adolescent health

The majority of documents, strategies and policy documents concerning youth in the Solomon Islands recognise the importance of strengthening collaboration between sectors to improve ASRH. However, very few document how this should be done or ways that it can be strengthened.

Literature on collaboration that is available is mainly concerned with the need for collaboration of international donors and key actors to improve efficiency, effectiveness and equity. Martiniuk's [2008] study, for example, involving interviews with key MHMS and NGO informants in the Solomon Islands, noted that there was a need for long-term co-ordination and integration of aid. Study informants were also concerned about external donors setting the countries health priorities, which were often different from the government's health priorities, and noted the need for all the private, public and civic organisations to work in partnership [Martiniuk et al. 2008].

The MHMS's health plan and HIV strategy outlines a sector-wide approach, recognising the need, for example, for the education sector to work more closely with the health sector to improve adolescent health.

A UNDP report noted that in recent years the Solomon Islands government has supported collaboration between youth stakeholders, and has charged the MWYCF to enable and encourage dialogue between relevant government departments, and youth organisations [Noble et al. 2011].

One example of this in practice is the National Youth Stakeholders Committee, which is composed of representatives from government, NGOs, CBOs and FBOs who work in youth programs. This group meets regularly to report progress and receive feedback from the government about progress of the youth programs [Pego 2012].

Formal partnerships or collaboration between sectors to improve health are promoted as a way to address complex determinants of SR health, (such as gender and education inequalities), which require the health sector to enter into partnerships with other sectors to address them.

The WHO defines inter-sectoral collaboration (ISC) as a relationship between sectors which form *"to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way which is more effective, efficient or sustainable"* [WHO 1997]. This type of collaboration does not involve organisations simply working together, but instead involves those partnerships with a commitment to mutual relationships and goals [Mattessich et al. 2001].

Although evidence is limited concerning the effectiveness of ISC, it appears to be a promising approach in low income countries particularly because it enables cost sharing, collective problem sharing, knowledge exchange and an increased capacity to sustain programs.

However, facilitating the involvement of organisations that have a different focus can be notoriously difficult as new processes must be set up to share power and decision making [Butterfoss & Kegler 2002].

Bureaucratic regulations, political barriers, cultural differences and high turnover of staff all create barriers to effective collaboration [Aguilar et al. 2010].

There are a number of NGOs, FBOs and CBOs who are engaged in STI and HIV prevention, but the government considers that the scope and range of their activities has been limited due to a lack of facilitated collaboration with other key actors, towards a functioning and coordinated multi-sectoral response.

The National Youth Policy for example, is considered a "document in name only" and alignment by

At a national level and NGO level, there is recognition that **there is a need for coordination of activities** so that there is more accountability and coherence of efforts.

development partners almost “non-existent” [Ministry of Women, Youth & Children’s Affairs 2012]. Nonetheless, there are some mechanisms to encourage collaboration, such as relevant line ministries and NGO quarterly meetings to plan ASRH programs [UNFPA 2006].

The government is leading a Sector-Wide Approach (SWAs) to pool development funding and they are increasingly moving towards joint planning, harmonisation and coordination [The Global Fund 2009].

Currently, there are moves for all relevant government departments to develop adolescent and youth plans and strategies together at a national level, but at a provincial level, collaboration is hampered by a lack of coordination for ASRH. There are 10 RH coordinators for each of the 10 provinces, but no-one is responsible solely for adolescent SRH.

In addition, an AIDs response progress report states that there are insufficient HIV and Adolescent Development coordinators, and a high turnover of health staff at the provincial and rural health units, which affects the performance of programs and outcomes [Government of Solomon Islands & SINAC 2012].

There has been criticism that collaboration between the MEHRD, MHMS and NGOs around ASRH issues for schools and out-of school youth is ‘weak’ – one report says there is a lack of concern by stakeholders about SRH issues [AHD section & SPC 2010].

Much of the criticism is directed at the lack of community stakeholder involvement in national planning processes. For example, participation of local communities and parents is sometimes neglected by education curriculum developers,

and people living with HIV and other key affected populations have had minimal input into designing and implementing HIV prevention and anti-discrimination activities [The Global Fund 2009].

In communities, NGOs work through schools, health centre committees, village development committees and women’s groups, but collaborative efforts are rarely documented.

At a national level and NGO level, there is recognition that there is a need for coordination of activities so that there is more accountability and coherence of efforts. Most NGOs work co-operatively with the MHMS and other agencies but there is said to be varying degrees of cooperation with health agencies.

A more complete picture will emerge if efforts to collaborate between sectors are comprehensively documented.

STUDY METHODS

Study sites

- Honiara Town Council, Solomon Islands
- Malaita Province, Solomon Islands

These sites were chosen in order to gather a variety of information from an urban centre where the majority of health services are located (Honiara), as well as rural locations where provincial hospitals and rural health clinics are located (Honiara Town council and Malaita province). The views of both rural and urban sector workers are therefore represented in this study.

Study design and data collection procedures

This study is underpinned by an approach using both qualitative and quantitative approaches in tandem. Data obtained from a literature review, key informant interviews, surveys, and FGDs were triangulated in order to provide a comprehensive analysis of the research issue [Creswell 2009].

The research methods employed to address the central aim of the study follow:

1. Scoping review of literature

A scoping review of literature [Arksey & O'Malley 2005] pertaining to existing ASRH services and projects in the Solomon Islands was undertaken. The purpose of this review was to explore the current state of services offered to adolescents and the sectors involved in their provision.

This 'scoping review' traversed relevant white and grey literature, including policy documents and recent reports. The literature identified as having relevance was examined by the researcher(s) through an inductive process referred to as 'charting', using *Microsoft Excel* and *Microsoft Word*. As described by Ritchie & Spencer [1994], 'charting' entails interpreting and synthesising data through a process of sorting it according to key themes and issues, and enables a synthesis of key sources of literature to be undertaken.

2. Focus group discussions (FGD)

Focus group discussions, which enable the production of rich qualitative data [Fontana & Frey 2005] of the

kind useful for a situational analysis, were conducted at schools, health centres and youth centres.

In order to ensure adequate cross-sectoral representation of relevant sectors and a diversity of views, focus group participants included public health workers; nurses and program officers from the health sector; teachers and curriculum developers from the education sector; as well as youth coordinators and adolescent health educators from the youth sector.

To provide adequate opportunity for discussion on the part of each and every participant, and to minimise the emergence of *group think* [Fontana & Frey 2005] each focus group consisted of a maximum of 8-10 participants, and was led by an experienced facilitator from the study team.

A total of 7 focus group discussions were facilitated in both Honiara and Auki consisting of a total of 56 participants. Each focus group lasted between 1 and a half to 2 hours. All discussions were digitally recorded and transcribed verbatim – where Pijin (Pidgin) was used, this was translated in to English by the Solomon Island research team.

The focus group discussions were conducted with a prepared discussion guide, which focused on the following questions:

1. **What are the current ASRH services?**
2. **What are the gaps and obstacles to service delivery?**
3. **What are attitudes to adolescent needs and who should be involved in service delivery?**
4. **What are training needs?**
5. **What are the opportunities for inter-sectoral collaboration between sectors?**

3. Key informant interviews

Semi-structured key informant interviews were carried out to determine health, youth and education professionals' (particularly opinion leaders) views on: gaps and obstacles to services delivery; attitudes to adolescent needs; who should be involved in service delivery; training needs; and opportunities for inter-sectoral collaboration between sectors in adolescent sexual and reproductive health.

4. Specialised surveys

A specialised survey was undertaken to collect information on what is known, believed and practised in the field of ASRH in the Solomon Islands with a small sample of health and education sector workers. All surveys were distributed in paper form. The Solomon Islands research partners collected completed paper forms and the data was manually entered into a database. The analysis of the survey was performed manually using Excel spreadsheets.

Specialised surveys facilitate focused research on priority issues, providing detailed information that can be linked to national statistics [Menchini & Yaqub 2007]. Findings from this survey are expected to provide a snapshot of ASRH service provision in the Solomon Islands.

5. Data analysis

Analysis of data collected was performed in Sydney, in consultation with all stakeholders primarily through teleconference and email discussion. Thematic analysis of key informant interviews and focus group transcripts, as well as detailed analysis of the survey findings was undertaken.

Interview and focus group discussion transcripts and survey data were entered in to the QSR NVivo software program (QSR International), where they were subsequently coded for thematic analyses. Key themes were established based on convergence of the collected data.

Development of joint recommendations

Two stakeholders' meetings were held in Honiara in September 2012 to feedback the findings and develop recommendations. Those contributing to discussion included:

- Study participants
- Key decision-makers in the Ministry of Education, Human Resources and Development (MEHRD), the Ministry of Health and Medical Services (MHMS) and the Ministry of Women, Youth, Child and Family Affairs (MWYCFA)
- NGOs
- Relief agencies

Ethical issues

This study gained approval from the Human Research Ethics Committee (HREC) of the University of New South Wales in August 2011, approval number 11362. In-country ethics approval was granted by the National Research & Ethics Committee (NREC) of the Ministry of Health and Medical Services, Solomon Islands in November 2011.

Study time frame

The research was carried out from July 2011 to October 2012.

Instruments

Study data collection tools include:

- Surveys for health and education sector professionals (questionnaire)
- Interview guide for key informant interviews with health, education and youth sector professionals
- Focus group discussion guide for health, education and youth sectors.

The survey was adapted from Pathfinder International tools [Adamchak et al. 2000], in consultation with the Solomon Islands research team. Survey responses are reported by the relative proportions of respondents.

The focus group discussion and interview question guides were designed to answer the key research questions. The focus group questions were pilot tested in the Solomon Islands prior to implementation to further improve content. Following a review by the research team, the tools were subsequently revised and refined.

The participants

1. Participant recruitment for specialised surveys:

Health and education sector workers were purposively sampled from the two regions of Honiara and Malaita from lists of relevant staff who worked in ASRH obtained from the Ministry of Education and the Provincial Services Authority. The participants were selected to provide a diversity of views, and efforts were made to ensure the groups were balanced in terms of gender and position of authority.

Key issues that emerged were explored further by means of qualitative techniques.

2. Participant recruitment for focus group discussions and key informant interviews:

Education sector

FDGs: After seeking permission from the Ministry of Education, Human Resources Development and the Malaita Education Authority, a list of all the schools and teachers in the provinces of interest was obtained. Forty-two primary and secondary schools in the areas of interest for this study were identified, and were stratified according to their Education authority (provincial secondary, primary, faith-based and private schools). Principals and teachers who are involved in teaching science, home economics and health subjects at these schools were selected. Education sector workers including Ministry of Education staff were also purposively selected to take part.

Education sector key informant interviews: A total of 8 health sector workers from both primary and secondary schools in the study areas were purposively selected by the Ministry of Health and Medical Services, Solomon Islands, to take part by the Solomon Islands research team. One refused to take part.

Health sector

FDGs: A list of all health sector workers from primary health care, National Health Programs and the National Referral Hospital, who are involved in SRH related activities, was obtained from the Provincial Health Services Authority (n=222 in Honiara and 44 in Auki). Of these 266 health workers, 20 potential participants were randomly chosen (10 in Malaita Province and 10 in Honiara Town Council). All 20 agreed to take part.

Health sector key informant interviews: A total of 6 health sector workers from a range of seniorities and experience in ASRH were purposively selected by the Solomon Islands Ministry of Health research team. All 6 indicated their willingness to take part.

Youth welfare sector

FDGs: A list of those working with adolescents was obtained from the Ministry of Women, Youth, Child and Family Affairs (MWYFA) Solomon Islands, and from 17 NGOs in Honiara Town Council and the Auki/Langalanga region (Malaita Province). Twenty participants were purposively selected based on a range of seniority, demographic and geographical context and experience in the area of ASRH.

Youth welfare sector interviews: A total of 5 youth sector workers from a range of seniorities and work experience in ASRH were purposively selected by the Solomon Islands Ministry of Health and the research team.

TABLE 1. SUMMARY OF INTERVIEWS, FOCUS GROUP DISCUSSIONS AND SURVEY CONDUCTED IN THE PROVINCES OF HONIARA AND MALAITA

Sector	Interviews with key informants	Focus Groups	Survey
Health	6 interviews (RH nurse, HIV/STI coordinator, RH program officer, community health nurse, HIV/STI program officer)	x2 FGDs (x1 Auki, x1 Honiara) with a total of 18 participants	25 participants (RNs, nurse aides, midwives, youth volunteer, national adolescent health & development project co-ordinators)
Education	8 interviews (6 principals, 1 head of health curriculum, 1 deputy head of curriculum)	X3 FGDs (x2 Honiara, x1 Auki) with a total of 22 participants	49 participants (teachers, pastor, project officers/ manager, coordinators, HIV officer, health curriculum officer, youth HIV/STI officer, activist)
Youth/welfare	5 interviews (HIV/STI youth coordinator, community health educator, youth coordinator, women’s desk officer, youth friendly services officer)	X2 FGDs (x1 Honiara, x1 Auki) with a total of 15 participants	
Total	18	55	74

The participants selected to participate in the focus groups, key informant interviews and the survey

worked in a variety of positions. Table 2 below shows the positions of the participants:

TABLE 2. EDUCATION, YOUTH AND HEALTH SECTOR PARTICIPANT ROLES

Education sector	Health sector	Youth sector
Primary teachers	Registered nurses	HIV officer
Secondary teachers (home economics, science)	Nurse Aides	Women’s desk officer
Principals	Clinical nurse instructors	Nurses
Curriculum developers	Midwives	Project officers
Youth coordinators	Reproductive health officer	Youth volunteer
Project officers	RH counsellor	Coordinators
School nurse	STI/HIV facilitator	Livelihood project officer
Project managers	HIV/STI programme officer	Youth development officers
Peer educators	Project officers	Reproductive health peer educator
Activist	Health educators	MCHN coordinator
School tutor	Employment project officer	Pastor
	Youth & HIV/AIDs co-ordinator	

Education sector participants are from both primary and secondary schools and hold a range of positions: heads of departments, deputy heads, head teachers, senior teachers and young class teachers.

Education sector workers who participated also included curriculum developers, project officers, a school nurse, peer educators and youth coordinators. They work within the education system in schools; the Ministry of Education, Human Resource Development (MEHRD); and in the community.

Those participants who worked in schools are from a variety of private and public primary and high schools (council, provincial, government and faith-based private schools). The schools are located in both rural and urban areas.

Health sector workers include: nurses, nurse aides, midwives, health educators, youth HIV/AIDS coordinators, counsellors, STI/HIV programme officers, and clinical nurse instructors. Their places of work include rural and urban health clinics, provincial hospitals, a tertiary hospital and the Ministry of Health and Medical Services.

The youth sector workers include: a pastor, youth development officers, peer educators, nurses, volunteers and a livelihood project officer. The facilities they work at include the Ministry of Women, Youth and Children’s Affairs, NGOs, FBOs and CBOs.

Table 3 below shows the participants place of work according to each sector.

TABLE 3. PARTICIPANTS’ PLACES OF WORK

Education sector	Health sector	Youth sector
Primary schools	Health Clinics (rural & urban)	NGOs, FBOs, CBOs
Secondary schools	Youth friendly clinics	Relief agencies
Ministry of Education & Human Resource Development (MEHRD)	Hospitals – church-run, provincial and public (children’s ward, maternity, RH, OPD, labour ward, post natal ward, administration)	Ministry of Women, Youth and Children’s Affairs (MWYCA)
NGOs	Ministry of Health & Medical Services (MHMS)	Health clinics
Relief agencies		

The participants are almost 50:50 male/female, although a majority of the health sector participants are women and the majority of education and youth sector workers are men. The average age of the participants is approximately 35 years.

All the participants identified as being Christian (except for 1 who did not respond), 78% as Protestant (mainly Seventh Day Adventist followed by South Seas Evangelical, the Church of Melanesia, and the United Church), and 20% Roman Catholic. This broadly corresponds with Solomon Islander Christian affiliation as a whole.

SURVEY FINDINGS

Education sector findings

Education sector respondents all work in the education sector in a variety of positions and settings (total number of respondents n=49). However, some questions are only relevant to principals and teachers (n=31) or those whom directly provide ASRH education to young people, including teachers and health educators in the community (n=46). Therefore, where indicated, some findings specifically refer to 'teachers and principals' or those who directly provide services and some refer to all 'education sector workers' surveyed.

Is SRH taught in your school?

The majority of principals and teachers reported that sexual and reproductive health topics are taught at their school n=26 (84%), and 13% reported that it was not. Of those principals and teachers who said that SRH topics are not taught at their school, all are from primary schools; 2 from church schools, 1 from a community school and 1 from a council school. Three of these schools are located in rural areas, and 1 is located in Honiara.

Eighty-four percent of all education sector workers surveyed believed that sexual and reproductive health should be taught in schools and only two respondents did not believe that it should be taught. One did not know and 5 did not answer this question.

Principals and teachers reported that the most common SRH topics taught at their school are: anatomy and HIV/STIs, then sexuality, gender and norms followed by contraception. The human relationships topic is only taught by 5 teachers across grades 6-13.

What topic areas should be covered in the school curriculum and at what age?

When the education sector workers were asked what topic they thought should be taught in schools, about half indicated that adolescents in grades 10-11 should be taught: anatomy: 49% (n=24), contraception: 47% (n=23), sexuality gender and norms: 49% (n=24), HIV/STI's: 55% (n=27) and human relationships: 55% (n=27).

For grades 12-13, the proportions are a little lower: HIV/STI's: 37% (n=18) and human relationships: 37%

Eighty-four percent of all education sector workers surveyed **believed that sexual and reproductive health *should* be taught in schools** and only two respondents did not believe that it should be taught.

(n=18), anatomy: 39% (n=19), sexuality gender and norms: 39% (n=19), contraception: 41% (n=20).

For children in grades 6-9, only 12 (24%) thought that contraception should be taught, but proportions are similar or in some cases higher than the older age groups for the remaining topics: 18 (37%) indicated human relationships, 22 (45%) anatomy, 24 (49%) sexuality gender and norms, 28 (57%) HIV/STIs. One respondent indicated that culture and religion should be taught as part of the ASRH curricula.

Who should teach SRH to students?

When asked who should teach SRH, 24 (49%) of all education sector respondents indicated that they preferred health workers, and 23 (47%) preferred school teachers to do this. Three indicated 'other'.

Attitude to teaching ASRH topics

Nearly three quarters (n=35, 76%) of the education sector workers surveyed who directly provide ASRH education to young people stated that they are "comfortable" or "very comfortable" discussing SRH topics with students. However, of the remaining, 7 (15%) are "very uncomfortable" and 2 are "somewhat uncomfortable" in this situation. Two did not answer.

Attitudes to counseling students in SRH

When education workers (who directly provide services to adolescents) were asked what they would do if a young person came to them for help with a sexual or reproductive health problem, 35 (76%) said that they would refer the student to a health centre, 25 (54%) indicated that they would refer the student

to counselling, and over half of the respondents (n=24, 52%) would counsel the students themselves.

Nineteen (41%) would also inform the principal and while 17 (37%) would inform the student's parents.

SRH training

Forty two percent (42%) of all education sector workers had either received no training (22%), gave no answer (16%) or didn't know if they had received training (4%). 57% had received basic training in SRH, most of whom had completed it between 1 and 10 years ago (n=15, 31%). Eight had completed basic training over 10 years ago. Three respondents had finished basic training less than 6 months ago.

Nearly all respondents who had received basic training were trained in anatomy/biology, sexuality/gender, HIV, and contraception. Only 15 (31%) of respondents had received basic training in the human relationships topic. Eight respondents did not answer this question.

SRH in-service training

The majority of education sector workers (57%) had not received any in-service training on specific topics to enhance their performance in ASRH. Seventeen (35%) had received in-service training in the following areas, HIV, sexuality/gender, contraception, human relationships and counseling.

Teaching assistance

Fifteen education sector respondents (33%) directly involved in teaching SRH topics reported that they had received teaching assistance. Assistance was usually provided by science teachers and public health nurses. Four had received help from social workers, counsellors, NGOs and the MHMS.

Aware of SRH institutional policies

Only 7 respondents (14%) said that they were aware of any SRH institutional policy, such as UNHRC Rights of the Child, UNAIDS student menstruation policy. Nearly 70% were not aware of any policy. There was no major disagreement with any policy mentioned.

Counselling students in sexual reproductive health issues

One third of respondents (n=16 or 33%) reported that they had ever been involved in counselling students with SRH problems. Twenty-nine (59%) had never counselled students in SRH and 2 were not sure. Two did not respond to this question. Of those who had counselled a student, the nature of the issue follows:

- Relationships (n=10)
- Sexuality/gender (n=8)
- HIV/AIDS (n=7)
- Anatomy/biology (n=4)

The outcome of the consultation was that information and advice was given to the student by nearly all (87%) of the education sector workers who had counselled students in the past (16/49 respondents). Five referred the student to a clinic. No respondent made another counselling appointment with the student.

Health sector survey findings:

The respondents in this survey (n=25) work in a variety of settings in the health sector; 20 of these respondents are nurses or nurse aides working directly with youth in the provision of clinical services.

Five respondents work in adolescent health but are not directly providing clinical services to young people. Their positions are: clinical nurse instructor (working in an urban hospital); youth volunteer (community service organisation in a rural area); 2 Registered Nurse (RN) administrators (MHMS and provincial hospital); and an ADH coordinator (MHMS).

When the findings relate only to nurses and nurse aides, this is indicated; otherwise all health workers combined are referred to as 'health sector workers'.

TABLE 4. SURVEYED HEALTH WORKERS' FACILITY, LOCATION, AND THE NUMBER WORKING IN EACH FACILITY

Facility type	Ward/department/	Rural/urban/ Provincial centre	Respondent qualification/ position	No. of respondents working in facility
Tertiary hospital	Children's ward	Urban	RN	1
	Postnatal ward	Urban	RN/midwife	1
	Labour ward	Urban	RN/midwife	1
	Outpatient dept.	Urban	RN	1
	Reproductive health	Urban	RN	1
Provincial hospital	Children's ward	Provincial centre	RN	2
	Maternity ward	Provincial centre	NA	2
	Outpatient dept.	Provincial centre	RN/STI program manager	1
	Reproductive health	Provincial centre	RN/Midwife/ RH manager	2
Ministry of Health & Medical Services	STI/HIV	Urban	RN/STI facilitator	1
Council health clinic	Paediatric clinic	Urban	NA	1
NGO youth friendly clinic		Urban	RN/RH VCCT counsellor	2
Rural health clinic (RHC)		Rural	RN/gender empowerment facilitator	2
RHC		Rural	NA	1
Aid post clinic		Rural	NA	1
				Total: 20

ASRH services provided by health workers surveyed in Malaita and Guadalcanal provinces

Twenty registered nurses (RNs), midwives or nurse aides (NAs) indicated that they provide a range of SRH services to children, adolescents and youth at their health facility. Registered nurses are able to prescribe contraceptives.

Approximately 15 urban, provincial and rural hospital wards and departments, rural health clinics, youth friendly clinics and council clinics are represented in this survey.

The health faculties in Honiara tended to offer contraception, STI/HIV diagnosis and treatment or stand alone maternity services.

The provincial hospital clinics were notable for providing a wide range of services, including maternity, STI treatment, HIV testing and reproductive health education for young clients.

Health worker training

Basic training

Nearly all nursing/midwifery staff had been trained in contraceptive counselling, antenatal care, maternity care/delivery services, postnatal care, treatment of incomplete abortions, nutrition counselling, infertility consulting, and reproductive health education. One respondent had not received any basic training and no-one had received any basic training on gynaecological examination or pregnancy testing.

Nearly half of all respondents had received their basic training less than 10 years ago, and the remaining half had been trained between 10-26 years ago. One had finished basic training 28 years ago.

Refresher training

Nearly half of RNs/midwives and NAs had received refresher training in contraceptive counselling, antenatal care, maternity care, postnatal care, reproductive health education and nutrition counselling.

Just over a quarter had received refresher training in treatment of incomplete abortions, infertility consulting, pregnancy testing and gynaecological exams.

Approximately 70% had attended refresher courses focusing on contraceptive clinical skills, program

management on HIV/STI counselling and STI diagnosis and treatment.

Years working at current health facility

The majority of RNs/midwives and NAs surveyed have worked at their current health facility for less than 5 years (n=17 or 81%). Six have worked at their current facility for over 5 years (2 have worked for over 20 years at their current place of work).

Prescribing contraception for adolescents

Provision of contraceptive counselling and method in the past 3 months

Approximately 70% of nursing/midwifery staff in this study had provided contraceptive counselling to youth clients in the last 3 months, 2 respondents were unsure and the remainder had not provided any counselling. Of those who had, the methods most often provided to youth clients was condoms, followed by OCs, IUCD, injectable, vasectomy and natural family planning. Emergency contraception was provided to 3 clients. No youth client had been provided with spermicide or a diaphragm.

Limits on prescribing contraception

The nursing/midwifery staff were asked if there is a minimum age below which they will not prescribe contraception in the absence of medical contraindications. The number of respondents, the method and the age of the client they would not prescribe for follows:

- 35% of respondents would not prescribe **condoms** to youth. Of these, five provided the ages of the clients they would not prescribe condoms to: ≤ 10 years, 10-14 years, ≥ 40 years.
- 25% of respondents would not prescribe the **injectable** to youth. The ages that 4 health workers indicated they would not prescribe to are: ≤ 10 years, ≤ 20 years, 15-30 years, ≥ 40 years.
- 20% of respondents would not prescribe the **IUCD** for youth. The specific ages they will not prescribe follow: ≤ 10 years, ≤ 20 years, 10-14 years.
- 15% of respondents would not prescribe the **OC pill** for clients aged: ≤ 20 years.
- 1 respondent will not prescribe the **emergency contraceptive pill** for youth.

In addition, 8 respondents indicated that they would not refer a client for female sterilisation if the client is younger than 20 years old.

Minimum number of children before contraception is prescribed to clients

Following are the responses to the question: is there a minimum number of children a young woman must have before you yourself will prescribe (*certain contraception listed*) in the absence of medical contraindications?

Seven nurse/midwives indicated that, in their opinion, the client must have 1 or more children before prescribing condoms, 5 said that the client must have 1 child, or less than 4.

Nurses/midwives who were a part of this study were asked if they would prescribe certain contraception to unmarried youth, (in the absence of medical contraindications). Nearly all respondents indicated that they will prescribe condoms, 9 indicated that they will prescribe the OC, 4 would prescribe the injectable, 3 the IUCD, 1 the emergency contraceptive pill, and no health worker will refer the client for sterilisation.

Parental consent

Three of the respondents (14% of nurses/midwife respondents) require parental consent before prescribing the pill; 2 before prescribing the injectable and 1 for the IUCD. Nine (43%) would require parental consent before referring for sterilisation.

Prescribing contraception for preventing pregnancy

In the past month, 16 nurses and midwives (80%) had advised youth clients to use contraception specifically for preventing pregnancy. Six had not advised any youth clients to do so, one did not know and 2 did not answer this question.

Contraception and breastfeeding

The nurses/midwives involved were asked if a youth client asks for contraception and is breastfeeding an infant under six months old, what advice would they provide? Over 76% of respondents involved in this study would advise their client to continue breastfeeding and start contraception, but over a quarter (28.5%) would advise their client to continue breastfeeding and use no contraception until menses starts. Two of the respondents would 'treat her like any other client' and 1 would advise their client to stop breastfeeding and use contraception.

Contraception and a 14 year old sexually active client

If a 14-year-old client, who admits to being sexually active, comes to the health worker for contraception, 14 respondents (67%) would advise the client to abstain from having sex, but would provide the client with some condoms, just in case. Seven respondents would ask the client what type of method he or she prefers and prescribe that method for the client, and 2 would provide counselling. One said they would provide information.

TABLE 5. CONTRACEPTION METHOD AND NUMBER OF CHILDREN A CLIENT MUST HAVE BEFORE RESPONDENTS WILL PRESCRIBE CONTRACEPTION

Method	No. of children client must have before prescribing	No. of respondents (total n=7)
Condoms	1 or more children	5
	2-5 children	1
	14-16 children	1
Injectable	1 child	1
OC	2 children	2
IUCD	1 child	1
	10-15 children	1

TABLE 6. WHAT METHOD WOULD YOU NOT RECOMMEND FOR YOUTH CLIENTS WITH AN STI?

Method NOT recommend for youth with an STI	No. of respondents (Total n=20)
IUCD	17 (81%)
Injectable	10 (48%)
OC pill	10 (50%)
Natural FP	10 (50%)
Diaphragm	8 (38%)
Spermicide	8 (38%)
Norplant	7 (33%)
None	2
Condoms	0
Other	0

Contraception and high risk for STIs/HIV

If a youth client visiting for resupply of contraceptive pills appears to be at high risk of infection by STIs or HIV/AIDS, the majority of respondents would advise their client to continue with the pill but also use condoms (15 respondents, 75%). Eight would advise their client to change from the pill to condoms and 3 would advise their client not to have sex. No respondents would advise their client to stop using any type of contraceptive method, nor to continue to use only the pill.

Contraceptive method individual health workers would not recommend for youth clients with an STI

There were a number of contraceptive methods that health workers would not recommend for youth clients with an STI. As no respondents indicated that they would not recommend condoms this method appears to be the most acceptable to health workers when prescribing for youth clients with STIs. Refer to table 6 above.

Contraceptive method respondents would not recommend for a youth client

Six respondents (28.5%) reported that there is a method that they would never recommend under any circumstances, 6 indicated that there was not. Three stated that that they don't know, 2 said that it depends on their client's health, and 1 indicated that it depends on both client health and client

preference. No respondents reported that it depends solely on client preference.

Six health workers did not answer this question.

The methods that the respondents would not recommend under any circumstances for youth are:

- IUD (24%)
- OC/pill (14%)
- spermicide (14%)
- diaphragm (14%)
- norplant (9%),
- natural family planning (9%)

No respondent indicated condoms or emergency contraceptive pill as contraceptives that they would not recommend under any circumstances.

Awareness of institutional policies on providing contraceptives to youth

No health worker surveyed is aware of any policy concerning the provision of contraception to youth. Two did not answer.

Determining pregnancy status

Determining pregnancy status of a client if they are not menstruating

The nurses/midwives surveyed were asked what actions they would undertake to determine the

pregnancy status of a client who comes to the facility and is not having her menses.

All health workers indicated that they would determine this by performing a pregnancy test and 11 respondents (52%) would ask the client if there had been no sex since menses. Nine health workers (43%) would perform a physical exam.

Six nurses/midwives indicated that they would ask the client if it had been less than 6 weeks since delivery and 2 would tell the client to return at menses. One said that they would scan the client to determine pregnancy status. No health worker surveyed said that they would not determine their client's pregnancy status.

STIs/HIV

Actions undertaken by health worker if they think their youth client has an STI

All nurses/midwives, except for one, would request a laboratory test for their client and all respondents would also provide counselling. Nearly all indicated that they would treat the STI (85%). Other responses follow:

- 14 respondents would issue a contact or partner notification slip
- 11 would diagnose the STI
- 6 would refer the client for counselling
- 6 would refer the client for diagnosis

Action undertaken by health worker if youth client may have HIV/AIDS

If a youth client presents with complaints suggesting that he or she may be HIV positive or have AIDS, the majority of nurses/midwives would counsel the client (81%) and refer the client for testing (90%).

Sixty-two percent would refer the client for counselling (13 respondents).

Nine would refer the client for treatment, and 1 would refer for VCCT.

Forty-three per cent said that they would make a diagnosis (9 respondents) and 38% would treat the condition (8 respondents).

Most of the health workers are comfortable or very comfortable **discussing sexual behaviour relating to HIV/AIDS with youth.**

Advising youth about condoms and STI/HIV

In the past month, 17 nurses/midwives (80%) had advised a youth client to use condoms specifically for preventing STIs or HIV infection. Five respondents had not and 2 did not remember/did not know.

Provision of reproductive health services to client with HIV/AIDS

The vast majority of respondents (nurses and midwives) would provide reproductive health services to a client who has HIV or AIDS (18 or 86%). Four would not.

Three respondents did not answer this question.

How comfortable health workers are discussing sexual behaviour relating to HIV/AIDS with a youth client

Most of the health workers are comfortable or very comfortable discussing sexual behaviour relating to HIV/AIDS with youth (95%). However, some respondents marked more than 1 category when answering this question, possibly indicating some ambivalence, or reflecting the variability of the circumstances:

- comfortable (13)
- very comfortable (7)
- somewhat uncomfortable (3)
- very uncomfortable (1)

Termination of pregnancy

When asked if they were aware of female youth coming to their facility for advice on termination of pregnancies, 15 health workers (71%) indicated that they were aware of this, and 7 indicated that they

were not aware of youth asking for advice about terminations. Two did not know.

Fourteen respondents (67%) reported that female youth come to their facility for medical treatment as a consequence of incomplete induced abortion.

Findings: Focus Group discussions and key informant interviews

What ASRH services should be provided in the Solomon Islands?

Many of the participants stated that specialised adolescent sexual and reproductive health clinics, 'youth friendly clinics', should be established. For example, two health professionals asserted that:

"We need to have special clinics for the adolescents with specialised trained nurses who know how to deal with adolescent issues."

"Each hospital should have friendly services or clinics, which should be set aside from public sites...for us here at Kiluufi, maybe we know of the behaviour and attitude of the young people even sometimes they need the services that we provide in their presence but it's too public for them, we should provide the services where they are set aside for them that is easy for them to use."

More than one participant mentioned the need for adolescent friendly services to be provided in both rural and urban areas:

"Establish youth friendly centres in Malaita province that young people should access and use for services such as STI and other sexual reproductive problems."

"Create centre for adolescents similar to what SIPPA [Solomon Islands Planned Parenthood Association] clinic is currently providing, specifically adolescent services and accessibility. There should be a consideration for one centre in each province as well."

"In the urban clinics most of our programs are integrated, however, I think adolescent program should be specific and not integrated; I think because of services and programs integration we are not focusing on adolescents, we put Fridays

for youth friendly clinics but the problem is integration of a lot of program."

Some participants argued for the need for existing services to better cater for adolescents:

"All provincial clinics should provide all the intervention ... for adolescents need on information on contraceptives, safe sex etc. Health settings should have a centre to provide these services that adolescents can identify to receive services from."

"Increase the number of youth centres in urban areas, these centres should be located in areas accessing youth with the services. It should provide an environment where young people come unnoticed, as sexual health is a sensitive issue due to culture."

"SIPPA is the only one that I see that they are doing it, why not our provincial health services sectors, big hospitals, if we can aim for these services to be provided, like friendly clinics or which is meant especially for them and not for whatever sort of person to come in for us here."

Some participants mentioned the importance of workers to be trained in ASRH:

"I want qualified people to provide this one, not volunteers, not anyone who says they know how to can give this because confidentiality is very important how we approach these young people is very important and very understanding, and also to make sure that these things are available even the service provider must know and have knowledge of the good things about family planning, they have to know everything in order to have the knowledge to demonstrate it, can talk clearly and more broader on these issues to the young people."

Participants also stressed that it was important that adolescents could easily access clinics that are suitable for their needs. In particular, concern was expressed that adolescents could be seen attending the clinics and that health workers were not friendly towards them:

"Youth can still be seen and noticed seeking services in the clinic. Young people visits clash with the clinic schedule can't accommodate seen

them. It's good to create a centre where these sexuality active young people can access services."

"Change of place and services for a more suitable environment and attitude of health workers to be more friendly."

"If they are scared or afraid of the nurse or hard to access clinic if they know they have a very conducive place where they know they can go to I think the place will be full every day."

"A service from friendly environment, young people will gain trust from health provider and open up to access services needed."

The provision of health education for adolescents was also a primary concern, and should be offered both at schools and at community sites for those out of school. The role of the education system was emphasised as a key avenue for informing, counselling and enabling adolescents:

"Provide the information to adolescent at school so that all information needed is provided."

"Integrate SRH in school curriculum to reach all children in the communities through formal education whether in secondary level or primary level schools."

Health professionals should be invited to provide health education to school children:

"... invite our health workers, nurses to come and help out in giving information in regard to reproductive health."

...also to provide ASRH counselling through schools:

"... counselling services by senior house master (for boys) and senior house mistress (for girls) at boarding schools."

"Counselling services provided in schools for students by qualified counsellor."

"More broken homes makes young people to become vulnerable to anything and to understand the frame of reference for each child is very important for really look serious into, rather than just say 'oh that child is a naughty child because he is like this and that' look from outside rather than emotionally look into the psychologically part of the young people is very important. Counselling

Some of the participants **highlighted the important role the churches have in providing ASRH education**, particularly as a way to capture out-of-school adolescents.

is a part that young people need which we still missed."

...however, the right materials are needed:

"Text books are the one we need to be provided with, as soon as it's provided then we will go with them or arranged others to come and help out in the schools."

"Provide books that will be available to be used."

Some of the participants highlighted the important role the churches have in providing ASRH education, particularly as a way to capture out-of-school adolescents:

"These youths some of them might not even go to schools, so through our churches these should be put forward too."

"Empower church workers with information and knowledge as they do interact with young people and can pass on information to young people."

"Establish and gain church support for ASRH activities provided in communities."

One participant believed elders had a role to play:

"Educate through the custom and culture type, yes, they would come sit down and we tell stories/discuss, maybe the girls there with the women to teach them, the older men to teach the young boys, especially adolescents."

Others stressed the need for parents and the wider community to be more involved in supporting and educating adolescents:

"For out-of-school, we talk about community awareness programs for them or can be through churches."

“More awareness is still needed to be done at a community level.”

“So to answer your question the services should be provided for our youths... one big area I see therefore in the communities is information, advocacy is a big area because a lot of youths... lack information reproductive health.”

What are some of the barriers and constraints to delivering ASRH services in the Solomon Islands?

The main barriers and constraints to delivering ASRH services were reported as:

- Cultural norms & gender norms
- Religious beliefs
- Teacher, health worker and community attitudes
- Geographical isolation and weather
- Lack of funding, infrastructure & equipment for activities
- Scarce human resources
- Lack of sustainability of ASRH programs

Cultural norms:

“In rural areas, custom is a big hindrance for some societies, for example in Kwaiwo, if a young boy talks with a young girl, the girl’s people will bring knives, but educating them is very important. After all custom is a big barrier because Solomon Islands is a multi-ethnic group.”

Cultural norms and customs were reported as being a major barrier to delivering ASRH services, primarily because SRH is a topic that is not openly discussed, between men and women in particular.

As one participant described it: *“we don’t feel good when you talk about our private parts”*, and another reported: *“stigma is attached to service providers associating with these groups of people”*.

This means that it can be very difficult for health workers, teachers and youth workers to provide either clinical services or information to people of the opposite gender, and often finding alternate staff of the appropriate gender can be impossible because of the shortage of trained workers:

Cultural norms and customs were reported as being a major barrier to delivering ASRH services, primarily because SRH is a topic that is not openly discussed ...

“When it comes to sexual and reproductive health issues, it does not normally converse by equal parties publicly, people don’t really feel free/open talk about, and we hardly hear people discussion these issues as politics discussion, when it comes to health issues because our custom even to tell the private parts in front of opposite sex, so I think one of the main barrier is culture.”

“... the idea of sexuality where I think as a male, I’ll talk on male issues only and female to talk about female issues only, so it can also affect the idea of this services, the other thing is there is no promotions of open discussion ...training people to talk openly about these issues.”

“Culture is a barrier. For example, a female cannot talk with a man privately or a young boy cannot talk with a woman privately. Culture is a barrier to taking the message to the young people.”

“The island of Malaita, you don’t talk ... with opposite sex unless they understand you and what you are doing... other thing that I see is ... for us the male nurses every time not to involve with female, or if we go to the rural areas, we find a lot of hard times dealing with opposite sex.”

“... in the office setting ... the barrier that I see is when the female nurse is out/gone out/off, then the barrier you will meet there, because most women often they came to see the female nurse, when they see me they always ask where is the female nurse, so they have to stop, stay away.”

Some teachers mentioned difficulties they have in educating students they are related to, or those of the opposite sex:

“... in terms of school... when we go back to culture, some of us have relatives in the classroom, it would be very, very culturally wrong

to preach or teach some of these things/issues inside the classroom, so we feel bad or sensitive about it, or maybe the one who is teaching not comfortable about these issues here."

"The main one [barrier] is culture, I think that's the biggest ... I would not feel comfortable to even talk with a big boy, form 7 or 6 who come in sit down and want explanation, so that barrier is everywhere, the sensitivity of cultures, that might stop the small help that I should give to the student and so I will not be able to give it, for the student alone he might not tell me anything."

Cultural norms which prohibit discussion about SRH were reported as being stronger in rural areas:

"Culture is still strongly upheld in remote rural area where work is carried out and it is still seen forbidden to talk openly about SRH issues."

Religion as a barrier:

Religion was viewed by some as a barrier to providing ASRH services also because of a lack of willingness to openly discuss the topic or because it was seen as encouraging promiscuity:

"Even the church is still not open to talk about it, there are some things that still hold us back."

"Some of our denomination say that ... if condom is promoted, we are encouraging young people to involve in sexual activities."

"Religion – providing education on SRH seen as bad, introducing sex activities in the communities."

"The church...always puts judgment on young people."

Community (parent and adolescent) attitudes:

The vast majority of participants commented about the attitudes of parents and/or adolescents which hindered the provision of services.

However, one mentioned the attitude of the community as a whole as a barrier because:

"Community people expect gifts and benefits before activity is carried out rather than [seeing] how the activity program could benefit community."

Parental attitudes:

Many participants said that parents constrained the work they do with adolescents because they don't understand the benefits of educating children about ASRH.

It was reported that many parents themselves are ignorant about SRH. One participant who worked in the community stated that:

"It depends very much on the parents so we have to make an awareness to parents before actually teach the students."

"When introduce to school children, the parent respond negatively against SRH education in schools which shows the parents not been aware of these information and don't see the benefits the children have."

"... in areas where customs are still strong, parents will always hold back but it's not time to hold back now it's time for us to be involve and help our adolescents in order for them to be aware of thing which will happen in their lives in years to come."

A teacher viewed the main barrier in providing SRH to adolescents was that many teachers are fearful of parents' response:

"I think one of the barriers that I see here in regards to adolescents in regards to reproductive health is fear, teachers are afraid to give it because the parents might talk, so it becomes barrier, it's that we're just afraid, which should not happen, personally thinking ... sometimes we would think we are afraid parents come and say, 'you talk about these you should not tell the children."

Adolescent attitudes:

All of the sectors involved believed that adolescent shyness and embarrassment of sexuality and reproductive health issues is an obstacle in the provision of services:

"There are a lot of services done in the clinics for adolescents but they are shy to come to the clinics especially when they have STI problems. We need to do more of STI counselling."

One teacher mentioned that bullying is a potential problem for students who disclose SRH problems:

"I think ... it's to do with the students themselves, sometimes it's their peers, sometimes it's between themselves. Just from my observation I come across, some don't want to come forward to tell their problems, having the feeling that whatever they might share will go out and another friend hears it, then the teasing and bullying might take place yeah, so some times the children, student fear this, and they don't want somebody who knows them to come and say 'ay this boy the girl said that he has sick/infection as this...[in] my opinion ... 'I don't want to tell anyone in case they might share my secrets', that fear what do you call it, confidentiality yes, even for themselves ,they might feel low, and not confident."

A health professional asserted that:

"Young people are sexually active and feel fearful to seek mature nurses for services."

Confidentiality was also an issue:

"The presence of cousins or 'wantoks'[relatives] at home or around it makes difficult or not deliver services at all as confidentiality is priority."

One participant complained about the mobility of young people:

"They never stay at a place where to find them."

Health worker attitudes:

Many health, education and youth sector professionals who participated in this study mentioned the impact of health worker attitudes on adolescents. Aside from the issue of gender that was discussed earlier, concern was also raised that health workers are denying or discouraging adolescent access to SRH services:

"Some have good hearts and some can give negative comments that can really stop the working morale with clients."

"The problem been encountered is the confidentiality and attitude of health service providers turn away young people."

"Both male and female clients experienced the same problem seeking a conducive environment

Many health, education and youth sector professionals who participated in this study **mentioned the impact of health worker attitudes on adolescents.**

in the clinic and the attitude of health workers turning away young people coming into the clinics."

Lack of funding, infrastructure and equipment:

A lack of funds was mentioned by many as a barrier in the provision of ASRH services, including this school principal:

"I think to be frank ... in terms of ... budget ... policy and transport, these things are non-existent in schools in regards to ASRH so we actually don't have support."

Four health/youth professionals commented about poor resourcing or delays in funding as a constraint to their work with adolescents:

"For provincial health services you two will laugh at the budget last year for here, it did reach ten thousand dollars for the whole of Malaita province ... one program ...in the southern region and we run out. This year they assured me because two to three programs we [want to] conduct, we have to apply for it to ministry, if there is a fund available then they will give it to us, if not we will have to sit down for the full year in the office ... if I try other means beside that amount if ministry or other office in the ministry cannot fund then its nil."

"The main constraints we find is with finance, for example, for us, we want to implement a program in the northern side, because this is a place which is high with teenage pregnancy ... but due to financial problems and delay of funds, she said we should implement it this year but until then finance is still a big constraint problem."

"Bulk budget has always got in the past but since the change of SRH coordinators this has been hold."

"I should say direct funds are the ones needed, to push the services out, because even the service which I provided here is very limited compared to the population, ok we need to reach the people, because since I took up the office am dealing with the town population only, we need to give more information outside, so those areas I need support for us to go out and preach the good news to the population, .those things are things that need finances before we can work better."

In some cases, people complained that they may receive funding but it often takes a long time to be dispersed to staff on the ground:

"Money is one thing that makes things slow and also senior people need for really support what we need to achieve."

"Financial process to get activity money is slow."

A lack funding for appropriate health facilities for adolescents was mentioned by many participants. This also raised issues of confidentiality because young people are recognised at the existing clinics where the rest of the community attend:

"Adolescents should also have their own clinic because all existing clinics do not have enough space to privately discuss adolescent issues or do counselling with them."

A lack of suitable facilities and overcrowding is a problem for many of the health workers, despite the perceived need for space for separate youth clinics:

"There is no space in the clinic, it is overcrowded and there is no privacy to deal with adolescent issues."

"There is no space in the clinic for this youth friendly services and most of our services are integrated. Therefore, when the youths came to see us, they are shy and there is no private room to see them as well so they have to sit and wait till the clinic is empty before they can come in to see us."

"But we do not have proper set up [in the hospital] so we used to refer them back to the clinics. These age group are not boomerang, when the nurse said come back tomorrow, they won't come back. We need to provide an integrated clinic on the spot."

A shortage of health staff was seen as an obstacle, not only because some adolescents preferred to see registered nurses rather than nurse aides, but also because their high workload often did not permit attentive counselling of young people.

"Infrastructure disparity within the province contributes to uneven distribution of NGO activities within the province."

A lack of basic equipment was also a concern because of the difficulty in carrying out tasks without it:

"The areas which I need them to provide support towards is furniture or other things that meets the financial budget that we are meeting on it, so we can set up the office so work can be good."

"The things that we need to work with the patient; we find it hard, unless all these things are available, for example, stationeries. [If] logistic things to provide services for the adolescents are available ...I think we will provide the services well."

"Clinics run out of condoms etcetera so services cannot be provided."

"At the moment ... my wife is the one that I depend on at this time, she is a woman who works with malaria group, so I usually get these information from her ... I get all my information from her."

"When pharmacy doesn't have stocks... it's a barrier as well, because this is when we wants it but it's not available, so it's good if pharmacy is always with stock because when needed it just come collect it."

Human resources:

A shortage of health staff was seen as an obstacle, not only because some adolescents preferred to see registered nurses rather than nurse aides, but also because their high workload often did not permit attentive counselling of young people:

“Sometimes, if they see nurse aides only they don’t want to come in but wait till the registered nurse is in the clinic.”

“... inside the clinic, as I see mainly it’s man power, if it’s full with outpatient people who came, then I will have no enough time to sit down with the adolescents, so some times its not complete what we want to tell them, because we want to rush things up to see other sick patients waiting.”

“In the children’s ward teenage mothers admit with their children however due to our workload we are unable to provide counselling that can help mothers.”

A participant working in health management also mentioned their heavy workload and its negative impact:

“I work alone looking after the AHD program with no assistants. There are 10 reproductive health program coordinators in each of the provinces and they are also focal persons for AHD program. Therefore, most of the AHD program activities are always left out and forgotten. I have talks with the director and we probably will have provincial AHD coordinators next year.”

Some health workers complained about the lack of recognition and incentives for working with adolescents:

“There is no incentives, as this is an extra work over my workload and there is no incentives so when one is discourages he cannot do these things.”

Limited training of health staff was also mentioned:

“I see it as a big area and overlap to achieve, and at the same time I have very limited training I should say it now, it’s not enough.”

More than one participant mentioned that the nurses are too lazy and unmotivated, in part because they are not rewarded for long service and for their skills:

“Most health workers are lazy and they are blaming or thinking that other people will provide this service.”

“I think there is no staff motivation. In my experience there are some nurses who work for long time but no promotion done.”

In the education sector, the unwillingness or embarrassment of some teachers to teach SRH to students is seen as a problem by some:

“... some of the teachers at times they don’t feel good about teaching reproductive health, only some teachers feel good about but some teacher always hold back, so information does not all go in one day, when they talk about, they left some for later.”

Geography and weather conditions as a barrier:

Providing education is hindered by the remoteness of many of the villages in the two provinces of concern in this study. People are difficult to access, there is a lack of transport and roads are poor.

In addition, some participants complained that the government is not providing many health services in the rural areas and the workload is heavy:

“... another barrier too is the remoteness of the places, Malaita is a big community, I mean very heavily populated... cannot reach everyone, so one barrier is that the population is spread wide and infrastructure to reach them is poor, so maybe a small portion of the population only receive awareness on this, the entire population does not have it, that’s something to do with infrastructure.”

“My role as a nurse who looks after HIV and STI on Malaita, I see it as a big area is still to cover, to follow up or testing and to work in line with other departments to do it, it’s hard for only one person to mandate the whole province because due to population wise it’s too much from me.”

“In the village you don’t need money to run your programs not like in town, we need money for transport to do those outreach activities.”

“Nothing is being done here to push out services to the rural areas and even within this hospital I need more support, for within the provincial health services level and maybe outside our ministry [MHMS].”

“Services provided, in Honiara young people might have the knowledge of where to access services but in the rural areas people still don’t know where services are provided.”

“People who need these services are down there too, and these services and equipments are provided as well it should be good, that should be a bonus, because I find out with the problem with health team, sometimes travel or arrange to meet them here, but they are lost on the way, we really need to get these services down.”

The participants work can be affected by the weather and a lack of facilities to provide services when there are bad weather conditions:

“Weather forecast hinders activity plan to be carried out that day or week.”

“There is no proper venue to provide services to young people and this affects activities to run smoothly in bad weathers.”

Sustainability of programs:

Although ASRH programs had been implemented in schools and/or communities, some participants argued that there was a need for the programs to be sustained.

In addition, trained staff would like opportunities to use any training they receive, because currently many believe they are not given the opportunity to do so:

“Some of us are trained as I’ve mention earlier. I’ve attend the workshop and when we go back to schools there is no programs for trained teachers for actually fit in or sustain the program in the moment we attend the workshop, that’s the end of it.”

“Project programs are not consistent and depend on funds available and also the attitude of service provider... depends on the availability of money before providing services.”

“After all, the sustainability part of the program is the problem. You can look into educating the people, budget and training on specialised field, we might have proper net-working but when there is no sustainability then all programs can fail. We need to sustain all our planned programs.”

Illiteracy:

Illiteracy was mentioned as a barrier. One youth sector worker mentioned that they are taking a life skills approach and offering literacy training prior to health education:

“One of our problems in providing those services to adolescents is literacy, we need to do literacy training them first prior to giving those information about reproductive health.”

Policy:

There was some discussion about the growing recognition of ASRH in some government frameworks; however, there was a general feeling that ASRH also needs to be recognised at a provincial level.

Malaita health operation plan and clinical program schedules were two examples where the participants felt ASRH should be included:

“Malaita health operation plan doesn’t include ASRH services and needs to look at. This is according to the hospital admin information.”

“Clinical program schedules does not include adolescent programs and so adolescent can feel services for them are not provided in the clinics.”

“Adolescent programs just come under reproductive health so has not been recognised. Now with recognition of this group ... and therefore management will now consider the issue.”

What interventions might address these barriers?

A summary of suggested interventions to address barriers include:

- Engage community gatekeepers
- Increased transparency and collaboration with stakeholders
- Regular dissemination of information and training
- Changes to the school curriculum
- Establishment of youth centres
- Accessible youth friendly clinics
- Further training and incentives for staff
- Changes in funding and policy for ASRH

Community gatekeepers:

It was suggested by some that difficulties in discussing SRH due to dominant cultural norms could be overcome by engaging and seeking ‘buy-in’ of key community gatekeepers:

"In terms of culture, I think we need to identify key people in the communities, like the chiefs and village leaders; we need to actively involve them so that they feel ownership and will be the ones to make the break-through at the community level by addressing these issues in a natural and acceptable approach in the village."

"We need money to run the program and we need to identify key people, educate them to educate our adolescents because our cultures are not the same."

"Recently, I went to Malaita last week upon invitation and met with all the chiefs and community elders. They were very happy and mentioned that this is their first time to see such when I highlighted to them the report on STI and the rate of teenage pregnancy in Malaita Province and the country as a whole. So, when they saw those figures it really motivates them, and as young as 9 and 10 years old they involve in sexual activities. They really like their young people to take information on adolescent issues, so I think giving such report or data to the community or public can play a big role in influencing them to support services for the adolescents. Looking at the young age involving in sexual activities, the chiefs mentioned that we need to start introducing adolescent issues to grade 1 student."

Educate and inform religious groups:

If the churches were more aware of the issues involved, some participants believed they would not oppose their work, as has been the case in the past:

"From my experience, religion is not a barrier if we explain the benefits of the services because in doing NSV [non-scalpel vasectomy] program in Savo, I've seen a lot of Catholics came for NSV so as long as we tell them the benefits they will accept and support what we want for the community."

Transparency and collaboration:

Many participants would like to see the government having a more transparent decision making process around ASRH. This means that development of standard training manuals and/or curriculum should involve those organisations concerned with adolescent issues:

"Aims and objectives for youth from the government should be available."

"What really need is to develop modules that specifically address the issues of adolescence to really see what stakeholders can do."

"It's good to have the knowledge of where is what, and be involved [in] bring[ing] them together and address the issues together as they are the same people pointing."

Some participants believed it would be beneficial to have a standard RH curriculum developed by key stakeholders:

"Ministry of Health and the MOE to put together one curriculum to address health issues especially SRH."

"Stakeholders, NGOs or whoever is concerned, to discuss together and talk over the teaching aid or approach to have and develop standard training manuals or teaching materials and the language of delivering information is same in all organisations."

"A standard reproductive health curriculum where all youth service providers or stakeholders should be speaking the same language."

In addition, there was a lot of emphasis on organisations working together to improve work practices and services:

"Stakeholders need to work together hand in hand, for example, MOH as the leader and NGOs as the supporters."

"Build network with other organisations and not to work in isolation."

"Collaborative effort – work with Ministry of Health, NGOs together to zone the area and know the boundaries to work reduce duplicating activities in communities."

And some discussion focused on the National Youth Committee representing all the relevant NGOs:

"All stakeholders, NGOs represented by National Youth Council representatives."

"NYC will bring everything to the national steering committee (all ministries' Permanent secretaries)"

during the meeting and the success of this will relieve everyone.”

However, the government should lead any joint effort:

“The government as the main body should liaise with NGOs and put awareness to whatever policy and their view and support will come from the NGOs.”

“Ministry of Health should be the leading role player for stakeholders to promote SRH and link stakeholders and responsible individuals from political leaders to grassroots people to collaborate and networking with each other.”

Women’s empowerment:

Any collaborative effort should also involve women as key partners in decision making, and one participant discussed the effort to do this is already beginning:

“On the 29th we will have our first meeting yeah... it’s about women and gender and whatever, because we see that gender is a cross cutting issue... I find out that if we only talk about leadership then we are not targeting what we should be targeting, we should try to see how we can lift people up so that what they do comes out in the broad daylight. And then men can say ‘OK women you can take the leadership’. It’s not us forcing ourselves in... and we can collaborate, and see what is the way forward for us here for Malaita, and I see this could be good for youth and children as well, so we are thinking of setting up a committee involving all the stakeholders individually together and we set up a committee that meet quarterly to see what is going on and to see each one can help, so this is the plan at this stage.”

Regular dissemination of information and appropriate training:

Teachers, principals and education sector decision-makers emphasised that they need regular up-to-date information on SRH issues and opportunities for further education on SRH issues:

“For schools I think we should use all other appropriate authorities so that we can have regular information or regular dissemination of information or a similar kind for students... What

I know is at the moment, we don’t have those services available.”

“We need regular, if not continuous supply of information... so that we can put it up for students, maybe we might have notice board somewhere, so we can put the health issues there.”

“Head teacher to attend TOT so that can come back and train staff on how to teach curriculum topics.”

And there was an emphasis on any training initiative or monitoring to also involve the provinces:

“In-service training for SICHE [Solomon Islands College of High Education] teachers to train student teachers how to teach new resource materials, as there’s not enough budget to visit provinces.”

“Train school inspectors from all provinces to go and monitor the programs.”

“Training of specific teachers from each province during school breaks.”

Changes to the school curriculum:

Many participants thought that SRH topics should be taught at primary school level and above, and could be taught as a stand-alone subject rather than part of the home economics curriculum. One mentioned that ASRH should be integrated into religious education classes:

“Integrate SRH in school curriculum in a way where it is appropriate to their learning.”

“If only this could be integrated into school curriculum, this can be shared in the classroom.”

“Basic health information taught at school, even at primary.”

“Integrate SRH into biblical teaching that fit the church people.”

“I think with the current curriculum within Solomon Islands, it is included in the home economics... if it’s [not a] subject alone, they will only see it as one of the subjects only, and then sometimes they will only take it lightly.”

In addition, curriculum should focus on improving the student’s self-esteem:

Health education messages about ASRH should be placed in the community, taking in to account high levels of illiteracy.

"we should be focus on is how these children should view themselves ... but I think we should a sort of training where it views someone to see the importance of them been a human being, that can be, because like when talking about people we are talking, attitude, the mentality, so I think the target now is to at least change the mindset ... because the way I see it most of young people don't view themselves as important that is why they turn to be careless about things they do about themselves, I think that is one thing that we should include."

Students could also be trained as peer educators:

"Students trained on how to give awareness and sent out into communities such as been effectively carried out by students in PNG."

Educate both boys and girls:

Provision should be made for both genders in school ASRH classes or in the community, because one participant believed boys in particular were missing out:

"... to make it even worse... most classes are entirely girls, only few boys included or attended, so when you talking about services, I think there must be a provision for both gender, yes, they must have access to these kind, one service am thinking of is continuing dissemination of information for dropouts or through talks or through workshops health for students."

In situations where teachers feel that they cannot teach classes with their relatives present, further training was suggested:

"I think to solve this cultural barrier with teachers, it's better to train them because I really believe after going through these trainings, these teachers, they will un-sympathise with themselves to remove these cultural barriers in teaching."

Inform the community of the issues:

A common belief of many is that the provision of health promotion or health education would encounter less obstacles if parents and the wider community were also aware of the issues involved. One suggested that this could be done through Parent Teacher Association (PTA) meetings, and should involve community leaders:

"PTA education at school on SRH and health topics taught at school."

"Community leaders to organise people to come and attend training."

"... if we could be trained for it, we will not have any fear ... then must tell the communities as well for them to be educated, parents must be educated, children must be educated as well, it's time we need everyone to be educated, parents, children, whoever on this age if they could understand it they should be educated, don't be scared of it lets do it now, the infections is already coming, for custom it need education as well... We must do something about it, whether we are in church or clinic or hospital or wherever you are, let's address it, let's get into it and help our children."

"In this kind of school setting parents are the ones that we should address first, have a good discussion with them so that they are aware of it."

"We need to reach out to the parents as well, sometimes parents from my observation, because I live with them, most of my in-laws them are village people, when I ask them, I think through education is the right way, as they are village people their way of thinking is different, people who are educated and those not educated sometimes they don't understand... but they must feel free to talk about to their children 'how are feeling or what's wrong with you' that part too of being a parent must come in and the one who are uneducated we must reach out to them."

Health education messages about ASRH should be placed in the community, taking in to account high levels of illiteracy:

"... it is better to do promotions ... what I mean is that we select the avenues to do these promotions, in public areas, in churches, in

Participants commented on the **need for community or youth venues** where adolescents could access information and activities.

schools, in schools I mean classrooms, it is better to put posters there, take poster of human anatomy both female and male, so that when they see it, it's a kind of one of the picture that gives aid to/among the students where ... they are illiterate... because for me, these the kind of group that needs addressing... those adolescents are the one who will be affected, because they are not well inform about this."

In addition the right messages should be put across to young people:

"One more barrier is the way we talk and putting across the right message. Most of us know the issue very well but the way to communicate it across for the young ones is not understandable. When I was a young nurse I am afraid to talk but the more I do it, the more I experience, the more I talk and I learn as well. Because sometimes we talk and talk we will learn from that, build on that, gain knowledge then experience."

Youth counselling:

There were many comments expressing the need for counselling and tailored information for adolescents:

"I think the basic one is counselling, and the two, dissemination of information... presentation of awareness and three, training proper training not only for students but all youths in and around the area, in terms of counselling and information dissemination. And ... the fourth one is idea sharing, experiences that each have and what some that others don't experience yet. By discussion among themselves they might come up with their own solutions."

"ICE materials such as leaflets etc should contain easy to read language simple and written in local languages common people speak. Information

converted into picture form, posters, leaflets in the simplest forms."

Out of school youth activities:

And activities should be established for out of school youth, not just focusing on ASRH topics but also on life-skills:

"Establish sustainable activities to engage young people to continue working with even after trainings provided and helps young people not to involve in behaviours affecting societies."

Youth venues:

Participants commented on the need for community or youth venues where adolescents could access information and activities.

One principal commented on the need for youth centres where they could access information. Many students did not talk to teachers about SRH issues as relationships between students were not permitted and the health clinic may tell the school if a student attends the clinic:

"... maybe they have it while accessing SIPPA without our knowledge because it's our school rule maybe it doesn't allow them, because the moment they go there to get condom, they will tell us the school that you're involving in a boy/girl relationship which is against the school rules. So students they have more access to SIPPA but us teachers are not aware of it."

"Build venue centre in each communities working with so activities can be carried out in them."

"Create a youth friendly centre for young people in Auki then if possible expand to other areas or provinces."

"I think if we have centre around here, especially in town apart from health clinics, one where they can go to it, maybe a place for youths only, like for health clinics as soon as you go there automatically they will look at you and then start questioning, but if we have youth centre where youths can come and voice out any issues that they have either social issues or health issues, if somebody to do counselling is there and available, so that after counselling they can refer straight to the appropriate authority."

Health awareness activities at schools:

Teachers and principals agreed that more health awareness talks or fun participatory events should be provided for students to be involved in:

"... more health awareness, health workers need to come out, make it a priority to come out and talk with the students, another thing I see, they might pick up leaflets yeah, reading through it sometimes in my classes, form six classes because I know some assessments in my class you have to prepare a speech, present it and they ask you, you are in a panel... because in the past I put up teenage pregnancy 'ok year five that's your theme anything to do with teenage pregnancy you will present it', and some of their students go out of their way and bring back these little pamphlets, the simplest form possible to reach out to everyone."

"Why not put the things that are of interest to them like musical, you sing you dance, but the message goes out, something to get their attention, I think it will work better that way because you just give them these and that and say read it, it's hard for them to read it."

According to one participant, the difficulty in treating or talking about ASRH to clients of the opposite gender could be dealt with by employing both male and female nurses at the same locations:

"All clinics should have both female and male nurses working together for addressing client situations."

Accessible clinics:

Clinics should also be more accessible to adolescents; including holding adolescent clinic days or separate clinics. Clinics should also be open longer:

"80% of our people are living in rural villages ... but they think everything is in the hospital. I agreed with [another participant], we need some space in our clinics that is accessible and available 24 hours because all these age group are very active so they can come around to see you anytime, therefore, we need adolescent service that is accessible and must be specific for them."

"I think we need to build on what we have. So might be at the clinic level we need to strengthen

our clinic times, for example, we set aside a day for adolescents. This is not an easy thing to do but we have to take one step and then build on how many steps."

"Integrated services area is not conducive and therefore separate locations or centres can provide youth the environment to come for services."

There was also some comment about the need for confidential health services for adolescents and youth, particularly because it is very difficult for students to talk to teachers because it is against school rules to be involved in a relationship:

"... information...maybe they have it while accessing SIPPA without our knowledge because it's our school rule ... it doesn't allow them... because the moment they go there to get condom they will tell the school... Boy/girl relationships are against the school rules, so students they have more access to SIPPA but us teachers are not aware of it."

Attitudes of staff in health facilities:

According to some participants problems with staff attitudes could be improved through having more staff, and through further incentives and training for staff:

"I think the first thing we need to do is to increase our manpower especially at the national level to assist our AHD national coordinator, we need to do this first before strengthening manpower at the lower level."

"We need to recruit more nurses to look after the AHD program at the clinic level."

Training and incentives for health staff:

"Strengthen trainings for public relations by IPAM [Institute of Public Administration and Management]."

"There should be incentives for workloads for nurses who stay long in the field."

"Friendliness, answering phone, but there's no motivation incentives to uplift the morale of the nurse."

"Train all health workers so everybody is included and can work as expected."

One or some participants suggested that only nurses who are compassionate and/or hold Christian values should be selected for nursing training:

“Selection of nurses for training should be looking on people who have compassion for people or fit the work.”

“Attitudes can change only if people have compassion that Jesus practised.”

Any further education provision for health workers should include ‘gender balance’ training:

“We need to do gender balance for training. There’s a group that undergo this NSV, Non-Scalpel Blade Vasectomy, and this group initiate ‘Men as Partners’ and this is one of the best training because men undergo this training for men, and it takes into account our custom, therefore, we also need men to train on a female dominated service like reproductive health.”

Funding for ASRH:

Some discussion in a focus group focused on the need to ‘pool’ funding from other government sectors to facilitate enhanced integration of planning and services at both national and provincial levels:

“I think the best solution to that is to put together resources from all other sectors and that is what happening in the region. This time, they would like to target Ministry of Youth, Women and Children and also Education in which most of the Family Life Education program will come under. Therefore, more integration of services will happen next year. And that is what highlighted by the Ministry of Youth, they would like all sectors to integrate their resources so that we can put together our plans and programs. This is at the national level. For the provincial level we also need to integrate our services too, when reproductive health team go for community outreach visits they should not forget our young ones. This time, most funding will go down to the provincial level so the provincial coordinators should work together.”

Two other participants would like to see a change in the way ASRH services are budgeted for:

“To address issues a budget plan has to be developed and put as a bid by the Ministry of National Planning and must be justified.”

“It’s best for stakeholders to provide Ministry of Women and Youth Affairs with data and put them together into a budget development for bidding.”

There also should be more consideration of where NGO funding is going, as well as more control by Solomon Islanders of which programs this money should be going towards:

“If we look carefully into all the NGOs that are in the country, they seem to be funding same project. World Vision, Save the Children and Oxfam. Everyone talk about HIV, HIV. Why don’t we build a network with them and ask them to put in money so that we will be the ones dishing out funds for the much needed new programs like adolescent services, one of the much-needed program in the country. Otherwise, all these NGOs telling us the same story, all the same information, same program year after year.”

Transparency and good management is also needed if international donors continue to invest in the Solomon Islands:

“We need to properly manage the money given to us; we use it for its purpose so that our donor partners can continue to trust us and throw in more money for the program. We need to have good network system within the Ministry of Health.”

“We need to motivate those implementing the services through the provision of training so that they have good knowledge on adolescent issues and willingly doing the job. It is just like when people come to your house and you don’t have food to feed them. With all these in place I believe all aid donors will pour in money to assist us.”

There was also comment about the need for more money to assist those working in the rural areas:

“In the village you don’t need money to run your programs not like in town, we need money for transport to do those outreach activities.”

On the other hand, as two participants noted, it’s possible to still work in the area of SRH without much in the way of funding:

“When I worked in the village, I did all these trainings in the schools; we used to separate boys with male nurse and from girls with female

Some saw the **need for someone to specifically look after ASRH programs in the hospitals**, rather than relying on guidance from the provincial level.

nurse. Even though we don't have enough money to run these programs, when the church invited me to give health talks I walked to their church. Despite culture, there are acceptable ways we can go about to educate our young ones. There was also once a volunteer doctor that used to come to the village at his own expenses under the Roman Catholic Church arrangement to visit friends and the provincial health clinics. I ask him if he could assist the village people and he did. He donated soccer uniforms for boys, volley ball uniforms for girls and 5 sewing machines for women. So, I believe there are ways that we can assist people despite we don't have money and through this type of teamwork our village people can work with us."

"There are some peer educators that SIPPA helped to train them in Central Island Province, they live in their community and despite on voluntary basis they are willing to do the job and are very helpful in educating their peers, they even refer risk mothers to the clinic or hospital. They also help in the Stepping Stone initiative introduced by SIPPA through the Church of Melanesia."

Changes to ASRH policy:

New policy could provide guidance on service provision in the community and in school curriculums, and current policy that is effective should be utilised:

"... policy must be establishment to provide guidance to the way services are implemented at the community level but based on much awareness evidence based on how it be adopted in the curriculum."

"What MWYCA ...needs to develop a MOU between stakeholders as there is no data available among stakeholders."

"We have a very effective youth policy and needs to be accessible."

Changes to ASRH management:

Some saw the need for someone to specifically look after ASRH programs in the hospitals, rather than relying on guidance from the provincial level:

"There must be someone to look after ASRH in the hospital, to look after adolescents programs. One person cannot do everything across the province and management must address."

"Reproductive health management needs improvement."

Current roles and functions of health, education and youth sector workers

Education sector roles and functions:

Principals saw their role as administrators, with responsibility for teachers and students:

"In the school setting, one of my roles is as an overseer for the whole school in terms of administration; I'm responsible for teachers and students."

"[My] role is to look after teachers, students and the parents. To make sure that link from parents to children and teachers must work together and to make sure duties are done by teachers and carried out promptly and complete."

In terms of ASRH some viewed their role to facilitate ASRH in schools:

"... if we relate my role as administrator to ASRH what I think is that I should be facilitator for this issue, I should encourage programs as these for the school, because I believe that education, one contributing factor to good quality education is students' health, so we must make sure they must be good healthy students, I will if possible I will try and arrange programs."

However, although some principals saw the need, their job descriptions did not include guidance on ASRH programs in schools:

"... we don't have any program that deals with ASRH at the moment, but I think supposing that it's good we must include it inside the job descriptions of the principal, because principals as

head of schools we must aware of this one, and if cases relating to this rises in schools we are in a better position to answer this one, so I think it's very important to include it in the job description of the school principal."

"[My function is] to deal with the administration work of the school and also responsible for organising programs for the school, for example, school trainings. This information only is included in the principal's job description."

One principal stated that parents are the final decision makers concerning what SRH topics are taught in schools:

"I must make sure whatever is supposed to be taught must be taught... normally for us here or the villages, what happens is that, we will have to refer it back to the parents, both school board come and sit down together and talk over and whatever decision they come up with. Parents will be the final decision makers."

And this is why he or she would like a job description or guidelines from the government:

"But to have a set description of what rules from the ministry for me to abide by not yet, I think .. next year, or maybe when they are working on it I think it should come, but for myself to learn it ... involve youth and the children, we do it, but for my job description it does not come as standard rule which me as the school principal must take on."

Science and home economic teachers are generally those responsible for teaching SRH topics. They commented that their job descriptions are 'broad', and they often said that their job is to teach what is in the school curriculum.

One teacher said that their main job function is to "provide counselling for students on their performance outcome on academic results", but if health problems are identified, their job is also to refer the student for a clinic visit.

Many education sector workers, (excluding teachers and principals) clearly defined their roles. For example, one curriculum developer commented that their job is to finalise resource materials, and

design and develop learners and teachers books. This participant said that their role is well defined:

"[I] coordinate workshops every month, the writers usually come from schools and health workers [and] work along advisors from universities, an overseas university to assess documents what need to add on and final comments on the materials."

Health sector roles:

Many of the health sector workers, particularly those working in clinics, do not have a job description or are not aware of one. As a result many felt that they were carrying out roles that they were not paid to do and were performing tasks beyond the scope of what they believe is expected. For example, a registered nurse aide in a rural aid clinic stated that:

"The services provided in the clinic is beyond what is required in the job description."

And although the nurse aid has worked in this job for 5 years, with regards to their job description he or she said:

"I have no idea what it looks like."

Many health workers did not have clear expectations of performance and also complained about the shortage of staff:

"I am responsible for the clinics and what the nurses want for the clinics, I'm the one who coordinates...but for this service, it's not in my job description, but through these nurses, I can give it out to them, so it's not included in this job description, but for clinics upon the nurses request I can ask for help."

"I work alone looking after the AHD program with no assistants."

And this participant also mentioned the shortage of staff in the provinces:

"There is an unfair distribution of manpower, more centralised in the city and less in the provinces, therefore, only one person playing all the roles."

Another participant described their role to:

"Carry out the general clinic responsibilities as well as be responsible for reproductive health specific client seeking services."

However, he or she is:

“Not aware of the job description responsibility.”

And another health worker:

“I am not sure about job descriptions [laughs] because I don't see the job description, but I think it's inside, but this role is for me [is] extra work on sexual reproductive health services.”

Some health workers felt that they did not have the capacity to do their job and found it overwhelming. A lack of a job description also meant that they adapted to the situation by trying to develop an understanding of the position from those who had been in the position before them:

“I see it as a big area and overlap to achieve, and at the same time I have very limited training I should say it now, it's not enough, my role as a nurse who looks after HIV and STI ... I see it as a big area is still to cover, to follow up or testing and to work in line with other departments to do it, it's hard for only one person to mandate the whole province because due to population wise it's too much from me, so mainly I have to work with the health promotion department, to do... reproductive health... Training counsellors, even though I take this role, am still not a counsellor one part is still missing, so if my patients come, I have to refer them back to the counsellors,... so am still working in line with the reproductive health coordinator who have had the role before me, so for me to come into the office am not fully aware of what has been done in the past, because at the present time there has never a proper handing over.”

Participants also mentioned the lack of rewards for staff who had gained additional qualifications or training as de-motivating. A nurse for example mentioned that despite attending training they were “just put back in the same position as before”.

A common point that was mentioned in all discussions was the lack of central coordination for ASRH. Although there are 10 reproductive health coordinators responsible in each 10 provinces, no-one is responsible solely for ASRH:

“There's no focal person and that is one of the main hiccups. I really tried my best to make sure that we

have coordinators as well to help carry out the roles and functions of the program to every province, health centres and the communities because we have a lot of midwives who have trained on this issue but they have a lot to do as well. Therefore, we need to train our nurses and this is the training officer's duty to liaise with reproductive health coordinators. I've seen that AHD is one of the Ministry of Health priorities, but the least important in the entire budget and everything.”

Youth sector:

Youth sector workers mostly appeared to be more adequately prepared for the jobs they were expected to perform. There are many examples of youth workers confidently describing their roles. For example:

“I work with two youth groups... and I coordinate proposed plans which are implemented and achieved using the SMART strategies in 2 communities. Mainly it's a community strength based approach. My function to coordinate what work is done in the two communities, monthly monitoring and if any problem is encountered to hold group discussion with appointed community group on how to solve the issues.”

And another describes his job description and job functions:

“[As an] employment project officer, [I] deal with adolescents and youths – 14 to 29 years – in five communities. [My] job description is to facilitate the process for identifying youths who are interested in having ...needs training for employment, facilitate them up to service providers and to find opportunities or avenues to push them into employment maybe part time job for few months. When they have built their capacity with the skill then can move on. [I] provide training for peer educators informally so that they can give awareness to the vulnerable youths.”

There was some discussion in the interviews and focus groups confirming that many are aware of avenues available for further education and training in the youth sector. For example, this participant trained youth sector staff in leadership and good governance:

“My office is responsible for the planning for women ... but just recently it has included the youths as well, so I’ll be looking at youths as well, and just last year this policy was launched, and my main job is to let everyone that works with me work along the government policy, and am also trying to get networking ... and to see if the training which has been taken place have targeted government priorities or not. And I am also doing training, especially for leadership and good governance. And then other stakeholders, like in the past, CST they’ve used me too to go out in the field and do skill trainings... Other training, I’ve identified local people to help me with them in the programs, like local trainers where they usually do those trainings, but then I also have network with the national council of women, MWYCA, only this year we’ve planned to broaden it more, to have everyone on board.”

But not all youth workers were able to confirm that all their duties they performed were in their job descriptions.

This worker for example, stated that his job functions are ‘partly’ described in his job description:

“Mostly I deal mainly with education, like awareness programs with health promotion... awareness provided in schools even in the communities, it’s part of the involvement of our job description...[so these functions are in your job description?]....yes they’re in my job description.”

And another youth worker stated that his job description mainly dealt with the provision of training, but said that in reality his job involved many more activities such as:

“... young people and volunteers to produce and develop materials to help ... develop skills [and] improve capacity building, and provide training and look for opportunities for what areas can help them to develop them as mentors.”

Unlike many of the health workers, youth sector workers tended to be clearer about lines of authority, coordination and collaboration. For example, this provincial youth coordinator’s role involves:

“Needs assessments on community needs, then identifies what programs fits to build up their capacity programs and liaise with service

providers who can provide the training, such as with...SIPPA or Ministry of Health to integrate their resources and do the training.”

And a provincial HIV coordinator for a church mentioned that a priority of their work is to build relationships with others:

“The focus is to build relationship with stakeholders, liaise for program partnership or organise who should assist in training communities about health issues affecting their communities.”

The guidance that strategic plans offer was also mentioned by youth workers. An HIV project manager, for example, described her job function:

“Manage, coordinate and implement what is in line to the project and with the national strategic plan HIV/AIDS and develop networking with government and NGOs.”

Sectoral perceptions of ASRH training:

The vast majority of education, health and youth sector workers said that they did not receive adequate training in ASRH, but they would like to be ‘regularly updated’ and receive a continuous supply of information. There is also concern about the lack of training opportunities in the rural areas.

Youth workers comments are typical:

“Training needed on how to work with young people and how monitoring can be carried on young people.”

“The problem is how to get the information further to others as often only few people in targeted community who are able to attend meetings. The areas where team can reach, then information is provided or shared out.”

“I need training that enhances innovative ideas such as the behavioural change communication. Have attended short courses overseas and this year attend attachment in Fiji and PNG to observe youth program coordinating.”

And from teachers and principals:

“We need more education on SRH and need to refresh knowledge.”

Health workers:

“Health workers are well equipped but we need specific training on reproductive health, on what information to provide, how and how to integrate with those adolescents themselves so as to provide those services.”

“[I] trained as MaP and not midwife so still...need to train more SRH and family planning methods. Referrals have to done where unable to provide certain services. I need more training to provide these services.”

“my education I think it’s ok, but in regard to adolescents themselves I still need trainings, so that its clear during our general nursing training we have limited knowledge but not fully clear yet, while these thing are coming up we need to continue upgrade on them.”

There were a few exceptions – a curriculum developer, for example, felt that a lot of training had been offered:

“[There has] been a lot of training conducted in and outside the country by international NGOs.”

And one youth worker said that his role is to work with adolescents and their SRH:

“I am confident to do this job.”

Who should provide ASRH services?

The participants would like teachers, nurses, doctors, parents, churches, community groups, and students themselves involved in providing SRH clinical and/or health education and promotion to young people.

Its *“everyone’s responsibility”* or *“everyone working together to provide services”* were common refrains.

There were also specific suggestions on who should be involved in SRH service provision:

In schools:

- Teachers:
 - Home economics teacher
 - Science teacher
 - Industrial arts teacher
 - Senior house master/mistress

In the health sector:

- Nurses and doctors in clinics

- All health workers
- Qualified people and not volunteer workers
- SRH trained personnel, either health workers or other service providers
- RH nurses and midwives
- Specially trained nurses
- Qualified life skill trainers

In religious organisations:

Church workers are seen as important in the provision of ASRH services:

- Pastors, ministers
- Church workers /volunteers

Parents:

- Both parents
- Mothers responsible for daughters and fathers responsible for sons

The community:

- Chiefs and community leaders
- Women’s groups
- Youth groups
- Other existing community groups

Students:

- Student peer groups

Do you work with other providers to improve ASRH?

Education sector:

Many of the education sector workers said that they do not work with other providers, but where partnerships were formed, action mainly centred on the provision of information by NGOs, churches and clinical staff. Some examples of this follow:

Many principals at primary and secondary schools coordinate with churches, which visit schools and provide awareness programs on *“leadership, discipline and health issues”*, but as one principal stated they *“don’t go in to detail, but the message they preach here relates to reproductive health issues”*. Baha’i was mentioned as one faith which has occasionally visited schools in the past.

A teacher mentioned school visits by the Red Cross to provide IEC materials, and the police *“always come and we allow them at least an hour”*. However, he/she didn’t know if anyone from the health sector had visited their school, but the school is *“open for people from health to come and have a talk or awareness”* and the *“links and support must be strong”*.

In one rural school, a grade 6 teacher is working with the provincial hospital so that health staff come and talk to the students about SRH issues such as STIs/AIDS, but no NGOs, faith-based organisations or the MHMS had ever collaborated with this school to provide services: *“nil totally nil”*. However this participant did also state that NGOs would:

“Write to us ‘let’s take part in the sexual reproductive health, we must have yes or no’, so we would make demonstrations here, then we would march with banners and things like that, posters, appeal to young people, adolescents and we involve in those things with them.”

In some situations there are informal links with other providers – one education sector worker in the community stated that he gets all his health information from his wife who works with the malaria group. This participant’s response to the question ‘do you work with other providers?’ was: *“At the moment not yet, only my wife is the one that I depend on at this time”*.

SIPPA and ADRA were mentioned by a number of teachers and principals as having strong links with primary and secondary schools, and have *“gone into teaching more about SRH services”*. However again there were complaints about some of the services not working with many rural organisations, therefore *“programs were not reaching most of the rural areas”*.

According to another participant, ADRA is currently working with the MEHRD curriculum development division, the MWYCA and the MHMS to develop health curriculum for children and to determine ways to integrate this curriculum into schools.

SIPPA also trained volunteer peer educators to work in the Central Island Province. These educators live in their community and *“despite working on a voluntary basis they are willing to do the job and are very helpful in educating their peers, they even refer risk mothers to the clinic or hospital”*. They

are also referred to by a youth worker as *“helping in the Stepping Stone initiative introduced by SIPPA through the Church of Melanesia”*. This youth worker also thought that working with the MHMS and the Reproductive Health Coordinators was valuable for them.

Health and youth welfare sectors:

In the health and welfare sectors, many of the programs that are developed are put in place by partnerships with the MHMS and the NGOs. Many of their initiatives also seek the cooperation and involvement of the churches and the wider community. Health clinics often collaborate with each other to provide more complete services. Some examples of this follow.

Health and youth sector workers often seek to develop relationships with key people in the community (teachers, pastors and headmen/chiefs) in order to facilitate health promotion programs and education for youth. When a program is ready to be developed health/youth workers often involve church leaders, nurses at other clinics, and the MHMS (particularly the health promotion unit and the RH coordinator) to help develop and implement the program.

A youth sector worker is involved with church youth ministry and youth groups, and has been regularly invited to retreats to give talks on *“STIs and teenage pregnancy”*. This worker argued that the churches would like to be more actively involved with youth, but the health services needed to strengthen their links with them so that the church workers are more informed about SRH issues so that they *“can assist us in taking out the message”*.

A provincial clinic works in the community by organising discussion groups with women’s groups on family planning and *“how mothers deal with situations faced by young people”*. These discussion groups are held in the community.

Save the Children is working with some clinics to improve knowledge on *“adolescent issues, treatment, investigation and pap smears”*. This clinic was also receiving assistance from UNICEF who helped the clinic to implement the Baby Friendly initiative, but UNICEF had not worked with this clinic to improve adolescent health.

Many of the NGOs and faith-based organisations such as ADRA, SCA and World Vision **meet to share ideas** and develop ways of disseminating information.

help expertise from them, I usually ask them for to come, in areas where I could not provide and they always come and take it, and likewise me too, when it comes to areas they want me to take and help them with workshops or trainings or sessions with them.”

One clinic worker in Honiara discussed the networking and support they used to receive from Save the Children (from 2007-2010). According to this participant, Save the Children no longer employed a program coordinator, but *“it would be good if they have this program coordinator again... this program is really effective for the adolescents”*.

Many of the NGOs and faith-based organisations such as ADRA, SCA and World Vision meet to share ideas and develop ways of disseminating information. For example, for World AIDS Day one youth worker described how all the stakeholders held a workshop and determined how they would promote healthy sexual behaviour. There is also a quarterly meeting of all NGOs to share information and activities.

Provincial and urban clinic staff also partner with SIPPA (an NGO) to provide information awareness in the community. In addition, provincial clinics and SIPPA collaborate to provide services for adolescents when the need arises, and the clinic also provides a female nurse when SIPPA's is not available. Both services refer patients to each other – for example a provincial clinic worker said that they refer adolescents *“who are interested in circumcision”* to SIPPA.

Another example of health providers working together to provide a more complete range of services is a from a health worker who collaborates with the MHMS provincial staff to provide a mobile health team and workshops:

“We have a health mobile team that usually go around together as a team and visit the communities and then other support too, whenever I conducted any workshop and need

SUMMARY OF RESULTS

Training in ASRH specific areas was a significant issue for education and health professionals. The vast majority of participants would like the opportunity to engage in further training, but amongst the education sector participants only 35% had received any, despite their central role in educating adolescents.

Over half had received some kind of basic training in SRH in the past 10 years.

In the health sector, nearly all participants had received basic training in SRH, but only half had received any kind of SRH refresher training. Thus, some health workers have not acquired appropriate skills; for instance, some refuse to prescribe condoms for young people but are willing to provide sterilisation, or they require young women to have children before prescribing contraception.

Over a quarter of the health workers surveyed would recommend to a breastfeeding client requesting contraception to continue breastfeeding and to use no contraception until menses begins. In addition, if a young client presents with complaints suggesting they may be HIV positive, some of the health workers said that they would 'treat' the condition.

Adolescents' options for confidentiality are limited at schools. Because it is against school rules to 'be in a relationship' it may be unlikely that they seek help from teachers or school nurses, and if they do, parents are likely to be informed.

Attitudes of some education and health sector workers could also limit appropriate care or access to information, particularly as some are not comfortable discussing SRH with young people, but also because of cultural beliefs that limit opposite genders discussing such topics (including in clinics and classrooms). Parents, churches, and the wider community also often view the discussion of SRH topics as taboo.

Many of the health services are integrated and therefore youth can be seen attending the crowded clinics, but even if they aren't seen, many of the health providers would seek parental consent before prescribing contraception.

Not surprisingly, staff shortages and lack of staff incentives and unclear expectations of work tasks also inhibited appropriate service provision.

Health, youth and education workers must cope with poor infrastructure, a lack of funds and basic materials and the geographical isolation of many of the communities they serve.

CONCLUSIONS

In order to explore the feasibility of improving ASRH health through inter-sectoral collaboration, this study sought to identify real and perceived gaps in SRH services for adolescents. The findings from this study highlighted the need for further training for many sector workers.

The majority of participants discussed the need for greater collaboration between sectors, not only between the relevant government ministries, but between all those sectors and organisations who are involved in youth welfare.

Although it is clear there are many barriers to the provision of SRH services in the Solomon Islands, action is being undertaken by education, health and youth welfare sectors to reduce these barriers.

Many participants in this study have suggested some innovative ways to reduce these barriers further. The majority of this action involves working in partnership with other providers and the community. But in order to effectively collaborate to improve ASRH, health, education and youth workers need the right information and tools to do so.

Ways to overcome these barriers include developing ways to regularly disseminate information to workers and involving the whole community in SRH education and awareness, not just those who work with youth.

Issues over confidentiality for young people seeking information or treatment are also of concern.

There is an expressed need for more 'youth friendly' confidential health services and many sector workers would like to see the provision of youth centres where young people can access counselling, information and life skills.

Staff who work with youth should be aware of their basic job descriptions, although they do not appear to have detailed job descriptions of guidelines for action.

Participants expressed an interest in initiatives that are already part of many workers' practice, or are slowly being introduced, such as engaging community gatekeepers to gain community 'buy-in' and providing sexuality education to younger children.

Participants also suggested changes at a national level, such as greater transparency in decision-making

and developing greater links with, and between, all the NGOs and ministries involved in youth issues.

There are already moves for all relevant government departments to pool funding and develop plans and strategies together, and for a restructure of the National Youth Council so that the government has more say in NGO funding priorities.

This study found that much of the work that is done to improve ASRH is currently done collaboratively, for instance, there are many youth programs and services that involve relevant organisations and health services working in partnership.

However, there are calls for greater coordination of these programs – at a national level from relevant ministries and from adolescent reproductive health coordinators, rather than relying solely on the reproductive health coordinator in the health sector. This includes the need for greater policy clarity and the provision of guidelines for professional responses to ASRH needs.

Improved coordination and guidelines may also help direct funding towards areas in greatest need and may better enable mechanisms to be put in place for students, sector workers, NGOs and the community to better access information about ASRH to keep abreast of emerging issues and approaches used within their own and other sectors.

RECOMMENDATIONS

(including from the Participants' Feedback Workshop)

For ASRH services provided in the Solomon Islands

At the national policy level:

- Embed a rights-based approach to the sexual and reproductive health of adolescents in all policy and service development initiatives relating to adolescents and young people.
- Prepare a policy framework on the roles and responsibilities of the education, health and welfare sectors in ASRH counselling, referral and service provision.
- Educate and inform religious groups and parents of the national population trends and the need for professional educators and health workers to discuss reproductive health issues with young people.
- Enforce legislation related to the use of violence against women and rape.
- Provide programs to support parents to maintain their children's enrolment in school.

For the Ministry of Health and Social Welfare:

- Provide information to all health workers identifying their professional responsibilities in responding to adolescents seeking help in SRH matters.
- Clarify and disseminate policy in relation to the rights of adolescents in seeking contraception or information on ASRH issues.
- Re-orientate established health services to be 'youth friendly' and roll out 'youth friendly' clinics in new areas with high youth populations.
- Involve youth in committees/ peer education/ designing health services.
- Support the provision of ASRH education in schools, including to those at risk of leaving school early.
- Provide ASRH education, including information on avoiding threatening situations, through community and youth groups to inform out-of-school youth.

- Incorporate ASRH training into in-service training for doctors and nurses working in SRH.
- Incorporate ASRH competencies into nursing/ midwifery training and standards.
- Identify potential for multi-sectoral training, technical seminars and workshops in adolescent specific issues.

For the Ministry of Education:

- Provide information to all education sector workers identifying their professional responsibilities in responding to adolescents seeking help in SRH matters.
- Ensure that non-judgemental ASRH counselling is provided in schools.
- Incorporate relevant SRH training into professional development for teachers.
- Involve education providers in established SRH NGO/health partnerships.
- Include SRH in education sector job descriptions and functions.
- Incorporate adolescent-specific counselling skills into job descriptions for relevant teachers in middle school.
- Engage in NGO and health sector partnerships in disseminating information on ASRH.
- Broaden the Health Promoting Schools Policy to include ASRH.
- Consider making ASRH an examinable subject in the school curriculum.

For inter-sectoral collaborators:

(MoH& SW, MoE, Ministry of Women Youth & Children's Affairs and NGOs in the health, education and welfare/social sectors.)

- Expand and support network memberships for young people (e.g. National Youth Alliance).
- Conduct joint community (or other) activities with youth that require their creative inputs and participation.

- Engage in wider consultation with community stakeholders and government officials at the national policy level.
- Collaborate between sectors in giving professional advice in and to communities.
- Develop ‘champions’ for youth and facilitate relationships with gatekeepers in the community.
- Engage community ‘gatekeepers’ in discussing processes of adapting to social change.
- Use the mass media, particularly youth radio programs to disseminate information.
- Provide user anonymous information systems, such as telephone counselling or providing information through texting services.

For international agencies and partnerships:

- Provide technical support to training initiatives in ASRH, particularly around achieving competencies.
- Provide technical support for policy and advocacy efforts in ASRH.
- Ensure adequate supply and easy access to appropriate contraception in youth friendly and youth specific clinics.
- Evaluate the effectiveness of designated ‘Youth Friendly Services’ to identify their particular advantages in reaching adolescents.

Stakeholders’ Meeting

11th September 2012, 18:00pm – 20:00pm in Honiara

The stakeholders meeting was organised by the Solomon Islands National Health Research and Training Institute and convened after hours by Dr Levi Hou for senior staff of the Ministry of Education, MHSW, senior clinical staff of the NRH and others. The WHO Country Representative Dr Fleischl attended the meeting. The PS Health Dr Ross had attended the feedback workshop on the previous day and registered his apologies. It was commented that “this consultation forum workshop was the first of its kind to bring stakeholders together to discuss common issues of ASRH”.

Dr Graham Roberts presented the key findings and elicited comments and suggestions to respond to and further inform the ASRH situation in the Solomon Islands: The following 5 proposals emerged.

1. Conduct an across-government policy analysis on matters related to ASRH and identify areas where ASRH issues can be addressed through collaboration among government ministries (health and education in particular but not exclusively) and with NGOs.
2. Mobilise political action by economic analysis of the cost to the nation of high rates of teenage pregnancy and early motherhood
3. Promulgate a national policy statement on the legal age of consent and the associated regulations and penalties.
4. Determine the cost of implementing the ASRH policy and seek support for funding the components of its implementation.
5. Identify the proportion of teenagers among all deliveries at the National Referral Hospital (and other hospitals where possible) and identify their social and demographic characteristics in order the better target preventative actions to those who most need them.

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ANNEX 1: KNOWLEDGE ATTITUDE AND PRACTICE IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH QUESTIONNAIRE FOR EDUCATION PROVIDERS

About you

- 1 Name of school you work at
-
- 2 Your position title
-
- 3 What is your sex?
-
- 4 What is your age?
-
- 5 What is your religion?
1. Protestant (e.g. Church of Melanesia; United Church; Seventh Day Adventist; South Seas Evangelical)
 2. Catholic
 3. Muslim
 4. Traditional
 5. None
 6. Other: _____
 7. Don't know

Your Experience and Training in Adolescent Sexual and Reproductive Health Education

- 6 Is sexual and reproductive health education taught at the school you work at?
- | | | |
|-----------------------|---------------------|-----------------------------|
| 1. Yes
Go to Q. 7. | 2. No
Go to Q 15 | 3. Don't Know
Go to Q 15 |
|-----------------------|---------------------|-----------------------------|
-
- 7 What content areas does the curriculum cover?
- A. Anatomy and biology of male and female reproductive systems
 - B. Sexuality, gender and norms
 - C. HIV/ AIDS and sexually transmitted diseases
 - D. Contraception
 - E. Human relationships
 - F. Other: _____
 - G. Don't Know
-
- 8 Do you teach sexual and reproductive health subjects?
- | | | |
|--------|---------------------|-----------------------------|
| 1. Yes | 2. No
Go to Q 15 | 3. Don't Know
Go to Q 15 |
|--------|---------------------|-----------------------------|

Your Experience and Training in Adolescent Sexual and Reproductive Health Education (cont.)

9 What reproductive health content areas do you teach and to what grade?
(Tick the appropriate boxes for each row.)

	Grade 6 - 9 10–14 Years	Grade 10 & 11 4-16 Years	Grade 12-13 16-18 Years
A. Anatomy and biology of male and female reproductive systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Sexuality, gender and norms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. HIV/ AIDS and sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Human relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10 How many years have you been teaching these subjects at School? _____ years Less than one year Don't know

11 Is your performance in teaching these subjects assessed by your supervisor and feedback given? 1. Yes 2. No
Go to Q 13 3. Don't Know
Go to Q 13

12 Who assesses your performance and provides feedback? Other teachers Health workers

13 Do you get any assistance teaching these subjects? 1. Yes 2. No
Go to Q 15

14 Who has provided you with assistance to teach adolescent sexual and reproductive health? A. Science teachers F. Social workers
B. Public Health Nurse G. Counsellors
C. Public Health Inspector H. Others: _____
E. Medical doctors at the MoH Office

15 Do you think sexual and reproductive health should be taught in schools? 1. Yes 2. No
Go to Q 18 3. Don't Know
Go to Q 18

Your Experience and Training in Adolescent Sexual and Reproductive Health Education (cont.)

16 What topic areas do you think should be covered in the school curriculum and what grade should receive information in this areas? (Tick the appropriate boxes for each row.)

	Grade 6 - 9 10–14 Years	Grade 10 & 11 14-16 Years	Grade 12-13 16-18 Years
A. Anatomy and biology of male and female reproductive systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Sexuality, gender and norms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. HIV/ AIDS and sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Human relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17 Who do you think should teach this material? (Circle which you think applies)

A. School teachers	C. Mature school teachers
B. Science teachers	D. Health workers

18 Have you been involved in counselling students in areas of sexual reproductive health?

1. Yes	2. No Go to Q 22	3. Don't know Go to Q 22
--------	---------------------	-----------------------------

19 What was the nature of the problem or issue of the last student you counselled?

A. Anatomy and biology of male and female reproductive systems
B. Sexuality, gender and norms
C. HIV/ AIDS and sexually transmitted diseases
D. Contraception
E. Human relationships
F. Other: _____

20 What was the outcome of the consultation?

1. Information and advice given	3. Referral
2. Another counselling appointment made	

21 Who was involved in addressing this student issue?

1. The Principal	5. Social worker
2. Another teacher	6. Police
3. Parents	7. No other professionals
4. Health worker	8. Other: _____

22 How many years ago did you finish your basic training?

_____ years	No basic training
Less than six months	Don't know

23 Did your basic training cover these? (Read A-F and circle if yes)

A. Anatomy and biology of male and female reproductive systems
B. Sexuality, gender and norms
C. HIV/ AIDS and sexually transmitted diseases
D. Contraception
E. Human relationships
F. Counselling adolescent students

Your Experience and Training in Adolescent Sexual and Reproductive Health Education (cont.)

24	Have you attended any in-service training courses specifically on adolescent sexual and reproductive health?	1. Yes	2. No Skip to Q. 27	3. Don't know Skip to Q. 27
25	Did that training include the following areas? (Read A–G and circle if yes)	A. Anatomy and biology of male and female reproductive systems B. Sexuality, gender and norms C. HIV/ AIDS and sexually transmitted diseases D. Contraception E. Human relationships F. Counselling youth G. Other: _____		
26	How long ago was that training? (If topic was covered)			
	A. Anatomy and biology of male and female reproductive systems	_____ years ago	less than 1 year ago	don't know
	B. Sexuality, gender and norms	_____ years ago	less than 1 year ago	don't know
	C. HIV/ AIDS and sexually transmitted diseases	_____ years ago	less than 1 year ago	don't know
	D. Contraception	_____ years ago	less than 1 year ago	don't know
	E. Counselling youth	_____ years ago	less than 1 year ago	don't know
27	Are you aware of any institutional policies on adolescent sexual and reproductive health?	1. Yes	2. No Skip to Q. 31	
28	If so, please describe these policies:	_____ _____ _____ _____		
29	Do you agree with the above policies?	1. Yes Skip to Q. 31	2. No	
30	If not, which policies do you think should be changed?	_____ _____ _____		
31	What would you do if a student came to you with a sexual or reproductive health problem? (Circle all that apply.)	1. Counsel student yourself 2. Refer for counselling 3. Refer for health check up 4. Inform parents	5. Inform Principal/ superior 6 Other: _____ 7. Don't know	
32	How comfortable are you discussing sexual and reproductive health topics with adolescent students? Would you say you are very uncomfortable, somewhat uncomfortable, comfortable, or very comfortable?	1. Very uncomfortable 2. Somewhat uncomfortable	3. Comfortable 4. Very comfortable	

ANNEX 2: KNOWLEDGE ATTITUDE AND PRACTICE IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH QUESTIONNAIRE FOR HEALTH PROVIDERS

About you

- 1 Name of Health facility you work at
-
- 2 Your position title
-
- 3 What is your sex?
-
- 4 What is your age?
-
- 5 What is your religion?
1. Protestant (e.g. Church of Melanesia; United Church; Seventh Day Adventist; South Seas Evangelical)
 2. Catholic
 3. Muslim
 4. Traditional
 5. None
 6. Other: _____
 7. Don't know

Your Experience and Training in Reproductive Health Services

- 6 What services do you yourself provide to clients of the age groups below at this health facility?
(Tick the appropriate boxes for each row.)

	10–14 Years	15–19 Years	20–24 Years
A. Contraceptive counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Emergency Contraceptive pill (ECP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Antenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Maternity care/delivery services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Postnatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. HIV/AIDS counselling/ information education communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. HIV/AIDS testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Other STI counselling/IEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Other STI diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Other STI treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Treatment of incomplete abortions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Experience and Training in Reproductive Health Services (cont.)

		10–14 Years	15–19 Years	20–24 Years
	L. Nutrition counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	M. Infertility consulting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	N. Gynaecological exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	O. Pregnancy testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	P. Reproductive health education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	How many years have you been working in this facility?	_____ years	Less than one year	Don't know
8	How many years ago did you finish your basic training?	_____ yrs	Less than six months	No basic training Don't know
9	Did your basic training cover these? (Read A-J and circle if yes)	A. Contraceptive counselling	F. Nutrition counselling	
		B. Antenatal care	G. Infertility consulting	
		C. Maternity care delivery services	H. Gynaecological exam	
		D. Postnatal care	I. Pregnancy testing	
		E. Treatment of incomplete abortions	J. Reproductive health	
10	Have you ever had refresher training in these areas? (Read A-J and tick if yes. For those areas checked yes, indicate the month of the training.)	A. Refresher Training? Tick if yes	B What was the month/year of your last refresher training?	
	A. Contraceptive counselling	<input type="checkbox"/>	_____	
	B. Antenatal care	<input type="checkbox"/>	_____	
	C. Maternity care/delivery services	<input type="checkbox"/>	_____	
	D. Postnatal care	<input type="checkbox"/>	_____	
	E. Treatment of incomplete abortions	<input type="checkbox"/>	_____	
	F. Nutrition counselling	<input type="checkbox"/>	_____	
	G. Infertility consulting	<input type="checkbox"/>	_____	
	H. Gynaecological exam	<input type="checkbox"/>	_____	
	I. Pregnancy testing	<input type="checkbox"/>	_____	
	J. Reproductive health education	<input type="checkbox"/>	_____	

Your Experience and Training in Reproductive Health Services (cont.)

11	Have you attended any refresher or post-basic training courses specifically on contraceptive clinical skills, program management or HIV/STI counselling, diagnosis and treatment?	1. Yes	2. No Skip to Q. 15	3. Don't know Skip to Q. 15
12	Did that training include the following areas? (Read A–O and circle if yes)	A. General clinical skills in contraceptive methods B. Contraceptive counselling C. Natural family planning methods D. Management E. Supervision F. Record keeping G. Stock keeping	H. STI risk assessment screening I. STI counselling J. STI laboratory diagnosis K. Syndromic approach to diagnosis and treatment L. HIV/AIDS counselling M. HIV/AIDS testing N. Special needs of youth O. Counselling youth	
13	How long ago was that training? (If topic was covered)			
	A. General clinical skills in contraceptive methods	_____ years	Less than 1 year	Don't know
	B. Contraceptive counselling	_____ years	Less than 1 year	Don't know
	C. Natural family planning methods	_____ years	Less than 1 year	Don't know
	D. Management	_____ years	Less than 1 year	Don't know
	E. Supervision	_____ years	Less than 1 year	Don't know
	F. Record keeping	_____ years	Less than 1 year	Don't know
	G. Stock keeping	_____ years	Less than 1 year	Don't know
	H. STI risk assessment/screening	_____ years	Less than 1 year	Don't know
	I. STI counselling	_____ years	Less than 1 year	Don't know
	J. STI laboratory diagnosis	_____ years	Less than 1 year	Don't know
	K. Syndromic approach to diagnosis and treatment	_____ years	Less than 1 year	Don't know
	L. HIV/AIDS counselling	_____ years	Less than 1 year	Don't know
	M. HIV/AIDS testing	_____ years	Less than 1 year	Don't know
	N. Special needs of youth	_____ years	Less than 1 year	Don't know
	O. Counselling youth	_____ years	Less than 1 year	Don't know

Contraceptives

14	In the last three months, have you yourself actually provided contraceptive counselling to youth clients?	1. Yes	2. No Skip to Q. 16	3. Don't know Skip to Q. 16
15	If yes, which methods have you yourself actually provided to youth clients in the last three months? (Circle all that apply.)	1. Oral contraceptives 2. Emergency contraception (ECP) 3. IUD 4. Injectable 5. Norplant 6. Condom 7. Diaphragm	8. Spermicide 9. Female sterilization 10. Vasectomy 11. Natural family planning 12. Emergency contraceptives 13. Other: _____	
16	Is there a minimum age below which you yourself will not prescribe (Read A–F), in the absence of medical contraindications? (Circle if yes.)	A. Pill B. ECP C. Condom	D. IUD E. Injectable F. Sterilization	
17	If yes, what is that minimum age?	List age here		
	A. Pill	_____		
	B. ECP	_____		
	C. Condom	_____		
	D. IUD	_____		
	E. Injectable	_____		
	F. Sterilization	_____		
18	Is there a minimum number of children a young woman must have before you yourself will prescribe (Read A-F), in the absence of medical contraindications? (Circle if yes.)	A. Pill B. ECP C. Condom	D. IUD E. Injectable F. Sterilization	
19	If yes, what is that minimum number of children?	List age here		
	A. Pill	_____		
	B. ECP	_____		
	C. Condom	_____		
	D. IUD	_____		
	E. Injectable	_____		
	F. Sterilization	_____		
20	Would you yourself prescribe (Read A-F) to an unmarried youth, in the absence of medical contraindications? (Circle if yes.)	A. Pill B. ECP C. Condom	D. IUD E. Injectable F. Sterilization	

Contraceptives (cont.)

21	Do you require parental consent before you will provide (Read A-F) to a youth client? (Circle if yes.)	A. Pill B. ECP C. Condom	D. IUD E. Injectable F. Sterilization
22	In the past month, have you advised any youth clients to use contraception specifically for preventing pregnancy?	1. Yes	2. No 3. Don't remember/ don't know
23	If a youth client comes to you for contraception and is breastfeeding an infant under six months old, what advice would you give her?	1. You treat her like any other client 2. You advise her to stop breastfeeding and use a contraceptive method 3. You advise her to continue breastfeeding and also begin a contraceptive method	4. You advise her to continue full breastfeeding and not use any contraception until her menses begin 5. Don't know
24	If a 14-year-old client who admits to being sexually active comes to you for contraception, what advice would you give her or him?	1. You ask the client what type of method he or she prefers and prescribe that method for the client 2. You advise the client to abstain from having sex and do not prescribe any contraception	3. You advise the client to abstain from having sex, but give the client some condoms, just in case 4. Other _____ 5. Don't know
25	If a youth client visiting for resupply of contraceptive pills appears to be at high risk of infection by STIs or HIV/AIDS, what advice would you offer?	1. To continue to use only the pill 2. To continue with the pill but also use condoms 3. To change from the pill to condoms	4. To stop using any type of contraceptive method 5. To not have sex 6. Don't know
26	What methods would you NOT recommend for youth clients with an STI? (Circle all that apply.)	1. Pill 2. ECP 3. Condom 4. Spermicide 5. IUD 6. Injectable	7. Norplant 8. Natural family planning 9. Diaphragm 10. None 11. Other: _____
27	Are there any methods you would never recommend under any circumstances?	1. Yes 2. No Skip to Q. 29 3. Depends on client's health Skip to Q. 29	4. Depends on client's preference Skip to Q. 29 5. Don't know Skip to Q. 29

Contraceptives (cont.)

- | | | |
|--|--|---|
| 28 What are those methods?
(Circle all that apply.) | 1. Pill
2. ECP
3. Condom
4. Spermicide
5. IUD
6. Injectable | 7. Norplant
8. Natural family planning
9. Diaphragm
10. None
11. Other: _____ |
| 29 Are you aware of any institutional policies on providing contraceptives to youth? | 1. Yes | 2. No
Skip to Q. 33 |
| 30 If so, please describe these policies: | _____

_____ | |
| 31 Do you agree with the above policies? | 1. Yes
Skip to Q. 33 | 2. No |
| 32 If not, which policies do you think should be changed? | _____

_____ | |

Other Reproductive Health Practices

- | | | |
|--|--|---|
| 33 How do you determine the pregnancy status of a client who comes to the facility and is not having her menses?
(Circle all that apply.) | 1. Don't determine pregnancy status
2. Tell her to return at menses
3. Ask if no sex since last menses
4. Ask if less than six weeks since delivery | 5. Ask if less than six months since delivery, with no supplemental feeding
6. Perform pregnancy test
7. Perform physical exam
8. Other: _____ |
| 34 If you think that a youth client has an STI, what do you do for your client?
(Circle all that apply.) | 1. Request laboratory test
2. Diagnose STI
3. Treat STI
4. Refer for diagnosis
5. Refer for treatment | 6. Provide counselling
7. Refer for counselling
8. Issue a contact or partner notification slip
9. Other: _____ |
| 35 What do you do for a youth client who presents to you with complaints suggesting that he or she may be HIV positive or have AIDS?
(Circle all that apply.) | 1. Counsel client
2. Refer for counselling
3. Make a diagnosis
4. Treat the condition in clinic
5. Refer for treatment | 6. Provide follow-up after treatment
7. Refer for follow-up after treatment
8. Refer for testing
9. Other: _____
10. Don't know |

Other Reproductive Health Practices (cont.)

36	In the past month, have you advised any youth clients to use condoms specifically for preventing STIs or HIV infection?	1. Yes	2. No	3. Don't remember/ don't know
37	Would you provide reproductive health services to a client who has HIV or AIDS?	1. Yes	2. No	3. Don't know
38	How comfortable are you discussing sexual behaviour related to STIs/HIV with youth clients? Would you say you are very uncomfortable, somewhat uncomfortable, comfortable, or very comfortable?	1. Very uncomfortable 2. Somewhat uncomfortable		3. Comfortable 4. Very comfortable
39	As far as you know, do female youth come to this facility for advice on termination of pregnancies?	1. Yes	2. No	3. Don't know
40	As far as you know, do female youth come to this facility for medical treatment as a consequence of incomplete induced abortion?	1. Yes	2. No	3. Don't know

This is the end of the questionnaire – thank you very much indeed for your time.

This questionnaire has been adapted from:

Adamchak, S, Bond, K, MacLaren, L, Magnani, R, Nelson, K, Seltzer, J 2000., *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs*, Pathfinder International, Washington, DC.

THE KNOWLEDGE HUBS FOR HEALTH INITIATIVE

The Human Resources for Health Knowledge Hub is one of four hubs established by AusAID in 2008 as part of the Australian Government's commitment to meeting the Millennium Development Goals and improving health in the Asia and Pacific regions.

All four Hubs share the common goal of expanding the expertise and knowledge base in order to help inform and guide health policy.

Human Resource for Health Knowledge Hub

University of New South Wales

Some of the key thematic areas for this Hub include governance, leadership and management; maternal, newborn and child health workforce; public health emergencies; and migration.

www.hrhub.unsw.edu.au

Health Information Systems Knowledge Hub

University of Queensland

Aims to facilitate the development and integration of health information systems in the broader health system strengthening agenda as well as increase local capacity to ensure that cost-effective, timely, reliable and relevant information is available, and used, to better inform health development policies.

www.uq.edu.au/hishub

Health Finance and Health Policy Knowledge Hub

The Nossal Institute for Global Health (University of Melbourne)

Aims to support regional, national and international partners to develop effective evidence-informed national policy-making, particularly in the field of health finance and health systems. Key thematic areas for this Hub include comparative analysis of health finance interventions and health system outcomes; the role of non-state providers of health care; and health policy development in the Pacific.

www.ni.unimelb.edu.au

Compass: Women's and Children's Health Knowledge Hub

Compass is a partnership between the Centre for International Child Health, University of Melbourne, Menzies School of Health Research and Burnet Institute's Centre for International Health.

Aims to enhance the quality and effectiveness of WCH interventions and focuses on supporting the Millennium Development Goals 4 and 5 – improved maternal and child health and universal access to reproductive health. Key thematic areas for this Hub include regional strategies for child survival; strengthening health systems for maternal and newborn health; adolescent reproductive health; and nutrition.

www.wchknowledgehub.com.au

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