HIV / AIDS Prevention and Capacity Development in the Pacific: Peer Education and Support Program Mapping Consultancy

Final Report

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Final Report

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1.0 Executive Summary

The purpose of the peer education and support program mapping consultancy was to undertake an assessment of national programs and/or organisations utilising the peer education methodology to work with identified HIV vulnerable populations in the Pacific region. The assessment identified the gaps and capacity building needs of the programs / organisations, which has fed into the development of a strategic framework for regional organisations like the Secretariat of the Pacific Community (SPC) to provide support to national peer education programs and behaviour change interventions.

An in-depth assessment of peer education programs working with identified vulnerable populations was conducted for ten selected countries—Cook Islands, Federated States of Micronesia, Kiribati, Nauru, Republic of the Marshall Islands, Samoa, The Solomon Islands, Tuvalu, Tonga and Vanuatu. The assessment was required to address the following:

1. Identify whether referral systems are in place for HIV & STI clients, and if present, the referral points.
2. Identify the processes used to develop or recommend capacity development of existing staff and volunteer skills, knowledge and program development in relation to working with vulnerable populations.
3. Define strategies to improve the capacity of staff and volunteers.
4. Recommend strategies (including skills training) for delivering effective and needs based programs/interventions for vulnerable groups.
5. Identify other pertinent issues that may impact on the effectiveness of current programs, including consideration of (i) a code of ethics; and (ii) common difficulties in interventions focused on vulnerable or marginalized populations.

These have been achieved and are detailed in this report.

Assessing peer education programs involved four specific activities: examination of national strategies, and other relevant documentation; surveying and interviewing national organisations involved in peer education; and consulting with regional organisations involved in the delivery of HIV & STI services.

In undertaking the assessment it became evident that the term *peer education* is used throughout the Pacific region to describe many different activities and methodologies. The lack of a common definition, or understanding of what constitutes peer education, did make the assessment more challenging. It was decided that for the purposes of the review peer education would be defined as *an education program conducted by, and for, members of the same peer group; and a peer was someone from the same group, in which the group members identified with each other because of certain features they have in common*. It is a specific methodology that has a set structure and process. Using this definition does not mean that other forms of education described in the report (mostly community education) are not worthwhile or legitimate. It is acknowledged that much is being achieved via different methodologies, and that other forms of education actually assist peer education methodologies because they provide the context and 'set the scene'.

From the review of national AIDS & HIV strategies for peer education content a number of consistent themes were noted:

- Strategies often identify vulnerable populations but frequently there are no specific actions linked to the groups, or alternately, actions are targeted at generic groupings (men, women, youth) with vulnerable populations confined as a subset of the general community (women, including sex workers). There is often no specificity of targeting.
- The engagement of affected populations in the design and development of interventions as demonstrated by the national strategic plans is selective. Whilst many of the strategies identify a readiness to engage, support and accept people living with HIV / AIDS (PLWHA), and facilitate their role as advocates and partners, very little is evidenced to engage those populations at high risk of HIV prior to being infected.
- The majority of strategies lack clear guiding principles that outline an underlying framework for the strategy.

National AIDS & HIV strategies need to be reviewed in collaboration with regional partners, and there needs to be a stronger definition of who the stakeholders are when consultation is undertaken to ensure appropriate representation for the vulnerable and marginalised.

In the course of this assessment a number of issues were consistently identified across countries and organisations. Effective monitoring and evaluation (M&E) was a dominant theme. M&E was identified as one of the major weaknesses of most peer education programs. The great majority of organisations raised the challenge of ensuring quality of content within peer education programs, and of well targeted interventions directed at the appropriate vulnerable group with measurable outcomes that indicate changes in knowledge, attitudes and practice. There is a need to move beyond the simple process evaluation (head counting) most commonly used by programs and embrace broader measures of outputs and outcomes. There is a lack of clarity about the reporting systems used by individual programs, the relevance and measurability of indicators, and to whom and how they report.

Thirteen regional organisations were also involved in the review. The consultations added a regional perspective to the issues raised within individual countries.

Limited coordination at regional and national levels was consistently highlighted with little coordination in the delivery of activities resulting in multiple programs cutting across or competing with each other. Coordination, networking and possible standardisation are seen as desirable goals. There appears to be no standardisation of management systems for peer education programs, and no standardised system of networking, recruitment, training, data collection and reporting. Emphasis needs to be placed on developing the capacity of national networks because of greater relevance in country, and the ability to encourage better sharing of resources, experiences and knowledge. However, these national frameworks should be linked with a coordinated regional framework.

A critical need identified was to ensure that those most at risk are the target of effective interventions. This includes appropriate matching of peer educators to the intended target. Most peer education in the Pacific has traditionally targeted young people, indeed has become synonymous with youth education, with other vulnerable groups included as incidental recipients within the community. Consequently there is an over reliance on young volunteers to assume educational responsibility for a diverse range of populations. There is a further gap of how vulnerability is identified even within youth populations, which are often defined in countries with large age ranges. There are significant issues as to who constitutes a peer for whom, and who would be most effective in being a peer.

The solution for many countries has been to broaden peer education to community education, to include vulnerable populations within that broad community umbrella, and to multi-task their peer educators to provide multiple services for multiple groups. Consequently, many peer based strategies become exercises in community education.

Peer education in many countries is hampered by physical, demographic and social constraints. Consequently, a number of organisations have prioritised:

- Additional funding to provide more training (both recruitment and refresher) to enable remuneration of volunteers, to enhance outreach activities to cover wider geographical areas and target other vulnerable groups, and to establish sustainable systems.
- More effective and informative M&E systems that can guide the development of appropriate programs targeting those most at risk.
- Uniform resources, training curriculum and M&E practices across national and regional networks with particular emphasis on training resources that are appropriate for members of vulnerable groups and account for their particular needs.
- Greater national coordination of various peer education programs with greater flow of communication and joint planning, referral and follow-up systems. Governments should be a key component of any national network, providing a framework for peer education. These national frameworks should be linked to a regional framework. Where particular countries or territories are too small for a national network, organisations did prioritise a need to be connected with regional networks. Establishing regional networks for vulnerable groups has been important for communication and support.
- The need for skill development among peers to be able to participate in their own governance, management and strategic coordination activities. Facilitation skills training was considered a crucial component of peer education training and should be regarded as important as content. It was noted that few peer educators have acquired experience and skills in project management and evaluation.

However encountering these barriers is the reality for many countries—small populations dispersed over a large geographical distance, poorly resourced with limited transport and communication infrastructure. Set against this context the many issues and gaps cannot be easily resolved. These include training, recruiting, remunerating, and sustaining peer educators; maintaining enthusiasm and motivation; monitoring of activities; issues of identification of, and engagement with, vulnerable communities; exposure to discrimination and stigmatisation and ability to network with peers at a local and regional level.

The review has shown that peer education is occurring across the region and that the methodology is a valid one to educate vulnerable populations about HIV & other STI transmission and prevention. Much of the effort is very effective and there is potential in the use of peer education for an effective sustained response to HIV in the region.

2.0 Abbreviations and Acronyms

This list of abbreviations and acronyms does not include individual organisations from individual countries. These may be found in the individual country sections.

ABC	abstinence, behaviour change, condom usage
ACON	AIDS Council of New South Wales
ADRA	Adventist Development Relief Agency
ADB	Asian Development Bank
AFAO	Australian Federation of AIDS Organisations
AHD	adolescent health and development
AIVL	Australian Injecting and Illicit Drug Users League
AMFAR	American Foundation for AIDS Research
ANCP	Australian Non-government Program
ARH	adolescent reproductive health
ARHP	Adolescent and Reproductive Health Program
ASRH	adolescent sexual and reproductive health
AusAID	Australian Agency for International Development
BCC	behaviour change communication
CPG	community planning group
CSM	condom social marketing
CSO	community service organisation
CSW	commercial sex worker
FSM	Federated States of Micronesia
FSPI	Foundation of the Peoples of the South Pacific
FTE	Full-time equivalent
HIV	Human Immunodeficiency Virus
IEC	information, education, communication
ILO	International Labour Organisation
IPPF	International Planned Parenthood Association
KANGO	Kiribati Association of Non Government Organisations
KAP	knowledge attitude (aptitude) practices (perception)
KAPB	knowledge attitude (aptitude) practices (perception) behaviour
KHATBTF	Kiribati HIV AIDS Tuberculosis Task Force
LGBTI	lesbian, gay, bisexual, transgender, intersex
M&E	monitoring and evaluation
MMM	Mobile Men with Money
MoH	Ministry of Health
MPH	Masters in Public Health
MSCS	Most Significant Change Stories
MSIP	Marie Stopes International Pacific
MSM	men who have sex with men
NAC	National AIDS Council

NAPWA	National Association of People living with HIV / AIDS (Australia)
NGO	non-government organisation
NHS	National Health Service (UK)
NSW	New South Wales
NZAF	New Zealand AIDS Foundation
NZAID	New Zealand International Aid & Development Agency
OSSHHM	Oceania Society for Sexual Health and HIV Medicine
PCC	Pacific Conference of Churches
PE	peer education (and peer educator(s))
PhD	Doctorate in Philosophy
PIAF	Pacific Islands AIDS Foundation
PICT	Pacific Island Countries and Territories
PLWHA	people living with HIV / AIDS
PNG	Papua New Guinea
PRHP	Pacific Regional HIV / AIDS Project
PRISP	Pacific Regional Strategy Implementation Plan
PSDN	Pacific Sexual Diversity Network
RMI	Republic of the Marshall Islands
SPC	The Secretariat of the Pacific Community
SPOCTU	South Pacific and Oceanic Council of Trade Unions
STI	sexually transmitted infection
SW	sex worker
UNAIDS	United Nations AIDS Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
VCCT	voluntary confidential counselling and testing (Also VCT)
WHO	World Health Organisation
WLWHA	women living with HIV / AIDS
Y-PE	Youth Peer Education
YTYIH	Youth to Youth in Health

3.0 Summary of the project

The purpose of the peer education and support program mapping consultancy was to undertake an assessment of national programs and/or organisations utilising the peer education methodology to work with identified HIV vulnerable populations in the Pacific region. The assessment identified the gaps and capacity building needs of the programs / organisations, which has fed into the development of a strategic framework for regional organisations like the Secretariat of the Pacific Community (SPC) to provide support to national peer education programs and behaviour change interventions.

The specific objectives of the assignment:

1. In-depth assessment of peer education programs working with identified vulnerable populations in selected countries in the Pacific region—Cook Islands, Federated States of Micronesia, Kiribati, Nauru, Republic of the Marshall Islands, Samoa, Solomon Islands, Tuvalu, Tonga and Vanuatu.
2. Identify whether referral systems are in place for HIV & STI clients, and if present, the referral points.
3. Identify the processes used to develop or recommend capacity development of existing staff and volunteer skills, knowledge and program development in relation to working with vulnerable populations.
4. Define strategies to improve the capacity of staff and volunteers.
5. Recommend strategies (including skills training) for delivering effective and needs based programs/interventions for vulnerable groups.
6. Identify other pertinent issues that may impact on the effectiveness of current programs, including consideration of (i) a code of ethics; and (ii) common difficulties in interventions focused on vulnerable or marginalized populations.

For complete details of the consultancy and project methodology see Appendices Two and Three. The consultancy commenced 20 January 2009 and concluded with the submission of the *Final Report* 20 April 2009.

The assessment of peer education programs involved four specific activities:

1. Review of national strategies and programs addressing vulnerable groups and using peer education methodologies and activities.
2. Review of other relevant documentation (e.g. national peer education policies).
3. Survey and interview of selected national organisations involved in peer education.
4. Interview of regional organisations supporting peer education activities in the region.

In the following sections and appendices each country is discussed using the information gathered from the above activities. There are common themes across the countries and they are investigated in the first parts of Sections 5.0 and 6.0. Discussions and recommendations specific to each country are also included the latter parts of Sections 5.0 and 6.0.

The mapping exercise generated much information that was reviewed and analysed to devise the recommendations laid out in this report. Due to the size and nature of the assessment the findings have been presented in several formats—this version, an abridged version of this report, and individual country reports—to be shared with relevant stakeholders.

4.0 Use of the term *peer education*

The term *peer education* is currently being used to cover many different activities and methodologies in the Pacific region. The historical context of peer education in the region details the evolution of this and is described in the next two paragraphs.

Peer education as a HIV prevention strategy / methodology was first introduced to the region between 1998-2000 when an intensive three-week peer education course was delivered by the Australian Federation of AIDS Organisations (AFAO) and the AIDS Task Force of Fiji (funded by AusAID). The course emphasized a one-to-one outreach model targeting sex workers, wheelbarrow boys and nightclub patrons, and provided high quality training with an emphasis on communication skills, record keeping and ethics. Rigid criteria were used to assess candidates and on-site training with strong follow-up was provided. The outreach project focussed on the dissemination of information, condom distribution and referrals to health services. The outreach workers provided this service in Suva for two years before presenting their program at the first Pacific Islands HIV/AIDS Conference organized by SPCs HIV & STI Section.

After the conference, a number of other organizations were keen to adopt the concept of peer education, and it became incorporated for example into the Adolescent Reproductive Health Program (later to become the Adolescent Health and Development (AHD) Program). Through the AHD Program, the original concept of peer education as a one-to-one contact through outreach has evolved and been adapted to suit resource and local capacity constraints. The length of training required to graduate as a peer educator has often been significantly reduced (in some cases down to only three days). Peer educators have then been posted to health centres with an expectation to present to groups on sexual and reproductive health, including HIV & STIs. They are often not provided with enough training for this role. Due to resource constraints in countries peer educators are also often required to take on coordination and other roles depending on the demands of the various organisations, health services and local communities.

Due to this evolution of peer education the term means different things to different individuals and organisations. Examples of what has been included in the catchphrase *peer education* include:

- Community education conducted by individuals who do not belong to the subpopulation being targeted.
- Awareness raising activities conducted by individuals who do not belong to the subpopulation being targeted (e.g. a 24 year old talking with school students).
- General condom distribution
- General resource distribution (pamphlets, posters and newsletters)
- Peer support (e.g. individuals with HIV meeting to support each other)
- Peer education trainers conducting community education themselves rather than training peers to conduct education with their own peers.

Much of this is falls outside the definition of peer education, so the assessment has been limited to the following definition:

The teaching or sharing of health information, values and behaviours by members of similar age or status groups.

Peer education therefore is an education program run by, and for, members of the same peer group; and a peer is someone from the same group, in which the group members identify with each other because of certain features they have in common. It is a specific methodology that has a set structure and process.

This does not mean that other forms of education or activities are not worthwhile or legitimate. It is acknowledged that much is being achieved through different methodologies, and that other forms of education actually assist peer education methodologies because they provide the context and set the scene.

Using this definition the information gathered through the assessment was analysed with the following ten criteria in mind:

1. The project **targets a vulnerable community** in the country. The intervention is well targeted. (Basis for this comes from the national strategy and from the feedback about what the vulnerable populations are in the country.)
2. **Governance.** The peers are involved in the way things are run and the decision-making. There is **engagement with the target population** in the design, implementation and evaluation of the project. There is engagement at some levels and constant attempts are made to pursue this engagement.
3. There is obvious **support** for the peer education project at an organisational and national level.
4. **Collaborative relationship** with other organisations who are undertaking HIV peer education based activities in the country so that there is no duplication (competition) of services.
5. **Recruitment strategies** for peer educators are appropriate, systematic, ongoing and sustainable. This includes developing defined marketing strategies. There is an accepted and celebrated **exit strategy** for peer educators.
6. There is initial and follow-up education for the peer educators. There is **sustainable capacity building** of peers.
7. **Referral systems** are in place to address the needs of the target population as things arise. This includes the ability to follow-up on whether anything happened as a result of the referral (did the person actually attend for VCCT), and an ability to assess whether the referring agency is effective and provides suitable service.
8. **Evaluation**. There are set outcomes. How is the **effectiveness of the project determined?** What agreed measures are in place to assess whether this project 'makes a difference' or not, and is there a defined mechanism to report against these? It is acknowledged that this is extremely difficult, however are there attempts to do this?
9. Monitoring. A code of behaviour is defined and followed. This includes a **monitoring mechanism for the knowledge, skills and conduct of peer educators**.
10. The project makes an **obvious and tangible impact**. Things that have changed as a result of the project being in existence are able to be discussed.

5.0 Discussion

5.1 Peer education references in national strategies

In analysing the peer education content of national HIV & AIDS strategies a number of consistent themes were noted.

5.1.1 Lack of specificity

Strategies often identify vulnerable populations but frequently there are no specific actions linked to a particular group, or alternately, actions are targeted at generic groupings (men, women or youth) with vulnerable populations confined as a subset of the general community (women, including sex workers). There is often no specificity of targeting. Similarly, peer education interventions are often referred to in a general sense with no particular target designated. Lack of identification of vulnerable populations in some strategies makes it difficult for local agencies to prioritise and design interventions without national acknowledgement of who is at risk.

Interventions are often targeted at young people without any differentiation made of subpopulations within youth culture. Without identifying particular subgroups of greater risk, there can be a tendency for peer education to target easy to access, highly receptive audiences rather than the more difficult to manage, yet higher risk group.

Vulnerable groups are mentioned in the strategies but specific groups such as commercial sex workers (CSW) and men who have sex with men (MSM) are notably excluded from particular national documents. Occupational groups are referred to, for example, police, seafarers and military, yet as with youth, there needs to be greater definition of the risk within these groups. High risk individuals comprise only a small subset and interventions are cost effective when directed at this subset. Targeting these individuals with appropriate peers, matched with respect to experience and background, is integral to the peer education process. Whilst identifying broad groupings may be useful for activity reporting and strategic planning, the development of targeted interventions needs greater understanding and defining of the context of risk (what, why, how, where).

Therefore a distinction needs to be made between vulnerable groups (occupational groups), and that subset which are marginalised (MSM, sex workers, transgender). Peer based activities are more easily designed and delivered to vulnerable occupational groups such as uniformed services than those that are legally and socially marginalised. This distinction needs to be acknowledged in national plans and actions designed accordingly.

5.1.2 Engagement of individuals within vulnerable populations

The engagement of affected populations in the design and development of interventions as demonstrated by the national strategic plans is selective. Whilst many of the strategies identify a readiness to engage, support and accept PLWHA and facilitate their role as advocates and partners, very little is evidenced to engage those populations at high risk of HIV prior to being infected. Whilst it is understandable and commendable that great efforts be made to establish supportive networks for PLWHA given their level of marginalisation, it would seem that these same efforts are often not as readily extended to other marginalised groups.

Collaboration as described in the national strategies is often with NGOs who administer peer education programs for targeted populations, and though peers are recruited and trained, the NGOs themselves remain separate to the vulnerable communities with few opportunities for the vulnerable groups to actively participate in decision making, planning and evaluation.

5.1.3 Guiding principles

The majority of national strategies lack clear guiding principles to outline underlying frameworks for the strategies. Examples of guiding principles that may be useful to assist the inclusion of peer education methodologies (among other things) include:

- Right of access to accurate and culturally appropriate education
- Principle of community partnership
- Inclusion and engagement of those most at risk and/or affected by HIV as collaborators in prevention efforts
- Inclusion of all marginalised and vulnerable populations in a spirit of partnership
- Confidentiality is paramount and maintained
- Strategies do not operate in the context of blame.

5.2 Scope of existing activities and interventions

Peer education activities were mapped in nine of the ten targeted countries as Nauru does not currently have any organisations undertaking HIV peer education. Twenty-three individual organisations responded to this mapping exercise.

5.2.1 Cook Islands

The current national strategy is the *National Strategy on the Response to HIV, AIDS & STIs 2008–2013*. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report. The national strategy demonstrates some strength when discussing peer education. Much of this is targeted toward young people; however other vulnerable populations are noted.

In the Cook Islands one organisation was identified as being involved in peer education and was interviewed: **Cook Islands Red Cross**. A full transcript of the interview is included in Appendix Twelve. There appears to be a slight disconnect between the national strategy and the peer education activities of the Red Cross program. The strategy highlights peer education for youth, migrant communities and tourist industry workers, yet the Red Cross program targets young people, MSM and transgender populations.

Other than process evaluation that measures activity outputs, there appears to be little monitoring of behaviour change over time. Nonetheless there appears to be a good system of communication between, and monitoring of, peer education activities.

Other than close collaboration with the Te Tiare Association for outreach to transgender and MSM, it is not clear to what extent peer educators recruited through the Red Cross program are appropriately targeted as genuine peers. The wide age range defined for youth (15–30 years) compounds this difficulty and blurs the boundary between peer education and general community education.

5.2.2 Federated States of Micronesia (FSM)

There are a number of strategies that cover the member states: *Pohnpei Strategic Plan, Kosrae Strategic Plan, Yap Strategic Plan and Chuuk Strategic Plan*. A detailed analysis of these strategies with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In FSM three organisations were identified as being involved in peer education and responded to surveys: **Adolescent Health and Development Program (Pohnpei), Chuuk State HIV Program and FSM Red Cross.** A full transcript of the interviews is included in Appendix Twelve.

A significant issue is the vast geographic spread of FSM and the implication this has on any attempts at coordinated program delivery and strategic planning. Coordination is of concern both between the states and between the organisations that are involved in peer education.

The small, scattered populations of FSM pose significant challenges to a number of programs:

- Difficulty in specifically identifying vulnerable populations
- Difficulty in communication and collaboration across programs, communities and states
- Difficulty in accessing remote, vulnerable communities
- Difficulty in retaining trained educators due to high population mobility.

Whilst some programs have made particular efforts in accessing vulnerable groups (sex workers) using appropriately trained peers, a number of programs target a very wide range of community groups. The lack of available resources within small communities necessitates that these resources be efficiently used for the whole community. Whilst this may run counter to the principle of peer education, it may be the most appropriate strategy given the limitation of resourcing.

5.2.3 Kiribati

The current national strategy is *Kiribati STI and HIV/AIDS Strategic Plan 2005–2008*. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In Kiribati four organisations were identified as being involved in peer education of which the first three responded to surveys: **Kiribati Red Cross, Adolescent Health and Development Program, Kiribati Family Health Association and Kiribati Association of NGOs (KANGO).** A full transcript of the interviews is included in Appendix Twelve.

Many of the components of an effective coordinated HIV peer education initiative are in place however confusion over the methodology does exist. At times community awareness and community based education activities are given the name of peer education although the specific activity may not be true peer education.

One significant area—common in other countries—is the need for effective monitoring and evaluation. There is an urgent need to devise a suitable monitoring tool that can engender greater accountability of peer education; to evaluate responses from the community; to better monitor peer education activities and to collect information from the community.

It is noted that there is a well organised network of NGOs involved in peer education. The network coordinates activities and avoids overlapping programs by designating particular villages to particular NGOs. However it is also noted that much of the activity described occurs in the main centre of Kiribati and there is a need to reach other parts of the country.

Payment for involvement in peer education is standard practice and appears to reap the benefit of continued involvement. An adverse outcome of payment for this type of activity is that the level of output may decrease as individuals are paid per session / activity rather than paid on outcome.

Groundwork for effective HIV peer education is in place and organisations are networked and collaborating on many initiatives.

5.2.4 Nauru

For this exercise the *Nauru Health Operational Plan 2008* was reviewed but there is no reference in it to peer education; identifying and targeting vulnerable populations; or the need to engage vulnerable groups in program design.

As there are currently no organisations involved in peer education three additional documents were reviewed:

- *Nauru National Youth Policy 2008–2015: A Vision for Quality of Life*
- *Pacific Regional HIV/AIDS Project (PRHP) Nauru Country Update 2003–2006*
- *Evaluation of Chlamydia Testing and Treatment Pilot, Republic of Nauru* by SPC and the Ministry of Health, Nauru, July 2008

An analysis of the documents is included in the Nauru country report.

Understandably when HIV was first identified within the Nauru community there was a strong urgency to dedicate national and community resources to address the potential health threat. It is equally understandable that the failure of the threat to materialise has led to a loss of motivation and commitment, with a resulting re-prioritisation of limited resources to other immediate health concerns.

This re-prioritisation should be viewed in the context of alarmingly high rates of other STIs such as Chlamydia. The implications for long term reproductive and antenatal health should urgently reinvigorate efforts to establish a new national task force, strategic plan, condom social marketing and peer education programs that address all STIs including HIV.

A public health and community infrastructure that has been established for the control of Chlamydia and syphilis could be easily adapted should HIV re-emerge.

5.2.5 The Republic of the Marshall Islands (RMI)

The current national strategy covers the period from 2006 to 2009. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In RMI one organisation was identified as involved in peer education and was interviewed: **Youth to Youth in Health (YTYIH)**. A full transcript of the interview is included in Appendix

Twelve. A low HIV prevalence coupled with the emergence of risk behaviours (transactional sex work, movement of seafarers etc.) present a window of opportunity for effective and well supported peer based initiatives.

While YTYIH conducts education among other populations, its primary focus is young people, hence most of its peer educators are young people. The national strategy highlights additional vulnerable populations but these are often targeted incidentally as part of the general community work of YTYIH. This cross over community education is very useful, but it is important that the vulnerable groups highlighted in the national strategy—MSM, PLWHA, sex workers and outer island residents—be targeted by dedicated peer based programs with recruitment from these target populations.

Discussions among key personnel imply that much of what is called peer education in RMI is more community education than true peer education. Capacity for development and support of true peer education is needed.

5.2.6 Samoa

Samoa is currently drafting its *National HIV and AIDS Policy & Plan of Action 2009* but it was not available to the consultants for review for the mapping exercise. Instead the *Strategic Plan for Responding to the Impact of HIV/AIDS on Women 2001–2005* has been used for this assessment. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In Samoa four organisations were identified as being involved in peer education of which the first three responded to surveys: **Samoa Red Cross, Samoa AIDS Foundation, TALAVOU Program (Ministry of Women, Community & Social Development)** and **Samoa Family Health Association.** A full transcript of the interviews is included in Appendix Twelve.

The development of a clear national strategy for HIV and other STIs is essential to address the needs of vulnerable groups in Samoa; and to establish the methods through which these needs may be met. Including a peer education methodology in this national strategy is warranted.

It is noted from feedback from regional organisations, as well as those in-country, that there is a strong collaborative network in peer education in Samoa. The impact of religion and tradition on the effectiveness of outreach programs into rural areas appears to be one of the significant challenges. The need for additional resources to support a greater geographical spread of programs was highlighted. A significant weakness of peer education programs was the difficulty of evaluating the quality of peer education interventions and the information being delivered.

Significantly, many of the programs described could be more appropriately described as community education, rather than peer education. The wide variety of target populations for some programs makes it difficult to conceive them as truly peer based.

5.2.7 Solomon Islands

The current national strategy is *The National HIV Policy and Multi-Sectoral Strategic Plan 2005–2010*. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In the Solomon Islands seven organisations were identified as being involved in peer education and were interviewed:

- Adolescent Health and Development Program
- Oxfam
- World Vision
- Save the Children
- Adventist Development Relief Agency
- Integrated Community Program
- Solomon Islands Planned Parenthood Association

A full transcript of the interview is included in Appendix Twelve.

The National HIV Policy and Multi-Sectoral Strategic Plan 2005–2010 sets out a solid framework for the conduct of peer education in the Solomon Islands. The document is inclusive of a number of vulnerable groups and presents a strong base for the development of effective peer education in the country.

Local organisations have utilised this strategic plan to coordinate their own work in peer education and a number of peer education programs were identified as particularly effective in engaging the participation of vulnerable populations and targeting specific at risk communities with appropriate peers. Young people (both in school and detached from education) and sex workers were particularly featured in a number of programs.

There appears to be a good level of networking and support between agencies, and some degree of coordination. Many of the programs however are limited in coverage, often concentrated around Honiara and rarely available in the outer islands. Similarly, there is an impression that while age based peer outreach was well resourced, there was an identified need for great targeting of other vulnerable groups, and consequently for resourcing and training to address this. There is a need for greater specificity in targeting strategies given the great diversity of interests and needs in communities.

Broader M&E of peer education programs is mixed. Given the level of existing M&E activities, coordination of mechanisms, standardisation of M&E approaches and development of robust M&E plans is possible.

5.2.8 Tonga

The current national strategy is the *Strategic Plan for Responding to HIV/AIDS and STIs in the Kingdom of Tonga 2001–2005*. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In Tonga three organisations were identified as being involved in peer education and the first two responded to surveys: **Family Health Association, Tonga National Youth Congress** and **Tonga Red Cross.** A full transcript of the interviews is included in Appendix Twelve.

The national strategic plan provides an example of a document that sets out a solid framework for the conduct of peer education. Its guiding principles highlight the need for

engagement of, and participation with, vulnerable groups; and the document is inclusive of a number of vulnerable groups. This presents a strong base for the development of effective peer education in the country.

The two organisations surveyed have sought to conduct their peer education programs within a model of best practice. This has included careful assessment of risk and needs, collaboration with local communities and vulnerable groups in the design and implementation of projects, careful evaluation with attention to the appropriate targeting of activities, close collaboration with other services and the integration of education with clinical service delivery.

Each organisation however has identified a wide set of target groups, it can therefore be assumed that much of the work must be kept at the level of community education in order to address a variety of demands and expectations. Support for continued coordination of existing peer education activities and building capacity to be able to reach more diverse populations is warranted. This includes involvement of populations on outer islands.

5.2.9 Tuvalu

The current national strategy is the *Tuvalu National Strategic Plan for HIV and AIDS 2009–2012*. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In Tuvalu two organisations were identified as being involved in peer education of which the first one responded to surveys: **Tuvalu Family Health Association** and the **National AIDS Council.** A full transcript of the interviews is included in Appendix Twelve.

The *Tuvalu National Strategic Plan for HIV and AIDS 2009–2012* offers a solid framework for the conduct of peer education in Tuvalu. The document is inclusive of a number of vulnerable groups and presents a strong base for the development of effective peer education in the country.

The size of Tuvalu's population presents both significant challenges and benefits when discussing HIV peer education. These challenges include the lack of information about vulnerable populations given their invisibility within a closed community; and the little that has been done to assess their level of risk to STIs. Additionally, the country is relatively isolated from other regional programs, both in terms of geography and communication, and this results in limited opportunities for peer educators to gain experience and knowledge through training and networking with other agencies and peer educators across the region. The small population imposes difficulties on achieving a local critical mass of expertise, further limiting training opportunities. Poor resourcing impedes access to regional training and skills.

In addition, the fear of exposure and stigmatisation within a small community creates great difficulties for any effective targeting of vulnerable groups such as sex workers and MSM.

However there are significant benefits for this small population. If an effective peer education methodology was coordinated across agencies, contact with, and broad coverage of the population would be achievable.

5.2.10 Vanuatu

The current national strategy is entitled *National Policy for HIV/AIDS and Sexually Transmitted Infections 2008–2012*. A detailed analysis of this strategy with reference to peer education appears as Appendix Nine with highlights of the strategy included in the individual country report.

In Vanuatu seven organisations were identified as being involved in peer education of which the first two responded to surveys: **World Vision, Wan Smolbag, Ministry of Health, Family Health Association, Young Peoples' Project, Save the Children** and **Oxfam.** A full transcript of the interviews is included in Appendix Twelve.

Despite the inability of a significant number of organisations to participate in the mapping exercise, the information received has demonstrated an effective and innovative delivery of peer and community based education in Vanuatu. The assessment suggests that Vanuatu has one of the strongest peer education programs in HIV in the region. A national network of organisations working in peer education exists and examples of collaboration and inter-agency referral are evident. Benefits of a functional network—coordinated guidelines and access to funding streams—are also evident.

It is noted that there are attempts to better coordinate service delivery—essential for the large number of programs operating in the country—and all seeking to deliver peer education. Funding was cited as a crucial issue, both with respect to training of peer educators and to remunerating them for their services.

5.3 Identification of gaps in methodology

5.3.1 Monitoring and evaluation

There is a critical need for stronger M&E systems. M&E was identified as one of the great weaknesses of most peer education programs. There is a lack of clarity about the reporting systems used by individual programs, the relevance and measurability of indicators, and to whom and how they report. Often M&E has been reduced to "head counting" or describing activities undertaken by programs or PE without any further analysis of the target population receiving the intervention, and how those activities translate to the level of outputs and outcomes i.e. the impact made upon knowledge, attitudes and behaviour. Most evaluation focuses on knowledge through the use of pre and post session surveys.

Recommendation One
Evaluation of peer education programs should move beyond process evaluation and activity reporting, to include a measure of outcomes with respect to behaviour change over time. A coordinated approach to effective evaluation across the region needs to be developed so that individual countries and organisations can draw on the expertise of this pooled knowledge.

There is a lack of baseline assessments of community behaviour which should be undertaken prior to program commencement to allow for accurate evaluation of behaviour change. Where behaviour change is measured the Most Significant Change (MSC) evaluation methodology is used, which is reported to provide useful information to programs, not only about medium term impact of

interventions, but concerning the needs and gaps in communities. However it is important that MSC is not used in isolation, but in combination with activity and output reports.

Key measures that are often not reported concern the ability of peer education programs to access those most at risk; proportion of peer educators who derive from vulnerable groups; the level of participation by these vulnerable groups in program design and evaluation as well as the program itself; and the extent to which interventions are adapted with respect to time and place to target particular vulnerable populations.

5.3.2 Coordination

Limited coordination at regional and national levels was consistently highlighted with little coordination in the delivery of activities resulting in multiple programs cutting across or competing with each other. Different sources of funding can create disorganisation. Whilst some countries have systems for local coordination between NGOs or with governments, coordination tends to decrease with increasing levels of hierarchy.

There appears to be no standardisation of management systems for peer education programs. There is no standardised system of networking, recruitment, training, data collection and reporting. Each country has its own network and mechanism for peer coordination but, with some exceptions, these systems are often weak. Donor requirements for reporting often mean that NGOs do not report to the national governments but use multiple systems of reporting across the region.

Recommendation Two
Formalised networking and coordination among the organisations involved in peer education in HIV in the region is warranted. Resourcing to support this coordination is important. The issue of inter-agency collaboration, communication and support between NGOs and Government should be addressed at national levels.

Collaboration across agencies appears to be strongest at the initial planning stage of projects but this momentum is often not maintained once programs commence.

Whilst there are opportunities for peer educators to come together for discussion and information sharing, it is important that decision makers and program managers meet as well to ensure that the issues and needs raised by educators can be responded to with practical support. This would also provide an opportunity to clarify for program managers the nature and requirements for effective peer education.

More emphasis should be placed on developing the capacity of national networks (rather than regional) because of greater relevance in country, and the ability to encourage better sharing of resources, experiences and knowledge. However, it was suggested that those smaller countries where only a few organisations operated would benefit from partnering with other NGOs on a regional level. Certainly the sharing of information across organisations was identified as an important task.

Establishing regional networks for vulnerable groups has been important for communication and support. Linking small vulnerable groups in small countries with other larger country

networks may be the most appropriate strategy rather than developing peer-based organisations within a country.

Governments need to show leadership and assume a greater coordination role, even in areas where it may not have expertise. The MoH needs to be multi-sectoral in its approach to ensure that even the marginalised are included in its planning and delivery. Consequently, there is a need to increase the support for national governments by establishing national frameworks for PE that are able to coordinate activity and planning, and to assume more responsibility for monitoring within countries. A single framework for PE should coordinate the multiplicity of agencies and facilitate all reporting through national governments. These national frameworks should be linked with a coordinated regional framework.

National HIV/AIDS strategies need to be reviewed in collaboration with regional partners, and there needs to be a stronger definition of who stakeholders are when consultation is undertaken to ensure appropriate representation for the vulnerable and marginalised.

5.3.3 Integration

Peer education has tended to be a standalone program, narrowly focussed on one area of intervention. It should be set within an integrated approach to health service delivery combining clinical services, counselling, and education. It is important that there be more comprehensive peer education that addresses a range of issues in social and personal development. However it should be recognised that any wider social integrated approach will create pressure for peer education to become community education and development.

Formalised networking and coordination among the organisations involved in peer education in HIV in the region is warranted. Resourcing to support this coordination is important. The issue of interagency collaboration, communication and support between NGOs and Government should be addressed at national levels.

Recommendation Three
Peer education should be set within an integrated approach to health service delivery combining clinical services, counselling, and education as peer education initiatives do not operate in a vacuum. Continued general community development is warranted, even if the purpose is only to support the specifically targeted peer education.

Referral systems are a key component of peer education with a need for close, practical links to clinical services for VCCT. Systems need to be considered for follow up and monitoring of referrals

Many peer educators have been incorporated into MoH facilities or NGOs where there is little understanding by program managers of the nature of peer education, and the intense support and monitoring it requires. Consequently peer educators must assume multiple responsibilities beyond the scope of their training. The nature of the parent organisation, its systems of service delivery, supervision and reporting will influence the activity of peer education and the direction it takes.

The shift from peer education to community education that has occurred in many programs has made peer education a means for organisations to work with a target group rather than engaging the target group as peer educators. Often peer education seems to comprise young people who reach out to a number of different vulnerable populations but without recruiting groups to become peer educators themselves.

5.3.4 Governance

Governance in this context may be understood to be a means in which the leading authority (those in the decision making roles) guide and monitor the values and goals of an entity through the development and implementation of policy and procedures. There are three areas of governance to be considered resulting from this mapping exercise.

Firstly, the strength and robust nature of governance structures within individual peer education organisations and programs varies across the region. A number of organisations have clear governance structures while many relied on the good will of those involved to 'keep the program going'. There are many examples where one organisation can learn from another and there are areas where joint effort to enhance governance practices can benefit all. The continuation of moves to policies and procedures that are based on systems rather than on personalities assists this process.

Recommendation Four
Upskilling in governance be included in any training and development package designed for those involved in peer education in the region. This is to include the proactive recruitment of peers to be involved in governance matters.

Secondly, coordination of peer education activities within individual countries and across the region has already been discussed in section 5.3.2. This coordination and collaboration will be assisted by the development of governance procedures for peer education networks across the regions. How is a network to be structured? Who can belong to a network? This is the second governance area to arise from this mapping exercise.

Thirdly, the mapping exercise highlighted the need for skill development among peers to be able to participate in their own governance, management and strategic coordination activities. The desire for more detailed, transparent and accountable structures was apparent in some organisations. This appears to be a part of the natural maturing process and to assist some assistance—possibly training in governance, management and strategic planning—may be warranted.

Governance matters plague all organisations and those involved in HIV peer education in the region are no different in this matter than any other. Attention to effective governance however can lead to greater positive outcomes, transparency, accountability and enhanced reputation.

5.3.5 Definition of peer education

As mentioned in Section 4.0 above the term *peer education* means different things to different individuals and organisations. Examples of what has been included in the catchphrase peer education included:

- Community education conducted by individuals who do not belong to the subpopulation being targeted
- Awareness raising activities conducted by individuals who do not belong to the subpopulation being targeted (e.g. a 24–year old talking with school students).
- General condom distribution
- General resource distribution (pamphlets, posters, newsletters)

- Peer support (e.g. individuals with HIV meeting to support each other)
- Peer education trainers conducting community education themselves rather than training peers to conduct education with their own peers.

Although much of this is not true peer education, it does not mean that these other forms of education are not worthwhile or legitimate. It is acknowledged that much is being achieved through different methodologies and that other forms of education actually assist peer education methodologies because they provide the context and 'set the scene'.

Recommendation Five
Peer educators need to be better supported to utilise their time effectively in delivering well targeted peer education rather than being increasingly burdened with other broader community responsibilities.

An outcome of the use of the term peer education to cover many types of education has been the dilution of time that peer educators are able to spend on their 'core business'. Tightly defining peer education allows peer educators to concentrate on a core set of tasks.

5.4 Identification of gaps in targeting vulnerable populations

An outcome of the mapping exercise was to identify gaps in targeting vulnerable populations in the region. The examination of national strategies highlighted a common set of vulnerable populations: youth, sex workers, MSM, seafarers and other individualised populations (e.g. those in remote areas, transgender, uniformed services and women). Regional strategies also highlighted similar populations. Through the mapping a key issue raised was the effectiveness of current peer education programs to target those most at risk. Often the focus of peer education was on coverage and participant numbers, rather than specificity of targeting.

Successful engagement of vulnerable, marginalised populations has required investment of time devoted to listening to and engaging with target groups to ensure that training and strategies are relevant to their needs. Particular attention should be given to the timing and location of interventions that is appropriate to the target group.

Many vulnerable groups are invisible so it can be difficult to recruit suitable peers for training. As a result many organisations aim broadly rather than specifically and behaviour change communication (BCC) strategies become broad rather than targeted, with the intention of capturing those most at risk within the wider community net. Consequently, many peer based strategies become exercises in community education. In larger countries it appears to be easier to identify and specifically target particular vulnerable communities and establish peer based groups. For smaller countries however specific populations are hard to identify for fear of stigmatisation, so in this instance, it may be appropriate to take a regional approach, linking those isolated vulnerable groups to other countries. Alternately, these populations may prefer generic community education or the utilisation of peer educators from an existing pool of young people. This may not be true peer education but it may be effective.

Recommendation Six
Careful review of (existing and planned) programs should be undertaken to ensure that they correctly access the target population that is most vulnerable, identify issues and address real needs, and are in line with local needs, priorities and the overall strategic direction.

Equally important is the need to avoid making assumptions concerning the preferences of populations, and that at all times consultation and engagement of the target group occur. There needs to be greater involvement of those most at risk in the reviewing of manuals and training.

Given these broad points of discussion, each vulnerable population is discussed in detail in the following sections. When responding to the survey almost all organisations indicated that they were targeting many vulnerable populations, however the following discussion limits itself to those targeted populations that were raised in detail through the interviews and survey responses. It is acknowledged this is a limiting mechanism but not all organisations provided information on all of their peer education initiatives.

5.4.1 Youth

The need to target young people with HIV prevention education was acknowledged by most national strategies; and the use of a peer education methodology to do so was generally accepted as appropriate. Almost all countries and programs involved in the mapping included youth as a target of their HIV peer education activities. However, a number of gaps were able to be identified.

A standard tight definition of the word *youth* is needed. This is an identified gap. A very broad definition of youth across the Pacific needs to be accounted for in program design. This raises issues of how peers are defined and recruited, particularly when ages may range from 15 to 30 years. Concerns were expressed that many peer based youth programs were in fact targeting persons between the ages of 20 and 30 whilst missing the more vulnerable adolescents. Targeting broad, mainstream populations was considered an "easy option" for young, inexperienced peer educators and convenient for achieving simple work plans.

Recommendation Seven
A regional network of organisations working in HIV peer education among young people should be developed for support and sharing of lessons learned.

Recommendation Eight
HIV peer education initiatives targeting young people need to account for the heterogeneity of this population by undertaking regular needs assessments among this group.

Additionally young people are not a homogenous group. For example, the needs of those in school differ vastly from those who have dropped out of school, and again differ greatly from those in remote areas without access to schooling, but this variation has not been translated into targeted peer education interventions for youth at risk. The lack of response to this heterogeneity is a second identified gap with this target population. Precisely which young people are at risk and why needs to be identified.

5.4.2 Sex workers

Involving sex workers in HIV peer education was also accepted as a legitimate strategy to reduce the spread of HIV in the Pacific. Sex workers were specifically mentioned in the national strategies of FSM (Kosrae and Chuuk), Kiribati, Tonga, Tuvalu and Vanuatu; and five of the ten countries surveyed had organisations that indicated involvement in peer education with sex workers. However sex work was often not easily identifiable in many countries due to its non-commercial or informal nature and labelling an activity 'sex worker peer education' was not conducive to making contact with this population. This was both because of the potential for stigma and discrimination and because many of those involved in sex work did not actually consider themselves sex workers.

Recommendation Nine
A regional network of organisations working in HIV peer education among sex workers should be developed for support and sharing of lessons learned.

Recommendation Ten
Methodologies to target sex workers with HIV peer education should be carefully defined as these will need to be specific according to the sex workers involved: commercial; transactional or opportunistic.

Strategies targeting sex workers are lacking in many countries due to limited data, assessment and behavioural surveys that specifically address these groups. Sampling methodology within small communities is a concern as they may not be sufficient to differentiate sub populations of risk. Nonetheless, these surveys are essential for establishing an M&E system.

5.4.3 Men who have sex with men

Involving MSM in HIV peer education was also accepted as a legitimate strategy to reduce the spread of HIV in the Pacific. Five of the national strategies specifically mentioned MSM: FSM (Chuuk), Kiribati, RMI, Solomon Islands and Tuvalu; and six of the ten countries had organisations or networks that indicated involvement in peer education. It is noted that MSM should not be necessarily identified as high risk, but there is a need to assess the extent and nature of risks, and whether the cultural context of MSM is supportive enough to mitigate against any risks.

While a number of organisations specifically targeted MSM with HIV peer education, many of them do not utilise peers that are MSM. The need to recruit MSM themselves to be involved in this peer education is important. This is an identified gap. The Pacific Sexual Health Diversity Network (PSDN) was an attempt to involve MSM in this way.

The PSDN is approximately two-years-old and attempts to support fledgling MSM networks in the region through grass roots community development. It was noted that this community development approach, while not direct peer education, will enable peer education to evolve within these populations over time. (An example of the Cook Islands was suggested as a specific successful case i.e. an MSM organisation had formed recently through the support and encouragement of the PSDN.) It was also noted that because of the size of—and obvious barriers for—MSM communities in smaller countries (e.g. Nauru, Tuvalu and Kiribati), it may be unrealistic to expect peer education to be sustained or even initiated in these countries

Recommendation Eleven
The existing regional network for MSM—the PDSN—should be supported to assist in the development of local MSM organisations.

Recommendation Twelve
Community development approaches that target life skills rather than HIV specifically should be supported among MSM.

without there being strong support from MSM regionally. In these cases, a regional rather than national program may be more appropriate.

It is noted that in many countries communities of MSM were organising their own networks, communities, activities in a voluntary capacity, and consequently, there now exists mechanisms to start resourcing peer education in this area.

However it is equally noted that sometimes governments will include vulnerable populations (e.g. MSM) in their national strategies and documents but actually do nothing about it. This is a second identified gap.

5.4.4 Fa'afafine, Fakaleiti

It is acknowledged that the term *transgender* is not fully appropriate when referring to those who are Fa'afafine or Fakaleiti. Transgender implies a move from one gender to another whereas those who are Fa'afafine or Fakaleiti have remained as one gender—a third gender. However some national and regional strategies refer to those who are transgender as a vulnerable population. Of note, only Tonga's national strategy refers specifically to Fakaleiti.

While only two countries highlighted those who were transgendered in their national strategies (Cook Islands and Tonga), three organisations indicated they were involved in peer education directly targeting Fa'afafine or Fakaleiti (in the Cook Islands, Kiribati and Vanuatu).

Recommendation Thirteen
A project to establish HIV transmission risk factors among Fa'afafine and Fakaleiti should be developed to inform the implementation of peer education initiatives among this population.

However there was no indication among these organisations (or any other) why Fa'afafine or Fakaleiti were considered an at risk population. This is an identified gap.

Informal networks among Fa'afafine and Fakaleiti themselves appear to exist in some of the Pacific countries and this includes informal regional networks. Utilising these networks for the purposes of HIV peer education appears to be limited.

5.4.5 Seafarers

Seafarers were noted in eight national strategies as vulnerable populations, and on some occasions noted as the source of HIV infection in the country. Through discussions with organisations across the ten countries the need to work with seafarers constantly arose. However any work being undertaken appears to be as an extension of working with young people, or with sex workers, rather than recruiting seafarers directly, or targeting seafarers directly with

Recommendation Fourteen
A project to establish HIV transmission risk factors among seafarers should be developed to inform the implementation of peer education initiatives among this population.

peer education. Additionally, in some areas seafarers access organisations that offer 'open door' services. The lack of a coordinated approach to education of seafarers that is based on the need of the seafarers themselves is an identified gap.

5.4.6 Remote communities

There is a need to move HIV peer education initiatives from the main centres in each country to the remote areas. It is acknowledged that this is extremely difficult and is very resource intensive. A further barrier highlighted is the weakening of any M&E strategy that may be in place as activities move further away from the coordinating personnel. Despite this however there is a need to acknowledge the level of risk of HIV infection in some remote communities and to respond appropriately.

Of note, two national strategies—RMI and FSM (Chuuk and Yap)—specifically mentioned those living in remote areas as vulnerable populations. However, only one organisation based in Solomon Islands indicated they were undertaking peer education in remote areas.

No specific recommendation is made here as recommendations about working in remote areas is country specific and have been made in each of the country reports where relevant (and also included in the recommendations section of this report).

5.4.7 Women

All of the national strategies—except Nauru—indicate that women are a vulnerable population that require specific HIV prevention education. While many organisations that participated in the mapping target women as a result of involvement in peer education to other populations (e.g. youth, sex workers and those living in remote areas), no organisation had a specific program that targeted women themselves. A gap identified through this mapping exercise has been the need for specific peer education based strategies to target women themselves.

Any peer education directed toward women needs to distinguish and target those who are most marginalised and those who are discriminated against within women's network's themselves. Peer education amongst those most powerless may be the most effective.

5.4.8 Uniformed and occupational groups

Uniformed services (e.g. police and military), civil servants, taxi drivers and travellers are mentioned in a number of the national strategies. A term to cover these populations as well as their risk behaviour is *Mobile Men with Money* (MMM). Although acknowledged as a sub-population that needs to be aware of HIV risk factors, and of their own influence on the spread of the epidemic, there was little specific peer education activities targeted toward this population. Specific peer education for this population is an indentified gap.

5.4.9 People living with HIV / AIDS (PLWHA)

PLWHA were mentioned in many of the national and regional strategies. The context in which this sub-population was highlighted was for support and care rather than education or specific peer education.

Recommendation Fifteen
Development of strategies to ensure the active and meaningful participation of affected communities in the design and delivery of peer education is needed, especially inclusion of PLWHA.

Few organisations were targeting those with HIV with their peer education initiatives however some were involving these individuals in their activity. While it is acknowledged this may be extremely difficult to achieve, there is an identified gap of involvement of individuals with HIV in peer education programs.

5.5 Capacity

Although a significant number of gaps in peer education in the region have been identified, there already exists much capacity to address them. The first main recommendation (Section Six) highlights the need to develop a strategic framework; and sets out a 'ten step plan' to develop further capacity. The following four sections on training; recruitment and retention; code of ethics; and true involvement would support the framework.

5.5.1 Training

Effective training is a key to increasing the capacity to use HIV peer education methodologies. There are many content areas to address, some include:

- Knowledge of HIV and STIs among workers
- Knowledge of HIV and STIs among peers
- Knowledge of peer education approaches, rationale and theory
- Suggested methodologies for implementation
- Effective skills in M&E
- Skill training for trainers
- Skill training for trainers of trainers
- Knowledge in needs and situations of the vulnerable populations

Facilitation skills training was considered a crucial component of peer education training and should be regarded as important as content. It was noted that few peer educators have acquired experience and skills in project management and evaluation.

Recommendation Sixteen
Uniform training resources should be developed for use across the region that account for language and literacy variances.

Recommendation Seventeen
Core skills of peer educators and trainers of peer educators need to be enhanced across the region and move beyond content to incorporate facilitation, program planning and evaluation. There is a role for a coordinated approach to effective training in this area.

Recommendation Eighteen
Training programs need to be developed which accommodate the needs for peer educators recruited from other vulnerable populations currently not receiving peer based services.

Training relates directly to the next section on recruitment and retention. Retention of volunteers in the region is problematic given the level of training and capacity developed over time, only to be lost when many of the volunteers leave. A number of solutions were offered including the further development of peer education skills, motivation and performance that facilitate their entry into further study and career advancement.

However, it was also emphasized that the skills acquired by persons to become PE provide a valuable asset for their future, therefore the attrition of PE from an organisation

should never be considered a loss because the community as a whole gains from the acquisition of skills by these individuals. Peer education, by its very nature needs to be recognised as a transitional state, yet there has been a tendency for some agencies to consider it as a full time occupation for selected persons. It should be recognised that often the people who benefit from peer education are the PE themselves with respect to the education and capacity gained.

A number of resources and manuals have been developed to address peer education training and delivery in the region but their relevance and adaptability to vulnerable groups has been questioned. A need was identified for the review of peer education training manuals and programs in consultation with vulnerable populations.

5.5.2 Recruitment and retention

The need for strategies for effective recruitment and retention of peer educators was a common theme through the discussions with individual organisations involved in peer education. There are many examples of effective recruitment (including payment of stipends) and retention (including the utilisation of former peers as Alumni). Sharing of ways to achieve effective recruitment and retention would be a desirable outcome of any newly developed peer education network.

As indicated in the previous section, addressing training requirements would be a significant step in achieving desired recruitment and retention goals.

Much of the discussion about HIV peer education focussed on youth peer education and the need for an ongoing recruitment strategy because of the rapidity by which young people 'age out' of being peers. In essence this is about succession planning. For this discussion, succession planning may be defined as the ability to sustain longevity by ensuring continual refreshment of personnel at all levels of the peer education program.

The need for structured succession planning relates to two common themes in youth based peer education highlighted throughout the mapping exercise: (i) drop-out rates; and (ii) the ageing out process.

There is a natural (and sometimes necessary) drop-out rate among those who first join as youth peer educators. It was noted that a percentage of individuals who first train as peer educators move 'through and out' due to other commitments, including study and work. A way to contend with this has been to have structured and rigorous selection processes for attendance at training and effective structured follow-up and evaluation procedures. It was noted that selection processes for training, and the training itself, are key to successful peer education programs, with examples of 'best practice' that can be emulated elsewhere. Mentoring of newer members by more experienced members is one way in which some programs ensure sustainability.

Although the mechanisms to ensure effective succession are in place, the verbalization and documentation of structured succession planning, and the celebration of individuals moving through and out of the network (rather than viewing this as a negative that needs to be fixed), can add to effective succession planning.

Developing local, national and regional capacity in effective recruitment and retention of peers from all vulnerable populations is a priority.

5.5.3 Code of ethics

The need to establish a code of ethics for peer educators is another area in which capacity may be increased. Examples of the usefulness of such a code were raised in discussions with several organisations in several different countries. Ethical issues concerning the behaviour of peer educators are significant, for example poor modelling of behaviour within villages. This often reflects the inability of programs to monitor the activity of peer educators dispersed over a wide area. This has similarly raised concerns regarding the accuracy and quality of education content and whether initial training of peer educators clearly outlines their scope of practice and code of conduct.

Recommendation Nineteen
A standardised code of ethics for peer educators should be developed at a regional level that is simple, explicit and able to be locally adapted by organisations working in peer education.

It is acknowledged that a code of ethics will not mean that breaches in ethical behaviour are not made however it does have the capacity to provide a baseline from which behaviour is able to measured as acceptable or not acceptable.

5.5.4 True involvement

'When is a peer a true peer?' and 'how much say does a peer have in the development of the education program of which they are the recipient?' are two themes that arose consistently during the mapping exercise.

The need to engage peers from the actual targeted vulnerable populations has been highlighted in Section 4.0. However to gain true involvement of peers, organisations could go a step further. For uniquely effective programs, the involvement of peers in the governance, management and strategic coordination of activities is desirable. This may be very hard to achieve but is a worthy goal. The rationale for this is that peers, of their nature, are the ones that truly know the mechanisms by which their community is vulnerable to the HIV epidemic. Development of the capacity of peer educators to be involved in this more detailed level is warranted.

Recommendation Twenty
Peers should be resourced to contribute to the governance, management and strategic coordination of peer education programs targeting their community.

5.6 Conclusion to the discussion

This discussion has reviewed national HIV strategies; the scope of current peer education activities; gaps in peer education methodologies and in targeting vulnerable populations; as well as the need for building capacity. This has resulted in the above 20 recommendations. The following section adds to these recommendations by including a strategic framework and by including all of the recommendations from each country report. This provides a comprehensive approach to develop a more coordinated, sustainable and best-practice approach to HIV peer education in the Pacific region.

6.0 Recommendations

6.1 Strategic framework

The main output from the mapping exercise is the development of a strategic framework for HIV peer education in the Pacific region. This is laid out below as a ten point plan.

6.1.1 Standardisation

There is no consistent definition or methodology for peer education, but rather a range of different understandings. Peer education is often confused with community education. Different organisations conduct individual based or group based interventions according to their capacity and local context. Vulnerable, marginalised groups are often targeted as part of broader community education, and despite the diversity of target groups, most peer educators are mainstream young people.

All aspects of HIV peer education across the region, particularly training and systems of monitoring and evaluation, should move to a standardised approach (though set within the context as described in 6.1.2).

6.1.2 Monitoring and evaluation framework

M&E is by its nature difficult for peer education, particularly when set within the context of wide geographic coverage, scarcity of resources, and lack of capacity. Nonetheless it is acknowledged that key outcome measures can be developed and accurately measured (e.g. access to health services). However regional M&E systems are only meaningful if effective national M&E systems are operating and producing the information needed to inform or report against the regional framework. Any proposed framework, standards or networks should be developed firstly at the national level to ensure relevance and local ownership by those directly involved. There already exist a number of national HIV & STI strategic plans with M&E frameworks linked with the current PRSIP, although currently there is limited implementation of those national systems.

Support from regional organisations to build effective national M&E systems should be a priority.

6.1.3 Integration of service delivery with health services

Peer education that exists in isolation has much less chance of success than peer education that is integrated with the goals and activities of local services, especially local health services.

Integrated referral and follow up mechanisms for testing, counselling, STI checks etc are warranted.

6.1.4 Needs assessment

The mechanism to source the true needs of vulnerable communities and to identify the cause and context for a particular population's vulnerability is needed to better plan methodologies and interventions. Needs assessments, although difficult, are required.

6.1.5 Identification of target population

Assumptions have been made about target populations. Exact identification of the specific nature of the target population is warranted. A common strategy has been the broad use of young peer educators to attempt peer education among other vulnerable populations or even among diverse groups of young people.

6.1.6 Involvement of the target population

True engagement, consultation and meaningful participation of the target population at all levels of planning, implementation and evaluation is essential if any peer education is to be effective.

6.1.7 Sourcing, resourcing and training peer educators

Recruitment, training and up-skilling of peer educators to ensure "culturally" appropriate and relevant interaction with those most at risk, and to enable opportunities for those most vulnerable to become peer educators themselves, is essential.

6.1.8 Development of networks

Networks of those who work in peer education can take many forms:

- Networks of organisations within one country
- Regional network of organisations
- Networks of organisations working with one vulnerable population, e.g. sex workers or seafarers
- Networks of peer educators (nationally, regionally and population based).

Each of these offer benefits—particularly to smaller countries—by facilitating the sharing of ideas, experience and best practice, and be creating economies of scale for resource development and training. Networks are also critical for fostering support amongst peer educators, particularly working from and within stigmatised populations who may feel isolated in their own small communities.

6.1.9 Coordination of resources

Resourcing across vast geographical areas of small populations living in constrained socioeconomic circumstances is extremely difficult. The gap between the potential activity that can and needs to be undertaken compared to the amount of resourcing (funds, personnel, skills) available cannot be easily crossed. Rational allocation and prioritisation of resources, targeting populations, and mainstreaming (where appropriate) is essential. A mechanism to partially address this is the establishment of national and regional coordination of activities and resources that allows for a reduction of duplication, appropriate and relevant targeting, geographical equity, sharing and pooling of resources and training opportunities.

6.1.10 Action Research

Often during the mapping exercise, the lack of strong evidence guiding strategies and priorities was apparent. This included a lack of epidemiological, knowledge and risk behaviour data relevant to specific marginalised groups (sex works, MSM, transgender) as well as limited measures for sexual and reproductive health within a population. The limited framework for M&E has resulted in a significant lack of evidence of efficacy of interventions—including peer education methodologies across the region. A coordinated, integrated and

standardised HIV peer education approach offers an opportunity for action research that satisfies many of these gaps. Research is an essential component of this ten point strategic framework.

6.2 Recommendation from the overall discussion

Recommendation One
Evaluation of peer education programs should move beyond process evaluation and activity reporting, to include a measure of outcomes with respect to behaviour change over time. A coordinated approach to effective evaluation across the region needs to be developed so that individual countries and organisations can draw on the expertise of this pooled knowledge.

Recommendation Two
Formalised networking and coordination among the organisations involved in peer education in HIV in the region is warranted. Resourcing to support this coordination is important. The issue of interagency collaboration, communication and support between NGOs and Government be addressed at national levels.

Recommendation Three
Peer education should be set within an integrated approach to health service delivery combining clinical services, counselling, and education as peer education initiatives do not operate in a vacuum. Continued general community development is warranted, even if the purpose is only to support the specifically targeted peer education.

Recommendation Four
Up-skilling in governance should be included in any training and development package designed for those involved in peer education in the region. This is to include the proactive recruitment of peers to be involved in governance matters.

Recommendation Five
Peer educators need to be better supported to utilise their time effectively in delivering well targeted peer education rather than being increasingly burdened with other broader community responsibilities.

Recommendation Six
Careful review of (existing and planned) programs should be undertaken to ensure that they correctly access the target population that is most vulnerable, identify issues and address real needs, and are in line with local needs, priorities and the overall strategic direction.

Recommendation Seven
A regional network of organisations working in HIV peer education among young people should be developed for support and sharing of lessons learned.

Recommendation Eight
HIV peer education initiatives targeting young people need to account for the heterogeneity of this population by undertaking regular needs assessments among this group.

Recommendation Nine
A regional network of organisations working in HIV peer education among sex workers should be developed for support and sharing of lessons learned.

Recommendation Ten
Methodologies to target sex workers with HIV peer education should be carefully defined as these will need to be specific according to the sex workers involved: commercial, transactional or opportunistic.

Recommendation Eleven
The existing regional network for MSM—the PDSN—should be supported to assist in the development of local MSM organisations.

Recommendation Twelve
Community development approaches that target life skills rather HIV specifically should be supported among MSM.

Recommendation Thirteen
A project to establish HIV transmission risk factors among Fa'afafine and Fakaleiti should be developed to inform the implementation of peer education initiatives among this population.

Recommendation Fourteen
A project to establish HIV transmission risk factors among seafarers should be developed to inform the implementation of peer education initiatives among this population.

Recommendation Fifteen
Development of strategies to ensure the active and meaningful participation of affected communities in the design and delivery of peer education is needed, especially inclusion of individuals living with HIV.

Recommendation Sixteen
Uniform training resources should be developed for use across the region that account for language and literacy variances.

Recommendation Seventeen
Core skills of peer educators and trainers of peer educators need to be enhanced across the region and move beyond content to incorporate facilitation, program planning and evaluation. There is a role for a coordinated approach to effective training in this area.

Recommendation Eighteen
Training programs need to be developed which accommodate the needs for peer educators recruited from other vulnerable populations currently not receiving peer based services.

Recommendation Nineteen
A standardised code of ethics for peer educators should be developed at a regional level that is simple, explicit and able to be locally adapted by organisations working in peer education.

Recommendation Twenty
Peers should be resourced to contribute to the governance, management and strategic coordination of peer education programs targeting their community.

6.3 Recommendations from each of the 10 country reports

6.3.1 Cook Islands country specific recommendations

The recommendations are reprinted from the report on HIV peer education in the Cook Islands. The background to these recommendations may be sourced from this report.

1. The level of vulnerability within populations should be more precisely defined in the national strategy to ensure appropriate targeting with relevant peers.
2. Target populations prioritised within the national strategy and by the Red Cross Program should be synchronised to ensure a commonality of purpose.
3. The compartmentalisation of funding created by different donors and requiring different reporting schedules should be addressed with a view to establishing more streamlined reporting, that is inclusive of the National Government.
4. Mechanisms should be developed for evaluating the effectiveness of referrals to STI and HIV testing, whilst maintaining the need for confidentiality.
5. The Red Cross should continue to be supported in its peer education initiatives among young people and others in the Cook Islands.
6. Evaluation of peer education programs should move beyond process evaluation and activity reporting, to include a measure of outcomes with respect to behaviour change over time.
7. The development of the role of Alumni (peer educators who have moved out of the system) should be championed and shared with other similar programs regionally.
8. The systems developed locally, including codes of conduct and the involvement of young people in decision-making processes, should be documented and shared with similar programs regionally.
9. Support of fledgling peer education among 'hard to reach' populations (e.g. MSM and transgender) be formalised in funding and strategic development decisions.
10. Peer education initiatives do not operate in a vacuum. Efforts in the Cook Islands illustrate the need for continued community engagement and education in broader HIV education and prevention and the impact of these on the effectiveness of specifically targeted peer education activities. Continued general community development is warranted, even if the purpose is only to support the specifically targeted peer education.

6.3.2 Federated States of Micronesia country specific recommendations

The recommendations are reprinted from the report on HIV peer education in the Federated States of Micronesia. The background to these recommendations may be sourced from this report.

1. Formalised networking and coordination among the organisations involved in peer education in HIV is warranted. Resourcing to support this coordination is important. Coordination can lead to standardisation of approaches. The issue of interagency collaboration, communication and support between NGOs and Government should be addressed at a national level, and particularly in Pohnpei.
2. Coordination of state strategic approaches is warranted. This approach may provide an overall framework for each of the state strategies by establishing guiding principles for peer education, the identification and targeting of specifically defined vulnerable populations, and the need for engagement of those vulnerable groups in program design.

3. The broad range of target groups often cited for particular programs, both in type and age, should be reconsidered with respect to the resourcing, training, personnel and skills available for peer based activities
4. The challenge of populations spread a large geographical area should be urgently addressed through the enhancement of personnel and resources, the development of sustainable, local community initiatives and efficient mechanisms for communication between communities and workers.
5. Recruitment of peer educators should ensure appropriate matching with target groups.
6. Standardisation of the recruitment process of potential peer educators should move from a reactive to a proactive 'review and select' approach—for example, call for volunteers four times a year rather than rely on 'word of mouth'.
7. Efforts should be made to actively engage members of the target population in the management, design and delivery of the projects identified as peer based.
8. Mechanisms should be developed for evaluating the effectiveness of referrals to STI and HIV testing, whilst maintaining the need for confidentiality.
9. Evaluation of peer education programs should move beyond process evaluation and activity reporting, to include a measure of outcomes with respect to behaviour change over time.
10. Strategies to cope with (and celebrate) the high turnover of personnel in peer education programs should be developed, especially among those that target young populations.

6.3.3 Kiribati country specific recommendations

The recommendations are reprinted from the report on HIV peer education in Kiribati. The background to these recommendations may be sourced from this report.

1. The national strategy should differentiate between the different vulnerable groups, particularly with respect to occupational versus social groupings and interventions should be designed to specifically address these.
2. Those who are most marginalised should be involved in the consultation in strategic planning and the implementation of programs. These should include sex workers and MSM.
3. Clarification on the aim, purpose and essential methodology of peer education should be undertaken to engender a uniform understanding amongst organizations involved in this area and to foster a standardised approach to this methodology.
4. Efforts to identify the needs of those within vulnerable groups should be undertaken. This includes an assessment of the levels of involvement capable of individuals within these populations.
5. Outreach and support to individuals living with HIV in Kiribati should be enhanced. This includes advocacy roles within organisations.
6. Greater outreach to the outer islands is warranted.
7. Specific training for sex workers needs to be considered within the context of small communities.
8. If recommendations 5, 6 & 7 are unable to be fulfilled, special consideration for the needs of particular vulnerable groups is to be included within broader community education.
9. The restrictions imposed on peer education outreach due to the financial impost of remunerations should be addressed with enhanced funding or more efficient/effective targeting of PE activities at those most in need.

10. Monitoring and evaluation processes need to be addressed, including the development of evaluation tools appropriate to the unique constraints of Kiribati (geographic spread, literacy levels, limited supervisory staff).
11. Increased opportunities for refresher and recruitment training should be considered to meet the growing demand of volunteers and rapid attrition rates.

6.3.4 Nauru country specific recommendations

The recommendations are reprinted from the report on HIV peer education in Nauru. The background to these recommendations may be sourced from this report.

1. The development of a national HIV and sexual health strategic plan that identifies vulnerable populations, and incorporates peer education based methodologies amongst its set of responses is warranted. The *Pacific Regional HIV / AIDS Project (PRHP) Nauru Country update 2003–2006* previously noted the importance of this:
   - Development of a new national strategic plan that integrates HIV and STI control activities into existing community based programs.
   - A national plan developed in consultation with total community, inclusive of local community leaders and specifically addressing the most vulnerable groups such as the youth.
2. Proactive efforts—from within Nauru and from external sources—to develop links with regional HIV prevention and peer education partners is warranted.
3. Revitalisation of previously existing peer education activities that target populations vulnerable to HIV is warranted.
4. Peer education initiatives do not operate in a vacuum. The need for community engagement and education in broader HIV education and prevention is strong. Continued general community development is warranted, even if the purpose is only to support any specifically targeted peer education initiatives.
5. The original recommendations made at the conclusion of the *Evaluation of Chlamydia Testing and Treatment Pilot* be acted upon, specifically:
   - The program should continue and more actively recruit youth (15–19 years) and men. This could be achieved through outreach to these populations, for example at schools, men's health check activities and workplace visits.
   - Community awareness of the program be increased through health promotion and outreach.
6. Training and up-skilling should be provided in-country rather than removing key personnel from the country1.
7. Given the high population rates of Chlamydia (and other STIs) a peer education program should be closely aligned with clinical service delivery to facilitate easy access to testing and treatment. The potential impact of Chlamydia on fertility rates and peri-natal health should be highlighted.
8. The very wide definition of youth (15–35 years) should be reconsidered with respect to its impact on program planning, targeting and resourcing and greater attention should be given to more precisely defining those sub-populations that present the greatest vulnerability to STI infection.

1 This was also noted in the report of the *Pacific Regional HIV / AIDS Project (PRHP) Nauru Country update 2003–2006*

6.3.5 Republic of the Marshall Islands country specific recommendations

The recommendations are reprinted from the report on HIV peer education in the Republic of the Marshall Islands. The background to these recommendations may be sourced from this report.

1. Vulnerable populations should be identified separately within the national strategy with specific interventions matched to each population. The grouping of target populations should be avoided.
2. Youth to Youth in Health should continue to be supported in its peer education initiatives among young people and sex workers in RMI.
3. Assistance with the development, implementation and adherence of protocols to increase the involvement of young people in the decision making processes of specific peer education initiatives should be undertaken. This includes governance.
4. Up-skilling in effective monitoring of peer education activities should be undertaken (acknowledging the inherent difficulty in this task).
5. Education on the importance (and implementation) of formative and summative evaluation should be undertaken among peer educators.
6. Peer education initiatives do not operate in a vacuum. Efforts in RMI illustrate the need for continued community engagement and education in broader HIV education and prevention and the impact of these on the effectiveness of specifically targeted peer education activities. Continued general community development is warranted, even if the purpose is only to support the specifically targeted peer education.
7. Recruitment, training and support to peers from other target populations—seafarers, MSM and outer island residents—should be undertaken.
8. Although the number is small, the development of specific peer based support (and ability to network) for individuals with HIV in RMI is warranted.

6.3.6 Samoa country specific recommendations

The recommendations are reprinted from the report on HIV peer education in Samoa. The background to these recommendations may be sourced from this report.

1. As a priority a national HIV & STI strategy should be developed with clear participation by vulnerable groups at all stages with clear utilisation of peer education methodologies.
2. Development of standardised, consistent and well targeted monitoring and evaluation mechanisms should be prioritised to ensure that the quality and relevance of peer education interventions can be assessed and knowledge, attitude and practices (KAP) outcomes measured.
3. Efforts to identify the needs of those within vulnerable groups should be undertaken. This includes an assessment of the levels of involvement capable of individuals within these populations.
4. Once identified, capacity development among vulnerable populations to be able to undertake peer education and, into the future, leadership roles within advocacy and support organisations is warranted.
5. Education and up-skilling in the precise methodology of peer education, and the roles and responsibilities of peer educators, is warranted both for peer educators themselves, and for members of the broader stakeholder organisations and community.

6. Peer education initiatives do not operate in a vacuum. Efforts in Samoa indicate the need for continued community engagement and education in broader HIV education and prevention and the impact of these on the effectiveness of specifically targeted peer education activities. Continued general community development is warranted, even if the purpose is only to support the specifically targeted peer education.
7. The issue of ongoing support and refresher training to be addressed, particularly with respect to high attrition rates. The concept of peer educators needs to be defined beyond those that are formal volunteers of an agency and include the broad membership of the target group and their informal social contacts.
8. Systems of following up referrals should be investigated. Models developed by other countries can provide guidance.
9. The impact of cultural and religious taboos on effectiveness of peer education and other HIV interventions, e.g. condom promotion needs to assessed and accounted for in program development.
10. The needs of rural communities, young offenders and the hospitality industry should be carefully assessed as a potential priority for interventions and appropriately resourced.
11. Outreach by relevant peers to sex workers should be prioritised.

6.3.7 Solomon Islands country specific recommendations

The recommendations are reprinted from the report on HIV peer education in the Solomon Islands. The background to these recommendations may be sourced from this report.

1. The national strategy should emphasise the need for partnership with, and engagement of, vulnerable stakeholders; the importance of peer education and training; and the specific targeting of interventions for specific groups.
2. A national system to facilitate greater coordination of peer programs across the islands should be considered as a priority, with particular attention to ensure inclusion of the complete cross section of vulnerable groups (rather than only youth) and sharing of strategies and interventions.
3. Projects within the Solomon Islands need to increase their coverage beyond the main island and prioritise the targeting of islands close to the border with Papua New Guinea; those islands with logging communities; and isolated communities.
4. Funded coordination and resource support should be provided to peer education programs to ensure that coverage extends beyond urban areas and includes remote areas of Solomon Islands.
5. Coordinated and uniform training resources and programs should be developed that target the complete set of vulnerable groups across all NGOs working in this area. Resources need to account for literacy levels.
6. A coordinated and uniform M&E framework that moves beyond process evaluation and measures outcomes should be developed as part of the coordinated network of peer education programs. Separate data collection for involvement of individuals from different vulnerable populations—youth, sex workers and MSM—is warranted.
7. Training of peer educators should extend beyond content in HIV and enhance skills in group facilitation, communication, program design and implementation, and M&E techniques.
8. Development of strategies to ensure the active and meaningful participation of affected communities in the design and delivery of peer education is needed, especially inclusion of individuals living with HIV.

9. Further development and coordination of referral pathways for clinical support and integration of this support into strategic plans for peer education initiatives is required.
10. Development of an inventory of HIV peer education providers—and other relevant service providers—for distribution to all stakeholders involved in peer training programs is a collaborative role that can be adopted by the Ministry of Health.

6.3.8 Tonga country specific recommendations

The recommendations are reprinted from the report on HIV peer education in Tonga. The background to these recommendations may be sourced from this report.

1. Support of existing peer education activities undertaken by local organisations is warranted.
2. Strengthening of existing collaborative links between organisations is recommended (especially in anticipation of expanding service delivery to vulnerable populations other than youth, sex workers and MSM and to populations in outer islands as noted below).
3. Education and up-skilling in the precise methodology of peer education, and the roles and responsibilities of peer educators, is warranted both for peer educators themselves, and for members of the broader stakeholder organisations and community.
4. Consideration should be given to implementing peer education to the outer islands.
5. Consideration should be given to implementing peer education with other vulnerable populations listed in the national strategy as well as those activities already targeting youth, sex workers and MSM.
6. Greater participation by the targeted vulnerable groups should be facilitated in the design, implementation and evaluation of peer education programs.
7. The broad scope of targeted populations for each organisation needs to be reconsidered with respect to the resourcing, training, recruitment and skills base of peer educators to ensure appropriate and effective targeting.
8. The creation of specifically targeted resources appropriate to each vulnerable group is needed.
9. Inequity of payment of peer educators between organisations involved in peer education within the same populations (youth) needs to be addressed so that this does not impact on volunteer capacity in any organisation.
10. Strategies to manage the high turnover of peer educators and for ensuring that an optimal level of skill and knowledge is maintained by new peer educators need to be developed.

6.3.9 Tuvalu country specific recommendations

The recommendations are reprinted from the report on HIV peer education in Tuvalu. The background to these recommendations may be sourced from this report.

1. Peer education among seafarers should be encouraged and continued.
2. Efforts to identify the needs of those within other vulnerable groups should be undertaken. This includes an assessment of the levels of involvement capable of individuals within these populations.
3. Outreach and support to PLWHA in Tuvalu should be enhanced. This includes advocacy roles within organisations.
4. Education and up-skilling in the precise methodology of peer education, and the roles and responsibilities of peer educators, is warranted both for peer educators

themselves, and for members of the broader stakeholder organisations and community.

5. Monitoring and evaluation processes need to be addressed, including the development of evaluation tools appropriate to the unique constraints of Tuvalu.
6. Formalised networking and coordination among the organisations involved in peer education in HIV is warranted. Resourcing to support this coordination is important so the mechanisms of interagency collaboration, communication and support between NGOs and Government may be addressed.
7. A system of networking and communication with other country peer education programs should be developed to provide support, in-service and guidance to local programs in Tuvalu.
8. A detailed assessment of the state of sexual and reproductive health amongst the population should be conducted, with particular focus on the most vulnerable populations.

6.3.10 Vanuatu country specific recommendations

The recommendations are reprinted from the report on HIV peer education in Vanuatu. The background to these recommendations may be sourced from this report.

1. Existing efforts in effective HIV peer education methodology should be applauded and reinforced, especially in the area of networking and coordination.
2. Though strong in many aspects, the national policy should be made clearer in its identification of specific vulnerable populations, peer education programs targeting these groups, and the nature of stakeholder engagement.
3. A system of networking and communication with peer education programs in other countries should be further developed to provide support, in-service and guidance to local programs based on lessons learnt in Vanuatu.
4. Education and up-skilling in the precise methodology of peer education, and the roles and responsibilities of peer educators, is warranted both for peer educators themselves, and for members of the broader stakeholder organisations and community.
5. Adequate funding for peer education programs should be addressed to ensure peer educators are supported and motivated in their work; that programs are sustained over the long term; that innovation be allowed to develop; and that sufficient capacity with respect to training and in-service be built into programs.
6. Attention should be given to those vulnerable populations currently not adequately targeted by HIV peer education including: taxi drivers, hidden Kava drinkers, young female sex workers and high school students.
7. Those who are most marginalised should be more involved in the consultation in strategic planning development and implementation of programs. These could include sex workers and MSM.
8. Systems to follow up referrals made between organisations need to be investigated. This includes mechanisms to evaluate the effectiveness of the referrals, especially those for STI and HIV testing. Similar processes developed in other countries could be instructive.

Appendix One

Background information

The Secretariat of the Pacific Community (SPC) is an international organization that provides technical and policy advice and assistance, training and research services to its Pacific Island members. It works in a wide range of sectors, including natural resources (agriculture, fisheries and forestry), health, statistics, human development, information and communication technology and social issues. SPC was established in 1947. It has 26 member countries and territories and its working languages are English and French. The organization has been expanding rapidly and now has approximately 350 staff and a total annual budget of XPF 4.9 billion (approximately USD 60 million). SPC's headquarters is in Noumea, New Caledonia. It also has regional offices in Suva, Fiji Islands and in Pohnpei, Federated States of Micronesia. SPC has gained a reputation for providing 'real solutions to real problems' in the Pacific (SPC Corporate Review, 2005) and strives to maintain professionalism, integrity and pragmatism in delivering its services.

SPC's Public Health Program (PHP) is part of the Social Resources Division. The Division's mission is, *to maximise the development potential of Pacific Island people in health, culture and information and enhance the empowerment of women and young people*. The PHP focuses on enabling and supporting healthier Pacific Island communities through two main objectives: prevention, control and management of communicable and non-communicable diseases; and enhancement of public health systems, including management and infrastructure. The vision of PHPs HIV & STI Section is *to lead a coordinated response to HIV in the Pacific that provides best-practice care to all people living with HIV and helps the people of the Pacific Community prevent further transmission of the virus*.

The HIV & STI Section monitors the implementation of the Pacific Regional Strategy Implementation Plan (PRSIP) and provides a range of integrated services to member countries in collaboration with partner organisations. Its activities are supported by a range of funding streams under the integrated framework of PRSIP. Donors include the Asian Development Bank (ADB), AusAID, the Global Fund, the Government of France and NZAID. The ADB Grant seeks to contribute to the reduction of the spread and impact of HIV in ten Pacific countries. The project has four components: (i) strengthening surveillance of HIV and other STIs; (ii) community-based interventions for prevention, testing and treatment of HIV & other STIs; (iii) targeted interventions for vulnerable groups; and (iv) project management and monitoring and evaluation.

The HIV & STI Section has expanded from four staff in 2006 to approximately twenty based in Noumea, Suva and Pohnpei. The expansion of the Section reflects the need to respond to issues relating to HIV and other STIs in order to prevent the pattern of other countries such as South Africa, where in the space of 10 years HIV prevalence increased from 2 per cent to nearly 20 per cent of the population, with more than 5.5 million people now living with HIV. In addition, the expansion aims to ensure that the vision set by Pacific leaders in the Pacific Regional Strategy is realised.

Recent surveillance data shows that the Pacific region—excluding PNG—still has low prevalence of HIV. However research shows high rates of other STIs in some countries, which means significant risk behaviours exist, setting the scene for the rapid spread of HIV, thus rendering the Pacific vulnerable to a HIV epidemic. Strategic information obtained from these studies has enabled SPC and other regional partner agencies to develop programs to address identified vulnerability factors.

SPC works in close collaboration with regional agencies and programs engaged in the implementation of PRISP, including UN agencies, the World Council of Churches Pacific Office and the Pacific Islands AIDS Foundation. The challenges of implementing PRISP are considerable, given the varying socio-economic conditions and levels of political commitment in countries. Dealing with multiple partner agencies also brings challenges, as each agency has its own strengths, weaknesses and regional mandate.

Appendix Two

Project outline

Purpose

The purpose of the consultancy was to assist the Secretariat of the Pacific Community's HIV & STI Section conduct an in-depth assessment of programs, particularly peer education programs, working with identified vulnerable populations (including but not limited to sex workers, MSM, marginalised young people, seafarers and other mobile populations). It was envisaged that the consultancy would contribute to improving the strategic approach of regional organisations like SPC to support future national peer education programs and behaviour change interventions.

Objectives

Original contract documentation noted that the consultancy would achieve:

1. An in-depth assessment of programs, particularly peer education programs, working with identified vulnerable populations in selected countries in the Pacific region.
2. Identification of referral systems in place for HIV/STI clients and where present who the referral points are.
3. Identification of processes used to develop or recommend capacity development of existing staff and volunteer skills, knowledge and program development in relation to working with vulnerable populations.
4. Definition of strategies to improve the capacity of staff and volunteers.
5. Recommendation of strategies (including skills training) for delivering effective and needs based vulnerable group programs/interventions.
6. Identification of other pertinent issues that may impact on the effectiveness of current programs, including consideration of (i) a code of ethics; and (ii) common difficulties in interventions focused on vulnerable or marginalized populations.

Further discussion with SPC personnel refined the first objective to concentrate this mapping exercise solely on peer education. This resulted in a very defined mapping exercise within the ten countries. It is noted that the use of the term *peer education* did not necessarily equate to actual peer education initiatives 'on the ground'. In some instances more broad community based education was undertaken and in other instances—where the term *peer education* was not used—there was true peer education underway.

Each of these objectives has been achieved and are presented in the main sections of this report.

Agreed Outputs

The contract for this project agreed that the consultants would provide the BCC Cluster Coordinator and the ADB Grant Coordinator with the following outputs on time and within budget:

1. Draft assessment plan including strategy, methodology and tools due as part of proposal submission and finalized one week prior to commencement of work.
2. In-depth assessment of programs working with vulnerable populations as beneficiaries.
3. Comprehensive Final Report covering the scope and achievements of the consultancy that is acceptable to the BCC Cluster Coordinator and the ADB Grant Coordinator
4. Directory of peer education programs and organisations working with vulnerable populations mapped by country.

Each output was submitted on time and this final report provides the final component.

Time Frame

Jan 20 – 27	Desk review (of existing documents of similar exercises and other relevant documents) and preparation of final assessment plan for approval.
Jan 23	Submission of criteria sheet for review
Jan 26 – 27	Completion of draft survey tool. Submission of assessment plan and survey tool for review and approval
Jan 28 – Feb 16	Circulation of survey tool through in-country partners
Feb 16 – 27	Collection of data from survey tool and from regional stakeholders through face-to-face meetings in Fiji; return of completed surveys; telephone interviews and email responses
Feb 28 – Mar 20	Collection of data from survey tools returned late data analysis and report writing
Mar 20 – Apr 6	Circulation of country report, findings and recommendations for verification and comments to country programs and partners
Mar 20 – Apr 6	Feedback and comments
Apr 8	Circulation of draft of final report, findings and recommendations for verification and comments to country programs and partners
Apr 8 – Apr 17	Feedback and comments
Apr 18 – Apr 22	Incorporation of comments and feedback into final report, including completion of recommendations and directory of peer education programs
Apr 24	Submission of final report
(April 30	Latest date for submission if the project were to overrun).

Target Populations

Countries

The 10 countries targeted through this mapping exercise were determined in consultation with SPC personnel. They are numbered in alphabetical order for ease of reference through this report:

- Cook Islands
- Federated States of Micronesia (FSM)
- Kiribati

- Republic of the Marshall Islands (RMI)
- Nauru
- Samoa
- Solomon Islands
- Tonga
- Tuvalu
- Vanuatu

Identified vulnerable populations

The following vulnerable populations were regularly identified in the documentation reviewed and comprise the total set of vulnerable populations discussed even though not all vulnerable populations exist in each of the 10 countries

- Young people (including marginalized young people)
- Women
- Sex workers (commercial and transactional)
- Persons occupying traditional transgender roles
- Persons working in manufacturing industries, logging and fishing
- People working in the hospitality industry
- Military personnel
- Police personnel
- Men who have sex with men (MSM)
- Victims of rape and sexual coercion
- Migrants and displaced persons
- Migrant workers / foreign workers
- Persons with traditional tattoos
- Seafarers
- Partners of Seafarers
- Individuals with HIV
- Mobile Men with Money (MMM)

Appendix Three

Methodology

Definition the parameters of the mapping exercise

This occurred in the first week of the consultancy between 20 & 27 January 2009.

The first part of this was to liaise with SPC's HIV & STI staff, including the BCC Cluster Coordinator and Peer Education Development Officer in Noumea and Suva, to define the parameters of this mapping exercise.

During this first phase, the consultants were guided by the ADB HIV/AIDS Prevention & Capacity Development in the Pacific Grant 0021-REG Design and the Pacific Regional HIV Strategy Implementation Plan (PRSIP), as noted in the EOI request document.

Document review (part one)

This occurred in the first week of the consultancy between 20 & 27 January 2009.

A review of key documents (including existing documents of similar exercises in other regions and countries) provided an overview of issues that may be considered during the course of this mapping exercise.

A second component of this preliminary document review was the examination of country (and regional) national HIV and STI strategies to assess inclusion of peer education methodologies in these national approaches.

Survey tool development

This occurred in the first week of the consultancy between 20 & 27 January 2009.

Utilising material found from existing similar exercises a survey tool to be utilised to map and assess peer education programs was developed and submitted to key SPC HIV & STI personnel for review and revision.

Accompanying the survey tool was a one-page criteria checklist so organisations and individuals may be able to check the relevancy of them being involved in this mapping exercise.

The survey tool was designed for both print and email use however most responses were by phone or email.

Data collection

The mapping exercise sought to evaluate and document current peer education programs addressing vulnerable populations. The evaluation utilized a combination of methodologies, triangulating between different information sources. Triangulation involves comparing findings between different data sources e.g. a project progress report may have a particular finding which can be validated by interviews. The methodologies employed by this evaluation included key informant interviews as organized by SPC's HIV & STI personnel, surveys of key informants and a review of project documents, including organisation reports, plans, evaluations and other program records where available. Information will be obtained from key informants through personal interviews, surveys and email communication. The mapping process included:

Document review (part two)

This occurred in two phases. The initial phase was from the home base between Jan 28 and Feb 16, while the second phase was in Fiji Feb 16–27.

In the first phase, prior to the commencement of key stakeholder interviews, a comprehensive literature review and desk study sourced and assessed HIV/STI strategies and projects targeting vulnerable populations in each of the relevant countries. The review utilised relevant strategic documents and reports of SPC, UNAIDS, ADB, AUSAID and other international bodies, and published journal and internet based sources, which provided an overview of the range of interventions, their strengths, weaknesses, threats and opportunities.

While Fiji a further review of locally sourced documentation of relevant materials concerning HIV/AIDS and sexual health peer education based programs and policies was conducted. Literature outlining epidemiological trends and latest research was collected to provide important background to understanding key issues, challenges and opportunities confronting each country and to provide an overview of all sexual and reproductive health programs in each country.

Interviews and survey responses

Survey responses were sought from stakeholder organisations between Jan 28 and Feb 16. Following from this, face-to-face, telephone and email interviews were used to follow up these responses while in-country from Feb 16–27.

Face-to-face meetings occurred with personnel from regional agencies based in Fiji with the assistance of personnel from SPC.

Email responses were sought from the beginning of the data collection phase of this exercise and follow up emails and phone calls were sent on arrival in country allowing stakeholders a small amount of additional time to respond to the survey tool. The number of individual organisations contacted and the response rate is contained elsewhere in this report.

As noted, phone interviews were used to follow up those organisations and individuals that did not respond to the survey tool within the time frame. During phone interviews, consultants asked the same questions as on the survey tool.

Field visits

Two field visits were also staged while Fiji. These occurred because groups of stakeholders were coincidentally meeting in Suva at the same time as the consultants' visit to Suva. The site visits and interviews were organized in collaboration with the BCC Cluster Coordinator.

The two field visits were to:

1. The Red Cross's Monitoring and Evaluation Workshop where peer educators from Kiribati, Samoa, Cook Islands and the Federated States of Micronesia were interviewed.
2. The Pacific Sexual Diversity Network (PSDN) where members of this organisation were interviewed as a group (n=13) to discuss needs of MSM.

This mapping exercise examined the implementation, progress and quality of each program activity with respect to the intended target population and to determine successful achievement of its objectives, indicators, and outputs.

Data analysis

Preliminary data analysis was started while in Fiji from Feb 16–27, however the major component of data analysis occurred at the home base from Feb 28 to Mar 13. To assist the analysis of specific peer education programs, the following ten criteria were used. These criteria are based on an amalgamation of:

- Reporting requirements from the contract
- Topics in the SPC Peer Education Guide
- Common themes from effective peer education programs.

1. The project **targets a vulnerable community** in the country. The intervention is well targeted. (Basis for this comes from the national strategy and from the feedback about what the vulnerable populations are in the country.)
2. **Governance.** The peers are involved in the way things are run and the decision-making. There is **engagement with the target population** in the design, implementation and evaluation of the project. There is engagement at some levels and constant attempts are made to pursue this engagement.
3. There is obvious **support** for the peer education project at an organisational and national level.
4. **Collaborative relationship** with other organisations who are undertaking HIV peer education based activities in the country so that there is no duplication (competition) of services.
5. **Recruitment strategies** for peer educators are appropriate, systematic, ongoing and sustainable. This includes developing defined marketing strategies. There is an accepted and celebrated **exit strategy** for peer educators.
6. There is initial and follow-up education for the peer educators. There is **sustainable capacity building** of peers.
7. **Referral systems** are in place to address the needs of the target population as things arise. This includes the ability to follow-up on whether anything happened as a result of the referral (did the person actually attend for VCCT), and an ability to assess whether the referring agency is effective and provides suitable service.
8. **Evaluation**. There are set outcomes. How is the **effectiveness of the project determined?** What agreed measures are in place to assess whether this project 'makes a difference' or not, and is there a defined mechanism to report against these? It is acknowledged that this is extremely difficult, however are there attempts to do this?
9. Monitoring. A code of behaviour is defined and followed. This includes a **monitoring mechanism for the knowledge, skills and conduct of peer educators**.
10. The project makes an **obvious and tangible impact**. Things that have changed as a result of the project being in existence are able to be discussed.

The mapping exercise also sought to analyse data collected and program activities according to the following criteria:

- **Relevance**: assesses whether programs correctly access the target vulnerable population, identify issues and address real needs, and are in line with local needs, priorities and the overall strategic direction. Questions to be considered include: Do the program objectives maintain relevance to the target population and its identified needs? Do addressed problems represent major challenges?
- **Effectiveness**: measures the extent to which programs achieve their purpose, or whether this can be expected to happen on the basis of the results recorded to date. Implicit within effectiveness is timeliness. Effectiveness should indicate the real difference made in practice as a result of a particular activity, timeliness of the intervention, optimal engagement of the activity, the benefits gained by the intended target group. In short, this measure seeks to answer whether the program adequately realized its stated objectives?
- **Efficiency**: measures how well the various programs have transformed the available resources into the intended results (outputs) maximizing quality, quantity and timeliness. This addresses the concept of value-for-money, that is, whether the results achieved at a reasonable cost compared with alternative ways to accomplishing the same objectives?
- **Impact**: assesses the wider effects of the program and its activities. Impacts can be short or long-term, intended or unintended, positive or negative, macro (community) or micro (individual). This measure addresses the various ways—socially, economically, politically, environmentally and attitudinally—the program has affected the intended beneficiaries and other stakeholders? What are the social, economic, technical, environmental, and other effects on individuals, communities, and institutions?
- **Sustainability**: measures the likelihood of a program to continue after the withdrawal of donor funding and whether a longer-term impact on the wider development process can be sustained at the level of the sector, region or country. This measure seeks to answer- Are the activities stated in the program sustainable after the cessation of donor support? Are the beneficiaries willing to continue to support the program? Have the program recipient institutions and/or organizations developed the necessary capacity and motivation to execute and administer similar programs? How far can the activity be self-sustained from domestic resources – financial, material and human?

Report Writing

Report writing occurred at the home base from Feb 28 to Mar 13 and the consultants provided the BCC Cluster Coordinator and the ADB Grant Coordinator with the following:

- Comprehensive Final Report covering the scope and achievements of the consultancy that is acceptable to the BCC Cluster Coordinator and the ADB Project Coordinator.
- Directory of peer education programs and organisations working with vulnerable populations mapped by country.
- Ten small reports specific to each country that contain the same information as the main report however which are in a format suitable to each individual country recipient.

The principal written outputs mentioned above were provided in MS Word addressing the abovementioned scope of services. They included recommendations based upon well-argued

and substantiated findings and experience. The Final Report includes an executive summary, main body and essential annexes. It also includes a list of abbreviations and acronyms used in the report and, attached as annexes, lists of people consulted during the process, a description of the methodology and field visit reports and phone interview reports.

Having assessed current programs addressing vulnerable populations as beneficiaries in identified countries and the prevention intervention methods utilized, the Final Report:

1. Identified if referral systems are in place for HIV/STI clients and where present who the referral points are.
2. Identified processes used to develop or recommend capacity development of existing staff and volunteer skills, knowledge and program development in relation to working with vulnerable populations.
3. Defined strategies to improve the capacity of staff and volunteers.
4. Recommended strategies (including skills training) for delivering effective and needs based vulnerable group programs/interventions.
5. Identified other pertinent issues that may impact on the effectiveness of current programs, including consideration of (i) a code of ethics; and (ii) common difficulties in interventions focused on vulnerable or marginalized populations.

A draft of the final report was circulated for verification and comments to country programs and partners on 8 April 2009. Following feedback the final report was updated and submitted by 22 April 2009. The actual timetable of events appears below:

Monday 16th February 2009		
Time	Activity	Personnel
8.00am	Initial Briefing	Joe Debattista SPC Office staff
9.00am	Review of Fiji and Solomon Islands national strategies plus summary of those already completed	Joe Debattista
5.30pm	Finish	
7.00pm	Continuation of review of documents previously downloaded from the internet. Summary into one document.	Joe Debattista
9.30pm	Finish	
Tuesday 17th February 2009		
Time	Activity	Personnel
8.00am	Continuation of review of national strategies	Joe Debattista
11.00am	Clarification meeting on project aims and parameters	Joe Debattista Jack Martin
12.00 noon	Calling Regional Offices based in Suva to arrange appointments.	Joe Debattista
6.00pm	Finish	
7.30pm	Continuation of review of documents	Joe Debattista
9.30pm	Finish	
Wednesday 18th February 2009		
Time	Activity	Personnel
8.00am	Continuation of review of national strategies	Joe Debattista
9.00am	Meeting with Dr Seng Sopheap, WHO HIV / AIDS Focal Point	Joe Debattista Dr Seng Sopheap
10.30am	Follow up phone calls to those who were sent the survey in the ten countries. Continuation with document review and sourcing support materials from each country.	Joe Debattista
12.00noon	Meeting with George Tavola, Program Development Officer, Adolescent Health and Development Section, SPC	Joe Debattista George Tavola
12.30pm	Follow up phone calls to those who were sent the survey in the ten countries. Continuation with document review and	Joe Debattista

	sourcing support materials from each country.	
5.30pm	Finish	
7.30pm	Continuation of review of documents	Joe Debattista
9.30pm	Finish	
Thursday 19th February 2009		
Time	Activity	Personnel
8.00am	Preparation for days meetings	Joe Debattista
9.00am	Meeting with Mr Aisake Casimira, Pacific Conference of Churches	Joe Debattista, Jack Martin Aisake Casimira
11.00am	Meeting with Mr Michael Sami, Marie Stopes International	Joe Debattista, Jack Martin Michael Sami
1.00pm	Briefing between Joe Debattista and Steve Lambert	Joe Debattista Steve Lambert
2.00pm	'Meet and greet' of those in the office and the layout of the office	Steve Lambert SPC colleagues
2.30pm	Follow up phone calls to those who were sent the survey in the ten countries and development of template for recording contact attempts and discussions	Joe Debattista Steve Lambert
6.00pm	Finish	
8.30pm	Continuation of development of template for recording contact attempts and discussions	Joe Debattista Steve Lambert
10.00pm	Finish	
Friday 20th February 2009		
Time	Activity	Personnel
8.30am	Development of timetables and timelines. Draft of template of final report	Steve Lambert
8.30am	Summary reporting and documentation of interviews completed to date	Joe Debattista
11.00am	Meeting with Steven Vete, UNAIDS	Joe Debattista Steve Lambert Steven Vete
12.30pm	Break	
1.00pm	Meeting with JM to go through: – Update on progress with country contacts – Decision re criteria for assessment of effectiveness of peer education programs – Access to SPC files re past 3 years submission for peer education projects	Joe Debattista Steve Lambert Jack Martin
2.00pm	Type up of meeting with Steven Vete. Phone call and email contact with country contacts Development of draft of final report template including assessment criteria	Joe Debattista Steve Lambert
5.00pm	Meeting with Peer Educators who are in Suva for Red Cross Conference. Interviews with Patience Vainerere & Danny Vakapora (Cook Islands) and Morgan David & Hans (FSM)	Joe Debattista Steve Lambert Morgan David Hans Patience Vainerere Daniel Vakapora
7.30pm	Finish	
8.30pm	Report template and writing	Joe Debattista Steve Lambert
10.30pm	Finish	
Saturday 21st February 2009		
Time	Activity	Personnel
11.00am	Continue write up of interviews to date	
3.30pm	Interview with Temonori Tiree, Kiribati Red Cross	Joe Debattista Steve Lambert

		Temonori Tiree
5.00pm	Review of SPC Peer Education standards, documents, meanings and the development of criteria to assess peer education projects. Write up of interviews	Joe Debattista Steve Lambert
7.00pm	Examination of one country to assess 'useability' of final report template – Cook Islands	Joe Debattista Steve Lambert
8.30pm		
Sunday 22nd February 2009		
Time	Activity	Personnel
12.00 noon	Write up of notes from meetings	Joe Debattista Steve Lambert
4.30pm	Interviewed Goretti Wulf, Samoan Red Cross at Holiday Inn	Joe Debattista Steve Lambert Goretti Wulf
6.00pm	Developed template for country reports and overall structure of final report. Write up of interviews.	Joe Debattista Steve Lambert
8.00pm	Finish	
Monday 23rd February 2009		
Time	Activity	Personnel
8.30am	Continue to write up meetings	Joe Debattista Steve Lambert
10.00am	Meeting with Ferdinand Strobel, UNDP cancelled due to unexpected leave.	
10.00 am	Phone calls to various countries (JD). SL completed development of report templates and began Marshall Islands Report.	Joe Debattista Steve Lambert
12.00 noon	Update on progress meeting with BCC coordinator	Joe Debattista Steve Lambert Jack Martin
3.30pm	Telephone interview with Linda Peterson and Rose Maebiru from SPC Noumea.	Joe Debattista Steve Lambert Linda Peterson Rose Maebiru
4.15pm	Arrange meetings with Dr Ruffina Latu, Jason Mitchell (OSSHHM) & Jack Martin	
4.45pm	Continue write up of interviews. Check on surveys sent in via email. Include in the summary write ups	
5.30pm	Check on progress meeting	Joe Debattista Steve Lambert
6.30pm	Finish	
8.00pm	Organising Appendices for main report. Write up of meetings	Joe Debattista Steve Lambert
10.00pm	Finish	
Tuesday 24th February 2009		
Time	Activity	Personnel
8.30am	Setting out templates for 10 individual country reports (4 to 5 pages each)	Steve Lambert
9.00am	Meet Dr Annefrida Kisesa-Mkusa, UNICEF.	Joe Debattista Dr Annefrida Kisesa-Mkusa
10.30am	Developing reporting templates, write up of interviews, phone calls, report development.	Joe Debattista Steve Lambert
12.30pm	Join members of PSDN for lunch to request interviews	Steve Lambert
3.00pm	Interview with Casper Supa at SI Save the Children Fund	Joe Debattista Casper Supa
4.00pm	Developing reporting templates, write up of interviews, phone calls, report development.	Joe Debattista Steve Lambert
5.30pm	Finish	
7.00pm	Write up of days interviews	Joe Debattista
10.00pm	Finish	

Wednesday 25th February 2009		
Time	Activity	Personnel
8.30am	Email contact with Kiribati agencies, telephoned Solomon Island, Tuvalu and Kiribati agencies. Write up of interviews, report development	Joe Debattista Steve Lambert
11.00am	Tim Sladden meeting, UNICEF. Dolphin Plaza, Suva	Steve Lambert Tim Sladden
11.00am	Interview with Dr Dennie Iniakwala	Joe Debattista Dennie Iniakwala
12.30pm	Meeting with MSM network at Peninsula Hotel to discuss peer education among MSM	Steve Lambert Ken Moala Members of PSDN
2.00pm	Briefing meeting with SPC staff	Joe Debattista Steve Lambert 6 SPC staff
3.00pm	Jason Mitchell, OSSHHM, interview	Steve Lambert Jason Mitchell
3.00pm	Interview with George Angoa at SI Planned Parenthood (Cancelled)	Joe Debattista George Angoa
4.00pm	Interview with Ollie Sandra Pokana at Church of Melanesia (Cancelled)	Joe Debattista Ollie Sandra Pokana
4.00pm	Write up of interviews. Begin formulating recommendations	Steve Lambert
5.30pm	Finish	
7.00pm	Write up of interviews and surveys that have been received via email	Joe Debattista
7.00pm	Dinner with MSM network. Meeting with Ken Moala, Samoa AIDS Foundation	Steve Lambert
10.00pm	Finish	
Thursday 26th February 2009		
Time	Activity	Personnel
8.30am	Continue write up of final report	Joe Debattista
9.00am	Elizabeth Cox UNIFEM, meeting	Steve Lambert Elizabeth Cox
10.00am	Interview with Eric Houma, SI Save the Children Fund	Joe Debattista Eric Houma
11.00am	Continuation of final report write up	Steve Lambert
11.00am	Phone interview with Pertina Albert FSM	Joe Debattista Pertina Albert
11.30am	Phone call meeting with Eleanor Sos, FSM, Chuuk State	Joe Debattista Eleanor Sos
12.30pm	Interview with Maoto Metai, Kiribati on 686 50344	Joe Debattista Maoto Metai
3.00pm	Progress report with Jack Martin and discussion of gaps in gathering the information	Joe Debattista Steve Lambert Jack Martin
4.00pm	Phone interview with BCC colleagues	Joe Debattista Steve Lambert Jovesa Saladoka
4.30pm	Continue to write up interviews	Joe Debattista Steve Lambert
6.00pm	Finish	
Friday 27th February 2009		
Time	Activity	Personnel
7.00am	Check in on list of things needed to complete the consultancy and the reports. Discussion of things that can be reported in the final brief to SPC	Joe Debattista Steve Lambert
8.30am	Report writing	Steve Lambert
9.00am	Interview with Sala Tupou-Tamani, SPC office	Joe Debattista Sala Tupou-Tamani

10.00am	Final follow up emails and calls	Joe Debattista
12.00noon	Interview with Dr Ruffina Latu	Joe Debattista Ruffina Latu
1.00pm	Report writing. Final emails. Write up of interviews	Joe Debattista Steve Lambert
2.30pm	Meeting with Emily Miller about FSM peer education	Steve Lambert Emily Miller
3.30pm	Depart for airport	
Post country visit	1 week to allow surveys to be sent via email. 2 weeks for finalisation of reports 1 week consultation and review 1 week for making changes to report. Final by end March 09	

Appendix Four

Documents reviewed

Country / Region	Document title Sorted by: 1) ten countries; 2) Pacific Region; 3) Other regions; 4) other countries
Documents from the ten countries included in this mapping exercise	
Cook Islands	National Strategy on the Response to HIV, AIDS & STI 2008-2013
Federated States of Micronesia	Federated States of Micronesia National Strategic Plan 2007-2011
	Kosrae Strategic Plan 2007-2011
	Yap Strategic Plan 2007-2011
	Chuuk Strategic Plan 2007-2011
	Gold, J. HIV and AIDS Situation and Response Analysis Yap 2006
	Gold, J. HIV and AIDS Situation and Response Analysis, Chuuk 2006
	Gold, J. HIV and AIDS Situation and Response Analysis, Kosrae 2006
	UNGASS Country Report – 2006 Federated States of Micronesia
Kiribati	Kiribati STI and HIV/AIDS Strategic Plan 2005 - 2008
	Draft Kiribati STI, HIV and AIDS and Sexual and Reproductive Health Peer Education Strategic Plan 2009- 2013
Nauru	Nauru Health Operational Plan 2008
	Evaluation of Chlamydia Testing and Treatment Pilot, Republic of Nauru, by SPC and the Ministry of Health, Nauru, July 2008.
	Nauru National Youth Policy 2008 – 2015: A Vision for Quality of Life - Bitune Eterō dōgit Itsimor Omo. Directorate of Youth Affairs, Department of Education, Republic of Nauru.
	Pacific Regional HIV / AIDS Project (PRHP) Nauru Country update 2003 - 2006
Republic of the Marshall Islands	Republic of Marshall Islands National HIV/AIDS Strategic Plan 2006-2009
Samoa	A Strategic Plan for Responding to the Impact of HIV/AIDS on Women 2001 - 2005
Solomon Islands	The National HIV Policy and Multi-Sectoral Strategic Plan 2005–2010
Tonga	A strategic Plan for Responding to HIV / AIDS and STIs in the Kingdom of Tonga 2001 – 2005
	Report on the Situational Analysis and Response Review on the Strategic Plan 2001- 2005 Regarding HIV-AIDS in the Kingdom of Tonga
Tuvalu	Tuvalu National Strategic Plan for HIV and AIDS 2009–2012
	UNGASS 2008 Country Progress Report Tuvalu
Vanuatu	National Policy for HIV/AIDS and Sexually Transmitted Infections 2008 – 2012
	Vanuatu Nation Strategic Plan Implementation Schedule 2008
	Antenatal Clinic STI Survey, Port Vila, Vanuatu. Ministry of Health and World Health Organisation August 2000
Selected documents from the broader Pacific Region	
Pacific Region	Pacific Regional Strategy Implementation Plan (PRSIP)
	Pacific Regional Strategy on HIV (2004–2008)
	Pacific Regional Strategy on HIV and Other STIs (2009–2013)
	Pacific Islands AIDS Foundation Draft Strategic Plan 2003-05, Jan 2003
	2006 Annual Progress Report of The Pacific Regional Strategy Implementation Plan (2004–2008)
	2007 Annual Progress Report Pacific Regional Strategy Implementation Plan (2004–2008)
	Adolescent Sexual and Reproductive Health Situation Analysis for Solomon Islands A Review of Literature and Projects, 1995 - 2005 Juliette Fleischl, UNFPA Office for the Pacific 2006
	An Integrated Picture: HIV Risk and Vulnerability in the Pacific. Research Gaps, Priorities and Approaches. Holly Buchanan-Aruwafu (PhD) February 2007
	Discussion Document on Analysis of Donor Requirements Relevant to Pacific Regional Strategy Implementation Plan (PRSIP) November 2007
	Franco-Australian Pacific Regional HIV/AIDS and STI Initiative Behaviour Change Communication Training Needs Assessment Report August 2004
	HIV/AIDS in the Pacific, Carol Jenkins, Ph.D. Asian Development Bank, October 2005
	Midterm review of the Pacific Regional Strategy on HIV (2004–2008) and its

Country / Region	Document title Sorted by: 1) ten countries; 2) Pacific Region; 3) Other regions; 4) other countries
	implementation November 2004 David Fowler Bill O'Loughlin Sister Vika Tikinatabua
	Pacific Island HIV and STI Response Fund 2009–2013
	Pacific Island HIV and STI Strategies Implementation Fund– Consultation Paper 2
	Pacific Islands Forum Secretariat "Pacific Aid Effectiveness Principles"
	Pacific: Children and HIV/AIDS A Call to Action Unicef 2006
	PASA, the Pacific AIDS Alert Bulletins. Nos 29-32
	Report and Recommendation of the President of Directors on a Proposed Asian Development Fund Grant to the Secretariat of the Pacific Community for the HIV/AIDS Prevention and Capacity Development in the Pacific Project, H Baxter, M Suga & L Lahm, Asian Development Bank October 2005
	Review of National AIDS Coordination Mechanisms in Pacific Island Countries, Final Report, Pacific Regional HIV/AIDS Project, April 2006
	Review of National Coordination Mechanisms in PICs – April 2006
	Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries (2004-2005)• Fiji• Kiribati• Samoa• Solomon Islands• Tonga• Vanuatu
	Waiting for something to happen: Trade Union responses to HIV/AIDS in the South Pacific Report of a needs analysis survey for ILO and SPOCTU. Union Aid Abroad – APHEDA, July 2004
Fiji	UNGASS 2008 Country Progress Report Fiji
	What is Stepping Stones 2007
New Caledonia	Consensus statement of the Donor Roundtable Consultation, 30–31 July 2007, Noumea, New Caledonia
Selected documents from other regions in the world	
Worldwide	Global strategy for the prevention and control of sexually transmitted infections: 2006–2015 Key messages
	National AIDS Programs: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people, World Health Organisation, 2004
	Paris Declaration on Aid Effectiveness 2005
	Youth Peer Education in Reproductive Health and HIV/AIDS: Progress, Process, and Programming for the Future, Family Health International, YouthNet Program, Virginia, 2006
Africa	Oxfam Australia: Sharing Lessons Learnt from Oxfam's Southern Africa HIV & AIDS Programs with the Pacific, Kathryn Dinh, Oxfam Australia August 2006
Eastern Europe	Assessing the Quality of Youth Peer Education Programs, Tool Kit United Nations Population Fund and Youth Peer Education Network (Y-PEER), New York, 2005
	From Theory to Practice in Peer Education, Training of Trainers Manual, Youth Peer
	Standards for Peer Education Programs, Youth Peer Education Tool Kit United Nations Population Fund and Youth Peer Education Network (Y-PEER), New York, 2005
Selected documents from other specific countries	
England	Behaviour Change, National Institute for Health & Clinical Excellence, NHS, London, 2008
	Quick Reference Guide to Community Engagement, National Institute for Health & Clinical Excellence, NHS, London, 2008
Australia	A framework for peer education by drug-user organisations S.Q. Wye, Australian Injecting & Illicit Drug Users League (AIVL), Canberra, January 2006
	Evaluation of Queensland Injector's Health Network's Mix Up Project, The Burnet Institute and VIVAIDS - The Victorian Drug User Organisation, January 2009
	Peer Education: From Evidence to Practice in alcohol and other drugs primer. Joanne McDonald, Ann M Roche, Mitch Durbridge, Natalie Skinner, National Centre for Education and Training on Addiction (NCETA), Flinders University of

Country / Region	Document title Sorted by: 1) ten countries; 2) Pacific Region; 3) Other regions; 4) other countries
	South Australia 2003
	Planning a Peer Education Program Fact sheet No 4.13, Drug Info Clearinghouse, Australian Drug Foundation, Melbourne 2006
	What is Peer Education, Fact sheet No 4.10, Drug Info Clearinghouse, Australian Drug Foundation, Melbourne 2006

Appendix Five

Personnel and organisations involved in the mapping exercise

Name	Organisation	Notes
Albert, Pertina	Adolescent Health & Development Coordinator, Ministry of Health, **Federated States of Micronesia**	Survey completed and sent via email with follow up phone discussion
Alfred, Julia	Manager Youth to Youth in Health, **Republic of the Marshall Islands**	Survey sent in via email
Angoa, Ben	Community Development Manager Planned Parenthood Association **Solomon Islands**	Survey sent in via email
Bob, Samantha	Adventist Development Relief Agency **Solomon Islands**	Survey sent via email
Bulu, Siula	Program Coordinator Wan Smolbag, **Vanuatu**	Survey sent via email
Caimira, Aisake	**Pacific Conference of Churches**	Face to face interview
Cox, Elizabeth	Coordinator **UNIFEM Pacific Region**	Face to face interview
David, Morgan	Peer Education coordinator Red Cross, **Federated States of Micronesia**	Face to face interview
Faasau, Sydney	Talavou Program Ministry of Women, Social & Community Development **Samoa**	Not sure here
Falani, Amouta	Youth Officer **Tuvalu** Family Health Association	Survey sent via email
Fationo, Julia (and Wayne)	HIV Program Coordinator Oxfam, **Solomon Islands**	Survey sent via email
Fuimaoono, Peone	**Samoa** AIDS Foundation	Survey sent via email
Gela, John	Secretariat National AIDS Council **Solomon Islands**	Disseminated information to local contacts
Hans	Peer Educator Red Cross, Kosrae, **Federated States of Micronesia**	Face to face interview
Hoponoa, Amelia	Program Coordinator **Tonga** Family Health Association	Discussed project on the phone and referred on
Houma, Eric	Save the Children **Solomon Islands**	Phone Interview
Iniakwala, Dennie	Section Head Public Health Program **Secretariat of the Pacific Community**	Face to face meeting
Kefu, Polikalepoku	HIV Project Coordinator **Tonga** National Youth Congress	Survey sent via email
Kisesa-Mkusa,	Chief, HIV & AIDS	Face to face interview

Name	Organisation	Notes
Annefrida	**UNICEF Suva Office**	
Lapa, Tophilau	Volunteer Management Officer Red Cross, **Samoa**	Survey Sent via email
Latu, Rufina	Adolescent Health & Development Adviser **Secretariat of the Pacific Community**	Face to face meeting
Leniston, Margaret	Regional Health Program Manager Helti Pasifik Komuniti Program **Foundation of the Peoples of the South Pacific - International (FSPI)**	Face to face interview
Loteba, Nnakina	Executive Officer **Kiribati** Family Health Association	Survey sent in via email
Maebiru, Rose	Youth Adviser **Secretariat of the Pacific Community**	Phone interview with Noumea office
Malverus, Jayline	Peer Education Coordinator Wan Smolbag, **Vanuatu**	Survey sent via email
Matio, Savali Kelese	Youth Officer **Tuvalu** Family Health Association	Survey sent via email
Matovu, Moses	HIV/STI Program Ministry of Health, **Vanuatu**	Disseminated information to local contacts
Metai, Maoto	Adolescent Health & Development Coordinator, Ministry of Health, **Kiribati**	Phone interview
Miller, Emily	"Stepping Stones" Program **Foundation of the Peoples of the South Pacific - International (FSPI)**	Face to face interview
Mitchell, Jason	Executive Officer **Oceania Society for Sexual Health and HIV Medicine (OSSHHM)**	Face to face interview
Moala , Ken and members	**Pacific Sexual Diversity Network**	Meeting with network members
Moala, Ken	**Samoa** AIDS Foundation & Pacific Sexual Diversity Network	Face to face informal meeting
Murphy, Catherine	Adolescent Health and Development **Tonga** Family Health Association	Survey sent via email
Petersen, Linda	Manager Human Development Program **Secretariat of the Pacific Community**	Phone interview with Noumea office
Pokana, Ollie Sandra	Integrated Community Program The Church of Melanesia **Solomon Islands**	Survey sent via email
Sami, Michael	**Marie Stopes International Pacific**	Face to face interview
Sasau, Temo	**Pacific Islands AIDS Foundation (PIAF)**	Face to face interview
Satorara, Lorraine	HIV Program Coordinator World Vision, **Solomon Islands**	Survey sent via email
Siama, Crispin	Peer educator Ministry of Health, **Solomon Islands**	Survey sent via email

Name	Organisation	Notes
Sladden, Tim	Adviser – STIs & HIV **UNFPA Office for the Pacific**	Face to face meeting
Sopheap, Seng	HIV / AIDS Focal Point **WHO South Pacific Office**	Face to face meeting
Sos, Eleanor	HIV program coordinator, Chuuk State, **Federated States of Micronesia**	Phone interview
Supa, Casper	Save the Children **Solomon Islands**	Phone Interview
Tavola, George	Program Development Officer Adolescent Health & Development **Secretariat of the Pacific Community**	Face to face meeting
Tiree, Temanori	Secretary-General Red Cross, **Kiribati**	Face to face meeting
Tupou-Tamani, Salaseini	**Secretariat of the Pacific Community**	Face to face meeting
Vainerere, Patience	Peer Educator Coordinator Red Cross, **Cook Islands**	Face to face interview
Vakapora, Daniel	Peer Educator Coordinator **Cook Islands** Red Cross	Face to face interview
Vete, Steven	Coordinator UNAIDS Pacific Program	Face to face interview
Visesio-Pita, Seletuta	Program Manager Talavou Program Ministry of Women, Social & Community Development **Samoa**	Survey sent via email
Warijo, Simo	HIV-STI Project Manager World Vision, **Vanuatu**	Survey sent via email
Wulf, Goretti	Health Coordinator Red Cross, **Samoa**	Face to face interview

Appendix Six

Criteria page for inclusion in the mapping exercise

Checklist of Inclusion Criteria
for Agency participation in the
Peer Education Suport Program Mapping Consultancy

Background
This simple checklist is to be used gauge the appropriateness and relevance of an organisation's potential participation in the 'Peer Education and Support Program Mapping Consultancy'.

If appropriate and relevant the NGO will be asked to complete a survey tool in the next couple of weeks.

Simply check all the relevant boxes below:

- ☐ My agency is responsible for peer education tasks identified in the National H and / or Sexual and Reproductive Health (SRH) strategy
- ☐ My agency is affiliated with a national or regional HIV and / or SRH network partnerships (including relevant government ministries)
- ☐ My agency targets interventions to least one locally recognised vulnerab population as identified in the national or regional HIV and / or SRH strategies. (some examples include: young people, seafarers, sex workers, men who ha sex with men, women etc)
- ☐ My agency has involved members of vulnerable populations in the developme and delivery of HIV and / or SRH interventions within the last 12 months.
- ☐ My agency has employed staff to manage peer education projects
- ☐ My agency has an active peer based network amongst at least one recognis vulnerable population and provides regular support to that network
- ☐ My agency provides training for paid and / or voluntary peer educators
- ☐ Management and governance personnel in my agency are supportive of th agency's involvement in peer education initiatives.

If you have checked 4 or more of the criteria above we would like you to be involved in this mapping exercise. Please return this by:

Fax:	+679 337 7021
Scan & Email:	jackm@spc.int.
Mail:	"Peer Education Review", Secretariat of the Pacific Community (SPC), Private Mail Bag, Suva, Fiji

Appendix Seven

Survey tool

Section One: Profile of your organisation

1.1 What is the name of your organisation?_____

1.2 In which countries does your organisation work?

☐ Cook Islands ☐ FSM ☐ Kiribati

☐ Nauru ☐ RMI ☐ Samoa

☐ Solomon Islands ☐ Tonga ☐ Tuvalu

☐ Vanuatu ☐ Others (for reference): _____

1.3 What is the number of paid staff in your organisation?_____
(Include only those working in the ten listed countries)

1.4 What is an estimate of the number of volunteers?_____

1.5 When was your organisation formed (approx year)?_____

1.6 Was your organisation started to specifically address HIV and / or sexual health issues?

☐ Yes ☐ No

1.7 Is your organisation involved in peer education?

☐ Yes (Please complete the entire survey)

☐ No (Please complete only sections 1 and 2 and return the survey)

1.8 Does your organisation use a set definition of peer education in any of its documentation? If so, please write it below:

_____

_____

_____

Section Two: Your Profile

2.1 What is your name?_____

2.2 What is your position in the organisation?_____

2.3 How long have your worked in the organisation?_____

2.4 Are you in a paid or voluntary position?

___ ___ ___

2.5 What is your personal definition of peer education?

_____

_____

Section Three: Involvement in Peer Education

Only answer the remaining sections if your organisation is involved in peer education in HIV and sexual health.

3.1 What % of all activity in your organisation is devoted to peer education?

_____

3.2 How many staff and volunteers work in peer education?_____

3.3 Which of the following populations are targets for your organisation's peer education initiatives?

- ☐ Marginalized young people
- ☐ Young people attending school
- ☐ Women
- ☐ Sex workers (commercial and transactional)
- ☐ Persons occupying Traditional Transgender roles
- ☐ Persons working in manufacturing industries, logging and fishing
- ☐ Personnel working in the hospitality industry
- ☐ Military personnel
- ☐ Police personnel
- ☐ Men who have sex with men (Gay, Bisexual and non-gay identified)
- ☐ Victims of rape and sexual coercion
- ☐ Migrants and displaced persons
- ☐ People living in rural / remote communities
- ☐ Persons with traditional tattoos
- ☐ Seafarers
- ☐ Partners of seafarers
- ☐ Injecting drug users
- ☐ Individuals living with HIV
- ☐ Other – please specify: _____

3.1 What types of peer education activities does your organisation provide?

- ☐ Direct one-on-one education in HIV and Sexual Health by peers
- ☐ Group based education by peers
- ☐ Education sessions (eg in schools) by peers
- ☐ Telephone information service staffed by peers
- ☐ On-line information service (including email) conducted by peers
- ☐ Social support activities for peers (eg meet for a community meal)
- ☐ Advocacy on behalf of the target population
- ☐ Advocacy for peer education as an effective intervention measure
- ☐ Condom distribution by peers to peers
- ☐ Resource distribution by peers to peers
- ☐ Resource production by peers. Please specify: _____
- ☐ Theatre / role play education by peers
- ☐ Media production and use by peers
- ☐ Knowledge training (in HIV & sexual health) for peer education workers
- ☐ Skill training (eg, in communication) for peer education workers
- ☐ Training for trainers of peer educators
- ☐ Other – please specify: _____
- ☐ Other – please specify: _____

Section Four: Specific Peer Education Initiatives

There is space here to outline one peer education project from 2008 in detail. If your organisation has not undertaken any specific peer education initiatives in the last 12 months but is generally involved in peer education more broadly, please skip this section and complete the remainder of the survey – sections 5 to 8.

If your organisation undertook more than one peer education project throughout 2008, please indicate and we will discuss further during a follow up phone call. Alternately, you can photocopy Section 4 and complete it for your other projects. If your organisation is currently undertaking more than 1 separate peer education projects, the mapping consultants would like to talk with you directly. Please make contact through email or phone as indicated on Page 2.

4.1 Name of the Peer Education Project:_____

4.2 Target population for the Peer Education Project:_____

4.3 No. of years this project has been operating:_____

4.4 Please provide a brief description of the aim of the project:

_____

_____

_____

4.5 Please provide a brief description of the activities of the project:
(The list in question 3.1 might help here)

_____

_____

_____

_____

_____

4.6 Who developed this project? Where did it originate?

_____

_____

_____

4.7 Why did your organisation decide to undertake this project?

_____

_____

_____

4.8 How is your organisation monitoring and evaluating this project?

_____

_____

_____

4.9 What indicators do you use to measure the success of the project?

_____

_____

_____

4.10 How do you personally think this project is going? Does it make a difference?

_____

_____

4.1 No. of paid staff directly involved in the Project:_____

4.2 Are the paid staff peers of the target population? ☐ Yes ☐ No

4.3 No. of volunteers directly involved in the Project:_____

4.4 Are the volunteers peers of the target population? ☐ Yes ☐ No

4.15 Throughout 2008, what is the estimated number of the target population that this project has reached:_____

4.16 How is this project funded?

_____

_____

4.17 What is the budget for the project? _____

4.18 How is contact generally made with the target population?

_____

_____

4.19 How are peer educators generally recruited?

_____

_____

4.20 Who decides what activities are conducted as part of this project?

_____

_____

4.21 How are members of the target population involved in the design, implementation and evaluation of the project?

_____

_____

_____

4.22 Through this project, what have you learnt about the needs of the target population?

_____

_____

_____

4.23 Have you any tips for working appropriately with this target population?

_____

_____

4.16 This mapping exercise is looking for examples of things that are working well. If appropriate, please provide a description (including dates, timing, numbers involved, amount of work etc) of one particular activity in this project that is worth repeating in other areas.

_____

_____

_____

_____

_____

_____

4.17 Are there examples of things that have not worked in this project:

_____

_____

_____

4.18 Have you any 'lessons learnt' to share from this project:

_____

_____

_____

4.19 Have any resources or materials been produced as part of this project?

1. _____
2. _____
3. _____

Section Five: Support and collaboration

5.1 Is your organisation mentioned in your country's national HIV or sexual health strategy?

☐ Yes ☐ No ☐ No national strategies exist

5.2 Is your organisation part of any formal national or regional network in HIV and / or sexual health?

☐ Yes (Specify:_____) ☐ No

5.3 Is your organisation a partner in any peer education networks?

☐ Yes (Specify:_____) ☐ No

5.4 When conducting peer education initiatives, is this undertaken solely by your organisation or is it conducted in collaboration with other parties?

☐ Just us ☐ collaboration with others (Specify:_____)

5.5 Through involvement in peer education activities, does your organisation refer members of the target population to other organisations if the need arises? (eg, to a sexual health clinic?)

☐ Yes (Specify:_____) ☐ No

5.6 Does your organisation follow up on people that it refers to other services and monitor their progress?

☐ Yes (Specify:_____) ☐ No

5.7 Generally, do you feel you have the support of your organisation to be involved in peer education?

☐ Yes ☐ No

5.8 Do you think the country's Ministry of Health (or equivalent organisation) know what your organisation is doing in peer education?

☐ Yes ☐ No

Section Six: Education and Training needs

6.1 Has your organisation conducted any training for staff and volunteers that work in peer education in the last 12 months?

_____

_____

_____

6.2 Other than training provided by your organisation, have any staff or volunteers attended training in peer education in the last 12 months elsewhere?

_____

_____

_____

6.3 What do you consider are the top 8 education and training skills for an individual to become an effective peer educator:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Section Seven: Identifying gaps

One of this aims of this mapping exercise is to identify gaps in peer education and offer ways to address these gaps.

7.1 Are their vulnerable populations in your area (eg young people, sex workers etc) that need some peer education but are not receiving any?

_____

_____

_____

7.2 What gaps in education and training for paid and voluntary peer educators can you identify?

_____

_____

_____

7.3 In your organisation, what gaps in understanding of concepts and theory of peer education can you identify?

_____

_____

_____

7.4 In your organisation, what gaps in support and collaboration can you identify?

_____

_____

_____

Section Eight: What have we left out?

The consultants who designed this survey tool realise there are lots more topics to discuss in this area. What have we left out? What other things would you like to let us know about?

_____

_____

_____

_____

_____

_____

_____

_____

Appendix Eight

Directory of peer education programs

Directory of Peer Education Activities (contacted through the mapping exercise)		
Country	**Organisation**	**Target Audiences**
Cook Islands	Red Cross	Youth, Transgender, MSM
Federated States of Micronesia	Adolescent Health and Development Program, Ministry of Health (Pohnpei)	Youth, Sex Workers
Federated States of Micronesia	Chuuk State HIV Program	Youth, sex Workers, MSM
Federated States of Micronesia	Red Cross	Youth
Kiribati	Red Cross	Youth, Sex Workers, MSM, Transgender
Kiribati	Adolescent Health and Development Program	Youth
Kiribati	Family Health Association	Youth
Samoa	Samoa AIDS Foundation	MSM
Samoa	Red Cross	Youth
Samoa	TALAVOU Program- Ministry of Women, Community & Social Development	Youth
Solomon Islands	Adolescent Health and Development Program	Youth
Solomon Islands	Oxfam	Youth
Solomon Islands	World Vision	Youth, Taxi Networks and clients
Solomon Islands	Save the Children	Youth, Sex Workers, MSM
Solomon Islands	Adventist Development Relief Agency (ADRA)	Youth
Solomon Islands	Integrated Community Program (ICP) The Church of Melanesia	Youth, rural communities, prisons
Solomon Islands	Planned Parenthood	Youth
Republic of the Marshall Islands	Youth to Youth in Health (Jodrikdrik nan Jodrikdrik ilo Ejmour)	Youth (aged 0 -25), sex workers
Tonga	Family Health Association	Youth
Tonga	National Youth Congress	Youth
Tuvalu	Tuvalu Family Health Association	Youth
Tuvalu	Tuvalu Red Cross	Youth, Seafarers
Vanuatu	World Vision	Youth
Vanuatu	Wan Smolbag	Youth, Sex Workers, MSM, Transgender

Appendix Nine

Analysis of peer education within national strategies

Country: Cook Islands Strategy Document: National Strategy on the Response to HIV, AIDS & STI 2008-2013		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	Page 10: All persons have the right to easy access to knowledge, counselling and treatment about HIV/STI and the means to prevent transmission.
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	All sectors of the community have a responsibility in the response to HIV/A and STI's especially in the support of people living with HIV/AIDS and to promote safe sexual behaviours. All PLWHA and other persons have the right to confidentiality and not be subjected to all forms of discrimination All service providers, stakeholders and clients should practice mutual trust, honesty and confidentiality as well as access to proper support networks
	Engagement of young people and their right to access education & prevention services.	All youth are entitled to a full education inclusive of safer sexual practises
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Priority 1: Prevention of transmission of HIV and other STIs Objective: Reduce the vulnerability of specific groups and general population to HIV/STIs. Activities refer to transgender community, prison inmates & seafarers. Priority 2 : Prevention and control of other sexually transmitted infections (STI's) Objective: Reduce the vulnerability of youth to STI's and other cause factors (Drugs, Alcohol) Activities refer to youth Priority 4: Treatment, care and support for people with HIV Strategic Output 4: Increased use of condoms by vulnerable groups.	
Does the Strategy highlight the importance of peer education as an intervention?	Priority 2, Activity 1.4: "Expand implementation of youth peer education programs…" Priority 3, Activity 1.7: "Conduct Peer Education Training for workers in the tourist industry and migrant communities" Priority 3, Activities 1.4-1.6: Train the trainers, training on "Stepping Stones" approach, implementation of "Stepping Stones" program. Priority 4, Activity 1.7: "Conduct training for peer distributors of condoms…" Page 26: "The Red Cross Youth Peer Educators (YPE) program is an initiative by Cook Islands Red Cross made up of youth who train and conduct education programs on HIV/Aids and STI's with 2 branches in the Outer Islands	

Country: Cook Islands
Strategy Document: National Strategy on the Response to HIV, AIDS & STI 2008-2013

	of Aitutaki and Mangaia. There is a plan to expand this program to other islands within the period of this strategy."

Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy	Population / Intervention	Transgender	Prison inmates	Sea farers	Young People	Tourist Industry Workers	Migrant Communities	Pregnant Women
	Base line survey	YES	YES	YES	YES			YES
	Develop Action Plan	YES	YES	YES				
	School based Education *NAC, MOE*				YES			
	Youth peer education programs *MOH, CIRC*				YES			
	Condom distribution in bars & nightclubs				YES			
	Bilingual information resources				YES			
	Peer Education Training *NAC, CIRC*					YES	YES	
	VCCT							YES
	Information resources							YES

Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	Reference to consultation with stakeholders, and community wide consultative processes during drafting of Strategic Plan
Does the strategy highlight the importance of training for peer workers? Refs.	Priority 3, Activity 1.7: "Conduct Peer Education Training for workers in the tourist industry and migrant communities" Priority 4, Activity 1.7: "Conduct training for peer distributors of condoms…" Priority 3, Activities 1.4-1.6: Train the trainers, training on "Stepping Stones" approach, implementation of "Stepping Stones" program. Page 26: "The Red Cross Youth Peer Educators (YPE) program is an initiative by Cook Islands Red Cross made up of youth who train and conduct education programs on HIV/Aids and STI's with 2 branches in the Outer Islands of Aitutaki and Mangaia. There is a plan to expand this program to other islands within the period of this strategy."

Country: Federated States of Micronesia Strategic documents: National Strategic Plan, and Pohnpei, Kosrae, Yap and Chuuk strategic plans		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	No comments
	Partnership and engagement with the affected community (i.e. vulnerable groups)	No comments
	Engagement of young people and their right to access education & prevention services.	No comments
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	From the Pohnpei Strategic Plan: 1.1.1 Develop and/or translate into Pohnpeian education materials with basic information about transmission and prevention of HIV and other STIs including where to be tested and men who have sex with men and disseminate at public places 1.1.11 Conduct workshops for youth groups about HIV and other STIs including unintended pregnancy, condom use, sexual behavior and behavior change, alcohol and other drug use 1.1.14 Conduct presentation on basic information on transmission and prevention and risk behaviors to inmates and distribute educational materials and condoms 1.1.19 Identify interested sex workers and train them to provide basic information about HIV/STI transmission and prevention, condom use, testing and counseling and use of alcohol and other drugs and distribute educational materials and condoms 1.1.22 Continue education to outer island populations focusing on transmission and prevention of HIV and other STIs and stigma and discrimination and provide testing for HIV 1.1.26 Develop and provide printed safe sex messages including pictures/diagrams to immigration and Continental Airlines to attach to boarding passes and to the Port Authority and Environmental Protection Agency (English and Pohnpeian) to reach frequent travelers and seafarers 2.1.9 Continue the existing Youth Risk Behavior Survey in schools including adding additional questions as necessary to direct program activities and collect information relevant for international indicators 2.1.10 Conduct survey on sexual behavior including gender of partner) and HIV/STI related knowledge of out-of -school youth aged 15 to 24 years 2.1.11 Assess the Chuuk survey of men who have sex with men and consider conducting similar survey in Pohnpei 2.1.12 Conduct survey of sex workers to identify their sexual behaviour, knowledge of HIV and STIs, and history of HIV/STI testing From the Yap Strategic Plan: 4.4.1 Identify travellers and seafarers on their arrival to Yap and survey them for high risk behaviours and offer testing for HIV and other sexually transmitted infections	

Country: Federated States of Micronesia Strategic documents: National Strategic Plan, and Pohnpei, Kosrae, Yap and Chuuk strategic plans	
	4.4.2 Survey youth 15 -24 (students & non-students) to assess knowledge and safe sex practices From the Chuuk Strategic Plan: 2.1.5 Conduct second generation surveillance surveys of sex workers 2.1.6 Conduct second generation surveillance surveys of youth aged 15-24 in Weno, Fefen, Tonoas, Tol and Udot 2.1.7 Conduct second generation surveillance surveys of men who have sex with other men 2.1.8 Conduct second generation surveillance surveys of pregnant women 2.1.9 Conduct surveys of seafarers and frequent travellers including offering testing
Does the Strategy highlight the importance of peer education as an intervention?	From the Pohnpei Strategic Plan: 1.1.19 Identify interested sex workers and train them to provide basic information about HIV/STI transmission and prevention, condom use, testing and counselling and use of alcohol and other drugs and distribute educational materials and condoms 1.1.24 Continue provision of adolescent health issues to students in classrooms and dormitories including demonstration of condom use and the influence of alcohol and other drugs 1.1.25 Provide information materials and condoms to employees in bars and hotels 2..1.10 Conduct survey on sexual behaviour including gender of partner) and HIV/STI related knowledge of out-of -school youth aged 15 to 24 years 2.1.11 Assess the Chuuk survey of men who have sex with men and consider conducting similar survey in Pohnpei 2.1.12 Conduct survey of sex workers to identify their sexual behaviour, knowledge of HIV and STIs, and history of HIV/STI testing 4.3.1 Conduct refresher training course for youth peer educators regarding current statistics, behaviour change, teenage/unintended pregnancy, condom use and use of alcohol and other drugs and distribute educational materials and condoms From the Kosrae Strategic Plan: 1.1.3 Information sessions for youth with particular focus on HIV/STI 101, condom use and alcohol and other drugs 1.1.6 Information sessions for communities on HIV/STIs 101 and other topics as appropriate 1.1.7 Information sessions for Walung on HIV/STIs 101 and other topics as appropriate 1.2.4 Awareness program/workshop targeting high school and college youth about how, why and when to use condoms and where they are available. 1.3.1 Awareness program to target adolescents on alcohol and other drug use and how it relates to risky sexual behaviour 1.6.5 Encourage people to be tested for HIV and other STIs, including high risk groups 3.3.3 Organizing community groups (youth, church, scouts, women's, senior citizens, family)and their activities relating HIV and other STIs 3.3.4 Disseminate information about HIV and other STIs to the communities From the Yap Strategic Plan: 1.1.6 Conduct awareness and education workshops for men's groups covering transmission and prevention of HIV and other STIs, responsible parenting, ABC, unplanned pregnancy, testing, alcohol and other drug use and peer

<table>
<tr><th colspan="4">Country: Federated States of Micronesia
Strategic documents: National Strategic Plan, and Pohnpei, Kosrae, Yap and Chuuk strategic plans</th></tr>
<tr><td colspan="2"></td><td colspan="2">pressure
1.1.7 Conduct awareness and education workshops for women's groups covering transmission and prevention of HIV and other STIs, responsible parenting, ABC, unplanned pregnancy, testing, alcohol and other drug use and peer pressure
1.1.10 Continue conducting education and awareness workshops in high schools (including continuing attempts to involve the private schools)
1.1.11 During health fairs, provide information to students concerning transmission and prevention of HIV and other STIs, sexual and other risk behaviours, condom use, peer pressure, unplanned pregnancies, alcohol and other drug use via skits, DVD presentations and other methods
1.2.12 Create and distribute brochures on the influence of alcohol and other drug use, peer pressure and how to use a condom
1.4.2 Incorporate peer educators into reproductive health education at all schools (elementary & high, public and private)
3.3.2 Conduct awareness workshops for male relatives (e.g. father–son, uncle–nephew) and for female relatives (e.g. mother–daughter) in villages
From the Chuuk Strategic Plan:
1.1.4 Identify sex workers using questionnaires and train them as peer educators
1.1.14 Identify men who have sex with men (MSM) using questionnaires and train them as peer educators
1.1.15 Provide educational information to MSM using a peer educator, one-to-one approach
1.1.16 Identify people on Tol and Naomulk and train them to be peer educators
1.1.17 Provide education information to people from Tol and Namuluk about all aspects of prevention and transmission of HIV and other sexually transmitted infections
1.1.18 Set up a parade float, banners, posters, distribute t-shirts, marching to certain places for World AIDS day including youth activities and contests (songs, speeches)
2.3.3 Involve people infected with HIV in conducting educational awareness programs to their peers and the community</td></tr>
<tr><td rowspan="5">Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy</td><td></td><td>Population
Intervention</td><td>The following populations are identified in each strategy however, there is no alignment with any of the listed interventions</td></tr>
<tr><td rowspan="4">Kosrae</td><td>Developing and printing educational materials in different media</td><td rowspan="4">Youth
Travellers
Inmates
Sex workers</td></tr>
<tr><td>curriculum development about reproductive health, teacher training and materials and resources</td></tr>
<tr><td>Information sessions</td></tr>
<tr><td>Increased availability and promotion of condoms</td></tr>
</table>

Country: Federated States of Micronesia Strategic documents: National Strategic Plan, and Pohnpei, Kosrae, Yap and Chuuk strategic plans			
	Yap	Conduct awareness and education workshops	Men Women Students Inmates Uniformed Services Seafarers Off island Communities Travellers Taxi Drivers Tourist Industry
		Conduct an awareness activity each year for World AIDS Day	
		Develop and broadcast a television program	
		Broadcast radio messages	
		Conduct a radio song contest for young people	
		display billboards, posters and brochures relating to HIV and other STIs	
		Create and send text messages	
		Create and distribute brochures	
		Develop and distribute printed materials	
		Develop and provide audiovisual and printed materials	
		Increase the availability and accessibility of condoms	
		Conduct awareness and education workshops	
	Chuuk	Provide education information	Men Women Sex Workers Inmates Men who have sex with men Seafarers Off island Communities Tourists
		Conduct workshops	
		Conduct an HIV prevention good will games	
		Make radio program for HIV prevention awareness	
		Develop video	
		Develop and distribute flyers, brochures and newsletters	
		Develop and implement a reproductive health education curriculum	
		Deliver/supply male condoms and brochures	
		Develop posters and brochures	
		Display banners and posters	
	Pohnpei	Conduct workshops Distribute educational materials & condoms Education & Presentations	Youth Women Men inmates Police Outer Island Communities

Country: Federated States of Micronesia Strategic documents: National Strategic Plan, and Pohnpei, Kosrae, Yap and Chuuk strategic plans			
			Bar and hotel employees
		Identify interested sex workers and train them to provide basic information about HIV/STI transmission and prevention, condom use, testing and counselling and use of alcohol and other drugs and distribute educational materials and condoms	
		Disseminate HIV/STI leaflets on transmission and prevention and condoms to taxi drivers and develop stickers for them to display in their taxi	
		Continue provision of adolescent health issues to students in classrooms and dormitories including demonstration of condom use and the influence of alcohol and other drugs	
		Develop and provide printed safe sex messages including pictures/diagrams to immigration and Continental Airlines to attach to boarding passes and to the Port Authority and Environmental Protection Agency (English and Pohnpeian) to reach frequent travellers and seafarers	
		Multimedia- radio plays, stickers, postage stamps, calling cards, television.	
		Provide condoms to bars, hotels, youth leaders and groups, Micronesian Red Cross Society, travel agencies, shops, taxi companies, EPA, Port Authority, public and private clinics, dispensaries, police stations, government offices, women's groups, community centres, schools, construction companies, student dormitories	
		Develop educational materials and raise awareness via inclusion of information about the relationship between excessive alcohol consumption and sexual behaviour in	

Country: Federated States of Micronesia Strategic documents: National Strategic Plan, and Pohnpei, Kosrae, Yap and Chuuk strategic plans	
	education programs
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	From National Strategic Plan: 1.13. To collaborate with the four states to develop consistent policy on roles and responsibilities of community members voluntarily involved in the response to HIV and other sexually transmitted infections From the Pohnpei Strategic Plan: 1.1.19 Identify interested sex workers and train them to provide basic information about HIV/STI transmission and prevention, condom use, testing and counselling and use of alcohol and other drugs and distribute educational materials and condoms From the Kosrae Strategic Plan: 2.3.1 Where possible, encourage the involvement of people living with HIV in program activities From the Yap Strategic Plan: 2.2.1 Conduct consultations with community to identify areas appropriate to include in reproductive health education including HIV and other STIs 4.3.3. Where possible, encourage the involvement of people living with HIV in program activities From the Chuuk Strategic Plan: 2.1.5 Conduct second generation surveillance surveys of sex workers 2.1.6 Conduct second generation surveillance surveys of youth aged 15-24 in Weno, Fefen, Tonoas, Tol and Udot 2.1.7 Conduct second generation surveillance surveys of men who have sex with other men 2.3.2 Existing men and women's HIV support groups to educate family members of HIV infected persons and communities on HIV transmission and prevention, stigma and discrimination and provide emotional and spiritual support 4.2.3 Reorganize and revise the by-laws to ensure adequate representation on the HIV community planning group, including more women active in the community and people living with HIV
Does the strategy highlight the importance of training for peer workers? Refs.	From the Pohnpei Strategic Plan: 1.1.19 Identify interested sex workers and train them to provide basic information about HIV/STI transmission and prevention, condom use, testing and counselling and use of alcohol and other drugs and distribute educational materials and condoms 4.3.1 Conduct refresher training course for youth peer educators regarding current statistics, behaviour change, teenage/unintended pregnancy, condom use and use of alcohol and other drugs and distribute educational materials and condoms From the Kosrae Strategic Plan:

Country: Federated States of Micronesia Strategic documents: National Strategic Plan, and Pohnpei, Kosrae, Yap and Chuuk strategic plans	
	1.1.12 Identify and train sex workers to be peer educators for other sex workers 1.1.13 Refresher training for peer educators and recruitment and training of new peer educators 1.2.2 Education for male and female educators on how to teach people to use a condom including encouraging their use (training of trainers) From the Yap Strategic Plan: **2.3.1** Identify, recruit and train youth peer educators 2.3.4 Conduct update education workshops for peer educators each semester From the Chuuk Strategic Plan: 1.1.13 Provide refresher training for existing youth peer educators, on communication, transmission and prevention of HIV and other STIs, behaviour change, stigma and discrimination, sex work, condom use, influence of alcohol and other drugs, assurance of confidentiality, signs and symptoms, unplanned pregnancy and treatment 1.1.4 Identify sex workers using questionnaires and train them as peer educators 1.1.14 Identify men who have sex with men (MSM) using questionnaires and train them as peer educators 1.1.15 Provide educational information to MSM using a peer educator, one-to-one approach 1.1.16 Identify people on Tol and Naomulk and train them to be peer educators

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	All people have the right to accurate information about HIV, AIDS, STI, voluntary counselling and testing (VCT) and sexual and reproductive health. All people and groups have the right to protection from HIV infection and to care, support and treatment if they become infected. Any person regardless of age, gender, status, or health has the right to live in a healthy and happy community. During the planning process, participants recommended that human rights be a priority area. Instead of maintaining human rights as a separate sixth priority area, three working groups incorporated human rights issues into their priority area plans: Priority Area 1, Priority Area 2 and Priority Area 5.
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	Stigmatisation and labelling, or discrimination towards a person living with HIV or AIDS should be considered as a breach of Christian ethics and illegal. All people be encouraged to prevent people living with HIV or AIDS from suffering humiliation and discrimination. Community members should be encouraged to support and help people living with HIV or AIDS, their spouses, families and others affected. Christian families and strong family ties should encourage and enhance genuine and compassionate love, care and pastoral care to meet the needs of PLWHA, their families and other's affected.
	Engagement of young people and their right to access education & prevention services.	Parents and families have a role to play in supervising and controlling their children for the prevention of HIV. Parents and families should have open communication with their children about sex, STI and HIV.
Does the Strategy highlight the importance of	Priority Area 2: Reducing the vulnerability of specific groups Goal: To stabilize and reduce the prevalence of HIV and other sexually transmitted infections (STI) in Kiribati within specific targeted groups	

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
Identifying and targeting vulnerable populations? Refs	Objectives: 2.1 Create an enabling environment to support behaviour change for vulnerable specific groups and the general population 2.2 Establish behavioural surveillance and research with targeted populations to assist in program design Output: 2.1.1 Improved knowledge among specific targeted risk groups on HIV, AIDS and other STI, and increased awareness on safer sex practices and the rights of those living with HIV or AIDS Activities: 2.1.1.1 Conduct workshops for specific risk groups on HIV, AIDS and STI and on safer sex practices 2.1.1.2 Conduct drama for specific risk targeted group on HIV, safer sex practices, and messages to reduce stigma and discrimination for those PLWHA, 2.1.1.3 Conduct radio spots twice weekly on safer sex practices 2.1.1.4 Negotiate condom promotion and safe sex promotion for TV 2.1.1.5 Peer educators conduct school visits on quarterly basis beginning at class six and with upper forms 2.1.1.6 Peer educator outreach to specific groups (seafarers, seafarers wives, PLWHA, prisoners, wharf labourers, officers, shipping agents, and police) Output: 2.1.9 Increased condom distribution and increased condom use by targeted vulnerable groups Output: 2.2.1 Baseline data and repeated surveillance completed with seafarers, young people and individuals having transactional sex Activities: 2.2.1.2 Identify key surveyors (10) for each surveillance targeted group 2.2.1.3 Train surveyors who have on how to conduct a survey, research ethics 2.2.1.6 Conduct baseline behavioural surveys for each targeted group 2.2.1.7 Data is input into a database, analysed and results compiled into surveillance reports 2.2.1.8 Behavioural surveillance reports are made available to stakeholders and utilized by stakeholders involved with target groups to improve their strategies and services Priority Area 3: Prevention & Control of sexually transmitted infections (STI) Goal: To reduce the number of reported cases (prevalence) of sexually transmitted infections in Kiribati Objectives: 3.1 To ensure effective treatment of STI through all health facilities and by traditional healers 3.2 To encourage VCCT amongst priority groups and people treated for STI 3.3 To conduct unlinked HIV and behavioural surveillance for people with STI 3.4 To reduce unprotected sex amongst targeted priority groups 3.5 To create a clear epidemiological picture of sexually transmitted infections by age and sex

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	Output: 3.4.3 Increased knowledge of STI, HIV, AIDS and safe sex of targeted groups (young people, bus drivers, police) Activities: (See Output 2.1.1 and related activities) 3.4.3.4 Provide information on STI, HIV, AIDS, and safe sex 3.4.3.4 Conduct workshops by trained peer educators with targeted groups (young people, bus drivers, police)
Does the Strategy highlight the importance of peer education as an intervention?	Output: 2.1.1 Improved knowledge among specific targeted risk groups on HIV, AIDS and other STI, and increased awareness on safer sex practices and the rights of those living with HIV or AIDS Activities: 2.1.1.5 Peer educators conduct school visits on quarterly basis beginning at class six and with upper forms 2.1.1.6 Peer educator outreach to specific groups (seafarers, seafarers wives, PLWHA, prisoners, wharf labourers, officers, shipping agents, and police) Output: 2.1.2 Competent Peer educators trained from each targeted vulnerable group and involved and supported in peer education activities Activities: 2.1.2.4 Ongoing Peer education with risk groups (FSP, ARH, Marie Stopes, church youth groups) is implemented Output: 2.1.7 Two youth friendly community centres established and functioning (South Tarawa and Kiritimati) that integrate VCT, sexual health, and condom distribution (See links with Priority Area1: Output 1.3.1 and Priority Area 3: Output 3.2.1) Activities: 2.1.7.4 Identify peer educators, VCT counsellors and staff who are going to manage the centre 2.1.7.5 Identify and train peer educators and health education staff in IEC materials production and desktop publishing at the centre. Output: 2.1.8 All local and overseas ships where local seafarers are on board are supplied with condoms and information and have seafarer peer educator outreach Activities: 2.1.8.1 Identify key seafarer peer educators that have been trained for ship outreach program 2.1.8.2 Create IEC materials with the input of seafarer peer educators and produce these materials 2.1.8.5 Link seafarer peer educators with the Maritime Training Centre activities Output: 3.2.1 Established and funded VCCT Centre where STI treatment is available (refer to link with Priority Area 1, Output 1.3.1: Priority Area 2: Output 2.1.7) Activity: 3.2.1.7 Identify and train peer educators, health workers, and other stakeholders in VCT (including counselling on STI), their roles in the referral system for care and treatment, data recording and reporting systems, and rapid HIV testing (refer to link with Priority Area 1, Output 1.3.1) Output: 3.4.1 Well-trained and competent peer educators (for youth, police and bus drivers) Activities: (See Output 2.1.2 and related activities)

Country: Kiribati
Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008

	3.4.1.2 Identify venues 3.4.1.5 Create support system for peer educator outreach Output 3.4.2 Increase in BCC materials produced Activities: 3.4.2.8 Peer educators distribute materials Output: 3.4.3 Increased knowledge of STI, HIV, AIDS and safe sex of targeted groups (young people, bus drivers, police) Activities: (See Output 2.1.1 and related activities) 3.4.3.3 Identify trained peer educators to run workshops 3.4.3.4 Conduct workshops by trained peer educators with targeted groups (young people, bus drivers, police) Output: 5.6.1. STI, HIV and AIDS resource centre running and used Activities: 5.6.1.4 Mobilize peer educators and volunteers from partner organizations to man the resource centre as part of their outreach

Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy	Population / Intervention	PLWHA	Prisoners	Seafarers & wives	Youth	Sex workers	MSM	Police	Bus Drivers
	Behaviour surveillance surveys			YES	YES	YES			
	Peer education Outreach *FSP, ARH, Marie Stopes, Red Cross AHD, KFHA, KANGO, church youth groups*	YES	YES	YES	YES	YES	YES	YES	YES
	Media campaign (Billboards) *KHATBTF including PLWHA*	YES							
	Condom Day *Peer Education committee*	YES		YES	YES	YES	YES	YES	YES
	Life skills education				YES				
	youth friendly community centres *ARH*				YES				
	IEC materials produced by peer educators *MTC, Marie Stopes*			YES					
	Safe sex workshops				YES			YES	YES
	Drama								
	BCC materials Distributed by peer educators								
	Condom distribution			YES	YES			YES	YES

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008									
	ARH, MTC, FSP, Marie Stopes, KHATBTF								
	BCC materials produced *HIV resource centre*								
	KHATBTF committees	YES							
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	In 1998, representatives from different sectors came together with the Ministry of Health (MOH) to create the Kiribati HIV/AIDS Task Force (KHATF). These sectors included: NGO's such as AMAK (Aia Maea Ainen Kiribati / Kiribati Women's Federation), the Red Cross, Foundation of the South Pacific (FSP), Kiribati Islands Seamen Wives Association (KISWA) and Kiribati Overseas Seamen's Union (KIOSU); the two major Church denominations of the Roman Catholic Church (RC) and the Kiribati Protestant Church (KPC); people from the business sector; and other Government representatives and Ministries. In 2000, based on the data and recommendations from the Interim Action Plan report, the Kiribati STI and HIV/AIDS Strategic Plan was developed. A multi-sectoral group led by the Kiribati Overseas Seamen's Union, with representation from government, NGOs, and the Churches developed the plan. The strategic plan presents answers and solutions to problems in Kiribati. The Kiribati HIV National Strategic Planning Workshop was held March 14 – 18 2005. Forty people participated at different times throughout the week with a range of sectors from government departments, non-government organizations including youth and a women's representative, churches, police services, members of parliament, a town council, and the representative from the Asia Pacific Leadership Forum (APLF). The development of this strategic plan has involved a variety of stakeholders including government ministries, local and international non-government organizations, church and community based organizations. Output: 1.2.4 IEC materials on care and support for PLWHA and on positive living are developed, produced and distributed Activities: 1.2.4.1 Establish a committee from the KHATBTF and involving PLWHA to develop and produce IEC materials on clinical and home care, VCT, positive living, anti-stigma and discrimination Output: 1.4.1 PLWHA are readily accepted in the community and in the health system Activity 1.4.1.3. Support the development of a network of positive people Output: 2.1.3 Media campaign with five billboards completed in high-risk areas within South Tarawa with messages on ways to protect oneself from HIV infection and to decrease stigma and discrimination Activity 2.1.3.4 Create a committee of stakeholders of the KHATBTF including PLWHA to develop the key messages and review billboard designs prior to their production (see link with Priority Area 1: Output 1.2.3, Activity 1.2.3.1)								

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	Output: 2.1.4 A condom day is established as part of World AIDS day activities with special attention to high-risk groups Activities: 2.1.4.2 Peer Education committee to take lead in creating a Condom Day 2.1.4.4 Invite all high-risk groups to participate in the condom day Output: 2.1.6 A Behaviour Change Communication Strategy is created with stakeholders Activities: 2.1.6.1 Plan training workshop for stakeholders on building Behaviour Change Communication and building BCC strategies 2.1.6.2 Identify key people to train the workshop (expertise support) 2.1.6.5 Participants develop a BCC strategy Output: 2.1.8 All local and overseas ships where local seafarers are on board are supplied with condoms and information and have seafarer peer educator outreach Activities: 2.1.8.2 Create IEC materials with the input of seafarer peer educators and produce these materials Output: 2.1.9 Increased condom distribution and increased condom use by targeted vulnerable groups Activities: (See also Output 3.4.4 and relevant activities) 2.1.9.1Conduct a consultation workshop for stakeholders to get agreement from partners to distribute free condoms and sell Try Time, create a system for record keeping, create clear information on condom use, and develop strategies for condom promotion and ongoing condom distribution 2.1.9.2 Condom promotion and distribution system created with stakeholders and guidelines are endorsed by the Task force and distributed to all stakeholders involved in condom distribution 2.1.9.3 Create a condom committee with stakeholders involved in condom distribution to analyse condom distribution monitoring data and supplies of in-country stock Output: 2.2.1 Baseline data and repeated surveillance completed with seafarers, young people and individuals having transactional sex Activities: 2.2.1.2 Identify key surveyors (10) for each surveillance targeted group 2.2.1.3 Train surveyors who have on how to conduct a survey, research ethics 2.2.1.8 Behavioural surveillance reports are made available to stakeholders and utilized by stakeholders involved with target groups to improve their strategies and services Output 2.3.1 HIV management legislation to protect the rights of people living with HIV, their families and communities is endorsed by Parliament Activities 2.3.1.1 Consultation workshop with key stakeholders and create a working committee including PLWHA Output 3.4.2 Increase in BCC materials produced

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	Activities: 3.4.2.1 Create a BCC committee with stakeholders Outcomes: Priority 5 5.1 A functioning coordination mechanism and secretariat is established for the KHATBTF 5.2 Improved organizational structure, membership and constitution for the KHATBTF 5.3 Improved capacity of organizations and stakeholders involved in the response 5.4 Strengthened political advocacy on HIV/AIDS related issues 5.5 NSP is coordinated, implemented, monitored, and evaluated by the KHATBTF 5.6 Improved access to STI, HIV and AIDS resource materials 5.7 Improved funding and support for NSP activities in Tarawa and Outer Islands by donors, UN agencies and international NGOs 5.8 Improved management of the KHATBTF and advisory body established 5.9 Reduced stigma and discrimination of PLWHA Output: 5.2.2 Membership of the KHATBTF expanded for a broader response Activities: 5.2.2.1 Membership of the task force is reviewed 5.2.2.2 Government and NGO and CSO are identified that could play a role in the HIV response in Tarawa and Outer Islands 5.2.2.3 Information pamphlet on KHATBTF is created and produced 5.2.2.4 Consultations are made with potential stakeholders in South Tarawa and Outer Islands and pamphlets are sent to other provincial governments and groups 5.2.2.5 New members are invited to KHATBTF meetings and trainings where appropriate Output: 5.9.1 PLWHA actively participate in KHATBTF committees, prevention, and treatment and care activities and anti-stigma and discrimination media campaigns Activities: 5.9.1.1 KHATBTF members are given sensitisation training about living positively and about human rights issues. 5.9.1.2 KHATBTF members encourage the involvement of PLWHA in activities, planning, campaigns and committees 5.9.1.2 Involvement of PLWHA is coordinated by the secretariat
Does the strategy highlight the importance of training for peer workers? Refs.	Output: 2.1.2 Competent Peer educators trained from each targeted vulnerable group and involved and supported in peer education activities Activities: 2.1.2.1 Identify participants from targeted populations for peer education training 2.1.2.2 Develop a peer educator-training package that considers the needs and approach of the targeted populations 2.1.2.3 Conduct training for peer educators (youth, seafarers, seafarer's wives, sex workers, MSM, young people) from targeted populations

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	2.1.2.4 Ongoing Peer education with risk groups (FSP, ARH, Marie Stopes, church youth groups) is implemented 2.1.2.5 Give ongoing support to peer educators and create a monitoring system Output: 2.1.5 Life Skills education is given to in and out of schools adolescents (South Tarawa and Outer Islands) Activities: 2.1.5.3 Invite trainers from development partners to conduct life skills training workshop 2.1.5.4 Conduct a Training of Trainers workshop TOT 2.1.5.5 Trained trainers to train their peers in life skills 2.1.5.6 Develop a support system for life skills trainers Output: 2.1.7 Two youth friendly community centres established and functioning (South Tarawa and Kiritimati) that integrate VCT, sexual health, and condom distribution (See links with Priority Area1: Output 1.3.1 and Priority Area 3: Output 3.2.1) Activities: 2.1.7.5 Identify and train peer educators and health education staff in IEC materials production and desktop publishing at the centre. Output: 3.2.1 Established and funded VCCT Centre where STI treatment is available (refer to link with Priority Area 1, Output 1.3.1: Priority Area 2: Output 2.1.7) Activity: 3.2.1.7 Identify and train peer educators, health workers, and other stakeholders in VCT (including counselling on STI), their roles in the referral system for care and treatment, data recording and reporting systems, and rapid HIV testing (refer to link with Priority Area 1, Output 1.3.1) Output: 3.4.1 Well-trained and competent peer educators (for youth, police and bus drivers) Activities: (See Output 2.1.2 and related activities) 3.4.1.1 Develop training (resource persons, manual and specific material for targeted groups) 3.4.1.2 Identify venues 3.4.1.3 Plan budgets for training workshops 4.3.1.4 Conduct peer educator training 3.4.1.5 Create support system for peer educator outreach Output: 3.4.3 Increased knowledge of STI, HIV, AIDS and safe sex of targeted groups (young people, bus drivers, police) Activities: (See Output 2.1.1 and related activities) 3.4.3.3 Identify trained peer educators to run workshops 3.4.3.4 Conduct workshops by trained peer educators with targeted groups (young people, bus drivers, police)

Country: Republic of Marshall Islands Strategy Document: National HIV/AIDS Strategic Plan 2006–2009							
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	All people, regardless of age, gender, religion and race, have free and equal access to accurate awareness information and education about HIV/AIDS, and how to prevent HIV/AIDS in their own language. All people have equal access to affordable and confidential testing, treatment and counseling. All people have rights, including people living with HIV/AIDS, which are protected by government, legislation and through community support.					
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	All communities are encouraged to preserve partnerships between government, health providers, churches, NGOs, private sector and civil society to educate the community about HIV/AIDS and provide care and support to people living with HIV/AIDS.					
	Engagement of young people and their right to access education & prevention services.	All adolescent youth (aged 12-19) have the right to access testing without parental consent.					
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Page 13 - 2.1.5 Conduct Second Generation Surveillance among most-at-risk-populations to provide evidence for program development and policy formulation Page 22 - 7.1 To reduce the risk amongst all vulnerable people of RMI, especially youths (school & non-school attendees), unemployed youth, commercial and transactional sex workers, low socio-economic groups, pregnant mothers & their children, and seafarers. Page 25 - 2.1.4 To develop BCC campaigns to reach vulnerable groups e.g. sex workers, MSMs, and non school attendees Page 26 - 5.1.1 Develop a CTR protocol with an emphasis on most-at-risk-populations, including men-who-have-sex-with-men, sex workers and seafarers						
Does the Strategy highlight the importance of peer education as an intervention?	Page 20 - 4. To increase education on prevention methods including abstinence, faithfulness, condom use and doing less risky sexual activities Page 20 - 4.1.2 Train school principals, teachers, PTA, church leaders, peer educators on HIV and sexual health education.						
Vulnerable Groups identified in Strategy and associated	Population Intervention	Youth 15-24 (School & Non schooled)	Seafarers	Women (including Commercial &	MSM	Outer Island residents	

Country: Republic of Marshall Islands Strategy Document: National HIV/AIDS Strategic Plan 2006–2009						
Prevention Strategies/Actions identified in Strategy		unemployed		transactional SW)		
	Public service announcements	YES				
	Outreach workshops using theatre, song, media *WUTMI, YTYIH, PTA, Churches, AKTS Inc, MOE, MOIA, Businesses, traditional leaders, youth, CARE Program, Mission Pacific*	YES				
	Periodical HIV/STD education *MOH, MOE, Health promotion & Human services, Churches, NGOs*	YES	YES			YES
	Train the trainers re BCC strategies *Reproductive Health, SPC, CDC, UNFPA*	YES	YES	YES	YES	YES
	Develop BCC campaigns *YTYIH, WAM, WUTMI, Mission Pacific*	YES	YES	YES	YES	YES
	Social marketing of condoms at Clubs, bars, youth clinics *Health Education, YTYIH*	YES				
	Develop new IEC materials in various languages to reach all target groups *Reproductive Health, Health Promotion & Human Services, International volunteers, Mission Pacific*		YES	YES		YES
	Develop a CTR protocol *MOH, YTYIH*		YES	YES	YES	
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	Preface: As part of the process to develop the Ministry of Health's National HIV/AIDS Strategic Plan for 2006-2009, a community planning workshop was held in April 2005, with fifty-nine participants from government sectors, the community, churches, non-governmental organizations (NGOs) and youth gathering to set priorities and create a plan for addressing HIV infection in the Marshall Islands. Overview: The National HIV/AIDS Strategic Plan 2006-2009 for the RMI was developed using various processes including multi-sectoral consultations, symposiums and discussions with those that actively work with HIV/AIDS issues in government and civil society organizations. This plan is the first attempt by the Government and civil society to create a national strategy on HIV. The coordination of HIV/AIDS activities will be lead by the Ministry of Health and driven by the Community Planning Group (CPG), which will be re-convened and invigorated with the support of the Ministry of Health and the Centres for					

Country: Republic of Marshall Islands Strategy Document: National HIV/AIDS Strategic Plan 2006–2009	
	Disease Control and Prevention. One of its functions of the CPG will be to inform the Ministry of Health, which in turn will keep Government leaders apprised of the program's needs and progress. Page 9: Each culture, individual and each community is distinctive, and so responses to HIV/AIDS will be distinctive as well. Bringing different agencies and community is necessary in order to have a plan that is acceptable and appropriate to the needs of the country. Page 13: 3. To revitalize the Community Planning Group (CPG) and include representatives from diverse sectors of society
Does the strategy highlight the importance of training for peer workers? Refs.	Page 20: 4. To increase education on prevention methods including abstinence, faithfulness, condom use and doing less sexual activities. 4.1.2 Train school principals, teachers, PTA, church leaders, peer educators on HIV and sexual health education.

Country: Nauru Strategy Document: Health Operational Plan 2008							
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	No comments					
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	No comments					
	Engagement of young people and their right to access education & prevention services.	No comments					
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	No comments						
Does the Strategy highlight the importance of peer education as an intervention?	No comments Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy						
	Population Intervention	None identified					
	STI awareness programs and screening & surveillance campaign/ STI project-						
	HIV/ AIDS awareness program/ campaign/ education on condom use						
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	No comments						
Does the strategy highlight the importance of training for peer workers? Refs.	No comments						

Country: Samoa Strategy Document: A STRATEGIC PLAN FOR RESPONDING TO THE IMPACT OF HIV/AIDS ON WOMEN IN SAMOA 2001–2005		
Strategic Plan include rinciples which highlight tance of:	The rights of all people to access education & prevention services;	Page 10-11: All members of the community have the right to HIV/AIDS education and ser Women should have equal access to ALL forms of education (including formal). Principles of the CEDAW (Convention on the Elimination o Discrimination Against Women) should be emphasized. Traditional Samoan methods of learning should be utilised for HIV/AIDS edu communities and community people.
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	Women should be regarded as responsible leaders and be encouraged to responding to HIV/AIDS.
	Engagement of young people and their right to access education & prevention services.	All heirs (children) should be acknowledged and treasured by families an passed to protect them should be enforced, and those who violate these prosecuted. (Abuse includes sending children out as street sellers during sch Children should be encouraged to express their views about things that affe to communicate fairly with their parents and their views should be v prevention amongst children should be promoted in the context of the Co Rights of the Child. Youth groups with special focus on female youth should be supported an share the most accurate and up to date information on HIV/AIDS.
Strategy highlight the ce of g and targeting vulnerable ns? Refs	**2.3.2** Encourage NGOs and DOH to investigate potential donors of condoms, to make them financially accessible vulnerable women and their partners Page 16: 1.1.2 Identify any groups of women not covered by existing programs (gap analysis) Page 16: 1.1.3 Conduct awareness raising outreach programs utilizing women's religious groups, to ensure HIV/ programs cover all women and girls, particularly those especially vulnerable (e.g. young women, abused women)	
Strategy highlight the ce of peer education as an on?	Page 12: Lack of peer support for WLWHA Page 13: Peer Support: 1.3.1 Identify peer support needs of WLWHA	

Country: Samoa

Strategy Document: A STRATEGIC PLAN FOR RESPONDING TO THE IMPACT OF HIV/AIDS ON WOMEN IN SAMOA 2001–2005

	▪ Conduct training for those WLWHA willing to act as peer counsellors ▪ Provide organized back up and support for peer counsellors ▪ Facilitate the development of a support group for WLWHA and their families ▪ Facilitate involvement of a support general practitioner for WLWHA Page 14: 2.5.2: Review and expand existing peer education programs, to ensure that there are peer educators specifica vulnerable women (e.g. young women, abused women) Page 17: 1.3.1 Identify existing peer education programs 1.3.2 In partnership, strengthen capacity of NGOs already involved in peer education (e.g. YMCA) to conduct peer edu specifically for vulnerable women and girls Page 17 2.1.6 Strengthen existing peer education programs reaching women, to ensure information on safer sexual behaviou options (such as non penetrative sex), and includes instructions on condom use Page 21: 1.1.4 Conduct targeted workshops, seminars and public awareness raising campaigns for women
e Groups identified in nd associated Prevention /Actions identified in	

Population / Intervention	Women	Young	Abused
Media Advocacy			
Social events			
Awareness raising and Advocacy			
implementation of HIV/AIDS curriculum			
peer education programs			
training for village women who are community leaders			
Conduct awareness raising outreach programs			
Expand, develop and disseminate contemporary and Pacific focussed IEC materials			
Develop appropriate IEC material on safer sexual behaviours including condoms			
Accessible and affordable health services including condoms			
"life skills" training for women in sexual health workshops			
Targeted media promotions utilizing existing radio (etc.) spots for women			

strategy highlight the e of	Page 17: 2.1.5 Develop partnerships with women's organizations to utilize their existing media activities to raise awaren about safer sexual behaviours

Country: Samoa Strategy Document: A STRATEGIC PLAN FOR RESPONDING TO THE IMPACT OF HIV/AIDS ON WOMEN IN SAMOA 2001–2005	
p/engagement with e groups? Refs	Page 18: 3.1.4 Utilize village women's committees to lobby village councils and business owners to police the sale and c alcohol to young people Page 28 3.2.1 MOWA to devolve women focussed health promotion responsibilities and functions to Women's groups NGOs Page 28: 3.3.4 Develop women focussed input into World AIDS Day
strategy highlight the e of training for peer Refs.	Page 14/17: 2.1.7 Strengthen capacity of village women's organizations to promote appropriate safer sexual behaviours Page 24: 1.3.1 Conduct training programs for influential leaders willing to act as advocates for WLWHA Page 28: 3.2.2 Conduct capacity building training of those NGOs to ensure their ability to fulfil women focussed hea responsibilities and functions

Country: Solomon Islands Strategy Document: THE NATIONAL HIV POLICY AND MULTISECTORAL STRATEGIC PLAN 2005–10		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	The vulnerable groups, (young people, women and children of the country) are sensitised through informed HIV awareness and behavioural change interventions to stop the transmission of HIV, and to ensure accessibility to quality voluntary, confidential, counselling and testing as the entry point for the HAART and the continuum of quality care for people living with HIV/AIDS.
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	
	Engagement of young people and their right to access education & prevention services.	See above
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Page 20: A situation analysis was undertaken whereby the existing responses to HIV of different stakeholders were examined. This information was collected during a two day review workshop and by carrying out surveys amongst 48 stakeholders. Page 20: It was recognised that the approach on these areas needs to be different for each target group. The target groups identified were; Youth and Children; Women; Men and the Health Sector. Different stakeholders associated with these target groups all have specific knowledge about these target groups. Therefore these stakeholders brainstormed together on different strategies to effectively reach the different target groups. Consequently, the strategies focused on reaching the target groups in an innovative as well as a realistic way. Each working group ensured the specific vulnerable groups within their target group (e.g. commercial sex workers, men having sex with men) would be addressed appropriately. Page 23: Issues of NGOs: Need to target other vulnerable groups rather than just youth and women. Page 26: Stop further spread through behavioural change interventions and increase condom utilization by vulnerable groups – Identification and involvement of all key stakeholders for the fight against STI/HIV – Identification of key vulnerable groups and their related issues and high behaviour risks to STI/HIV. – Reduction of vulnerability to STI/ HIV in youth, women and men, and a particular recognized group such as the seafarers, loggers and border crossers. Policy 1: Reduction of risk-behaviour and vulnerability to HIV and STIs. – Key Result Area 1. Reduction of vulnerability by means of prevention & advocacy based on Gender approach: Youth/children/women/men	
Does the Strategy highlight the importance of peer education as an	3.4 Distribution of condoms and IEC materials Through networking with agencies for international shipping and fishing industries and taxi services for locals- Peer groups Training and Logistic Support	

Country: Solomon Islands Strategy Document: THE NATIONAL HIV POLICY AND MULTISECTORAL STRATEGIC PLAN 2005–10					
intervention?					
Vulnerable groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy	Population Intervention	Youth & Children	Men (loggers, seafarers, MSM)	Women	Prisoners
	Condom Social Marketing	YES	YES	YES	
	VCCT &STI clinics	YES	YES	YES	YES
	production of IEC-BCC on ABC	YES	YES	YES	
	sex education curriculum (formal & informal) schools	YES			
	PMTCT.				
	IEC resources for BCC. I.e. increased posters, bill boards/ media-radio & TV, newspapers	YES			
	Support expansion and strengthening 'Men as Partners in Reproductive Health'		YES		
	Establish new Youth friendly centres,	YES			
	Establishment of men's clinic.		YES	YES	
	Through Mass Media and other related activities Such as Drama, video show, condom demo and distribution for young people.	YES			
	To Mission to Seafarers, which include [1] STI/HIV awareness and prevention.		YES		
	Develop a seafarer's alliance against STI/ HIV prevention. And create Network with agencies for international shipping lines and domestic seafarers.		YES		
	Promoting reproductive rights			YES	
	Capacity building for women's organizations and networks.			YES	
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	Page 19: All steps of the process were developed with input and contribution of different stakeholders which, is hoped to lead to a sense of ownership amongst all stakeholders. As a result, the proposed plan should be broad and targeted in its approach as well as realistic in its achievements. Page 26: Strengthen national responses through increasing integration and coordination of planning, implementation, and evaluation of all prevention and care by all government sectors, non-government sectors including the Churches and Community Based Organizations. Page 27: Strengthen national response through capacity building to manage, implement, monitor and evaluate prevention and care programs and services by key stakeholders. KRA1 Strategy: Expand men as partners in reproductive health'. KRA4 Objective: To ensure a coordinated and targeted national HIV response through appropriate political support and by strengthening the capacity of relevant key stakeholders to implement the activities of the national multi-				

Country: Solomon Islands Strategy Document: THE NATIONAL HIV POLICY AND MULTISECTORAL STRATEGIC PLAN 2005–10	
	sectoral HIV response plan KRA5 Objective: To develop an environment conducive to the rights of PLWHA through development and implementation of relevant legislation and consequently resulting in behaviour change to ensure appropriate prevention and care for HIV/AIDS. Page 51: 3. Assist in strengthening and empowering of NGO's capacity in decision making, management, planning, and ME. 3.1. Strengthen the organizational links through partnerships for HIV prevention and care between the Government sectors and NGOs (including the churches and the private sectors). Page 42: 4.8. Include women in decision making at all levels such the politics and AIDS Council. Page 77: 5.3. Protect women and children against HIV transmission through abuse: Empower girls and women through awareness and life skill trainings. Increased awareness of women's right to HIV prevention. Increase No. of women aware of rights More respect for women at all level Recognition/participation at all level Increase status of women Increase change in men's attitude
Does the strategy highlight the importance of training for peer workers? Refs.	4.4. Strengthen women's networks and organizations 4.4.1. Assist capacity building for women's organizations and networks. 4.4.2. Provide technical support to women's network and organization in implementing STI/ HIV prevention initiatives in women.

Country: Tonga Strategy Document: A STRATEGIC PLAN FOR RESPONDING TO HIV/AIDS AND STIs IN THE KINGDOM OF TONGA 2001–2005		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	Use of traditional, community participatory and informal learning methods such as dancing, singing and dramas, should be used at all levels to share information about HIV/AIDS/STI. Education is one of our strongest values. People at all levels need to be empowered with knowledge about human sexuality and relationships, including information about HIV/AIDS. All persons should have equal opportunity to this full education. Education at all levels should be used to break down barriers, create awareness and strengthen knowledge on HIV/AIDS. The community should take responsibility for empowering people with information on, and the means to protection from, HIV/AIDS/STI.
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	The strong Christian values of equality, forgiveness, acceptance, unconditional love in action, care and support – the fruits of the Spirit – should be extended to all people regardless of age, gender, race, religion, sexual preference or HIV status. The sense of belonging in the Tongan community is very strong. This should extend to and empower all people, including people living with HIV/AIDS. HIV/AIDS AFFECTS EVERYBODY IN THE COMMUNITY!! The strong *api* values of care and support, inclusiveness, hospitality, love and reciprocity should be encouraged and extended to all people, including those living with HIV/AIDS. Working with and listening to, those most at risk and most affected (including PLWHA), should be a key feature of the response to HIV/AIDS/STI in the Kingdom of Tonga.
	Engagement of young people and their right to access education & prevention services.	nil
Does the Strategy	Page 7: increasing number of vulnerable groups like youths, seafarers, sex workers, recipients of blood donations, staffs	

Country: Tonga Strategy Document: A STRATEGIC PLAN FOR RESPONDING TO HIV/AIDS AND STIs IN THE KINGDOM OF TONGA 2001–2005	
highlight the importance of Identifying and targeting vulnerable populations? Refs	of Defence services and health workers. Page 10: Reducing the vulnerability of specific groups and promotion of safer sexual behaviour. Certain groups are at a higher risk of infection because of social situation, age, employment circumstances, or lifestyle decision. Information and awareness activities are needed to specifically target these vulnerable groups increasing both their knowledge of STIs and their awareness of their own vulnerability, and promoting means and methods to increase their level of protection and safer sexual behaviour. Page 12: To increase access to information on and the means to protection from STIs, for specific target groups. Page 19 3.1.1 Develop and conduct tailored awareness raising workshops for vulnerable groups including seafarers/ship crews; army/navy/police; prisoners; fakaleitis; sex workers; civil servants and business men **3.1.2** Review and expand existing IEC materials targeted at specific groups to ensure relevant, contemporary information in Tongan is widely available on safer sexual alternatives and protection Page 20: 3.3.2 Conduct social research with vulnerable groups assessing - attitudes towards condoms - accessibility (number/location of outlets, cost) Page 20: Review and expand existing drug and alcohol outreach services to increase access for groups particularly vulnerable to HIV/STI
Does the Strategy highlight the importance of peer education as an intervention?	Page 7: youth council and peer education; **1.2.4** Include information on STIs in existing peer educator training programs Page 18: 2.1.1 Review and expand current training programs for peer educators to ensure availability in all parts of Tonga and to youth at particular risk (e.g. unemployed, out of school, casual sex work, delinquents) 2.1.2 Identify sources of funding to allow peer education programs to safely access youth at particular risk (e.g. providing transport for peer educators working on the streets after dark) 2.1.3 Utilise village and church youth groups to raise awareness of peer education and other services available Page 19: 3.2.3 Select members of specific vulnerable groups to participate in current peer educator training programs Page 21: TNYC: - Outreach program (School youth groups, organise community, TMPI) - Peer educator training - Awareness programs (3 day workshops for youth, TBU/outer islands) - Production of IEC materials - Condom distribution - Magazine - Radio show - Referral • Peace Corps: - Awareness workshop

Country: Tonga

Strategy Document: A STRATEGIC PLAN FOR RESPONDING TO HIV/AIDS AND STIs IN THE KINGDOM OF TONGA 2001–2005

- Funding for youth peer educator training
- Develop life skill manual in Tongan

- Leuleumafana AIDS Foundation:
  - As in TNYC
- Leiti's Association:
  - Training workshops
  - Liaise with gay/homosexual associations overseas
  - Human rights activities

Page 49: Peer Educator potential for education on drug abuse

Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy	Population / Intervention	Civil Servants B'men	Youth	Prisoners	Travellers	SW	Women	fakaleitis	Seafarers	Uniformed services	People with STIs, or HIV/AIDS
	Targeted media to raise community awareness of STIs										
	Awareness raising workshops										
	Education – health education, formal and informal education										
	Develop IEC materials on STIs										
	awareness raising programs utilising traditional learning methods including drama, theatre, singing and dance (particularly at village community level)										
	Newspaper articles and radio interviews										
	Peer education										
	Distribute IEC materials through youth drop in centre, night clubs, sporting groups and youth groups										
	Disseminate IEC materials										

Country: Tonga Strategy Document: A STRATEGIC PLAN FOR RESPONDING TO HIV/AIDS AND STIs IN THE KINGDOM OF TONGA 2001–2005											
	through workplaces, bars, hotels and taxi drivers										
	HIV/STI prevention is included in training of recruits and refresher courses for existing personnel										
	Conduct informal training programs for employers (e.g. army, shipping agencies, hospitality industry										
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	Page 17:1.2.4 Utilise community participatory methodology through key contacts at village level to identify community knowledge level, attitudes and information needs Page 18: 2.1.3 Utilise village and church youth groups to raise awareness of peer education and other services available Page 19: 3.2.3 Select members of specific vulnerable groups to participate in current peer educator training programs Page 30: 1.2.1 Utilise Church leaders, community leaders, PLWHA and their families to act as advocates in lobbying decision makers to increase funding allocated to providing support for PLWHA Page 33: 1.2.3 Encourage PLWHA to act as advocates on confidentiality issues Page 35: 3.2.3 Encourage and support PLWHA to be actively involved in advocating for the protection of the human rights of all Tongans, regardless of HIV status Page 38: 3.1.5 Encourage and support PLWHA to act as public advocates through meetings and the media, to raise the profile of HIV/AIDS/STI and gain the commitment of decision makers										
Does the strategy highlight the importance of training for peer workers? Refs.	Page 17: 1.2.1 Review and expand existing training of trainer programs, to ensure that trainers are available for working with the Church, schools, youth, community groups, employers/employees, risk groups and in the outer islands Page 18: 2.1.1 Review and expand current training programs for peer educators to ensure availability in all parts of Tonga and to youth at particular risk (e.g. unemployed, out of school, casual sex work, delinquents) Page 19: 3.2.3 Select members of specific vulnerable groups to participate in current peer educator training programs Page 20: 4.1.5 Include drug and alcohol issues in current peer educator training Page 45: Peace Corps to train 50 peer educators by 2002 Peace Corps and UNICEF funding) Page 48: Young people do discuss sexual issues with their peers – great opportunity for peer education programs, and promoting acceptance of other forms of sexual expressions other than sexual intercourse										

Country: Tuvalu Strategy Document: Tuvalu National Strategic Plan for HIV and AIDS 2009–2012		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services;	No comments
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	No comments
	Engagement of young people and their right to access education & prevention services.	No comments
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Page 18: Policies, legislation and traditional laws that discriminate against vulnerable populations including women, sex workers and men who have sex with men reviewed and amended. Appropriate policies that underpin the enabling environment are an essential part of an effective HIV response. This output will entail a comprehensive review of policy and legislation that might inadvertently give rise to discrimination, along with recommendations for changes that bring such policies and legislation into line with Tuvalu's international obligations on human rights. 1.C. Policies, legislation and traditional laws that discriminate against vulnerable populations including women, sex workers and MSM reviewed and amended 1.C.1 Assess existing policies & legislation to identify those discriminating against vulnerable populations including women, sex workers and MSM Page 18: Behaviour change strategy developed. Given the complexity of achieving effective behaviour change in any community a thorough study will be undertaken to ensure that whatever interventions are undertaken, they meet the needs of the highly specific and unique situation. This study will inform the BCC strategy for Tuvalu. Page 18: Strategy for HIV and STI prevention among Tuvalu youth devised and implemented. Page 18: Prevention strategies specifically targeting vulnerable groups designed and implemented. Such measures are seen as a cornerstone of an effective response in low prevalence settings like that of Tuvalu. Seafarers are among the Pacific's most vulnerable population sub groups and Tuvalu is no exception. Although sex work is not as common in Tuvalu as it is in some other Pacific island nations it does happen and may become more common. These are among the groups that need specific interventions based on good information. 2.C Prevention strategies specifically targeting vulnerable groups designed and implemented 2.C.2 Undertake KAPB studies to inform behaviour change strategies with vulnerable groups 2.C.4 Design, pre-test, publish and distribute culturally specific BCC materials for vulnerable groups 2.C.6 Review seafarers HIV education campaign 2.C.7 Design HIV prevention campaign for entertainment venues where risk behaviours are known to be prevalent 2. D.9. Engage in targeted condom and lubricant distribution campaign for identified vulnerable groups in targeted condom and lubricant distribution campaign	
Does the Strategy highlight the importance of peer	2.A.5 Design "life skills" training program for teachers, health workers, community leaders, NGO personnel, young people and other suitable key players incorporating communication, negotiation skills, sexuality, Gender respect and responsibility, and safe sex	

<table>
<tr><th colspan="3">Country: Tuvalu
Strategy Document: Tuvalu National Strategic Plan for HIV and AIDS 2009–2012</th></tr>
<tr><td>education as an intervention?</td><td colspan="2">2.B.7 Adapt existing peer education support materials
2.B.8 Monitor peer education activities
2.C.5 Implement peer education program for sex workers to provide condoms and safe sex education
3.D.1 Establish peer support network for people infected and affected by HIV</td></tr>
<tr><td rowspan="12">Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy</td><td>Population
Intervention</td><td>Seafarers | Young People | MSM | women | SW</td></tr>
<tr><td>World AIDS Day campaigns</td><td rowspan="11">The populations listed above are not aligned to any of the interventions listed in the strategy (on left)</td></tr>
<tr><td>“life skills” training program</td></tr>
<tr><td>stepping stones program</td></tr>
<tr><td>Produce (print/record/make) culturally specific/ sensitive HIV and STI behaviour change materials</td></tr>
<tr><td>media HIV strategy</td></tr>
<tr><td>broadcast a series of radio messages on HIV and STIs</td></tr>
<tr><td>Arrange with Telecom and design mobile phone spot messages</td></tr>
<tr><td>youth HIV strategy</td></tr>
<tr><td>pilot implementation of HIV and Sexuality curriculum in selected schools</td></tr>
<tr><td>Distribute condoms and information</td></tr>
<tr><td>Provide IEC and other behaviour change materials to support VCCT</td></tr>
<tr><td>Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Ref</td><td colspan="2">No comments</td></tr>
<tr><td>Does the strategy highlight the importance of training for peer workers? Refs.</td><td colspan="2">2.B.4 Develop/adapt a peer education training manual
2.B.5 Identify, train/ retrain youth peer education teams
2.B.6 Devise Peer Educator support mechanisms</td></tr>
</table>

Country: Vanuatu Strategy Document: National Policy for HIV/AIDS and Sexually Transmitted Infections 2008 – 2012		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	Page 1: "With the spirit of compassion inherent in Vanuatu cultural and religious values and committed leadership, stop the spread of HIV and STIs by ensuring everyone receives the right information, has easy access to quality services, and the rights of people living with or affected by HIV are respected."
		Page 1 Ensure that all men, women and young people have access to accurate information Ensure that all People have access to appropriate services and information Continue awareness raising based on peoples existing knowledge Ensure adequate access to condoms through continued free distribution and by developing and implementing a social marketing plan.
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	Page 1 Be cross-sectoral and multi-sectoral, and be developed with the participation of multiple stakeholders
	Engagement of young people and their right to access education & prevention services.	Page 1 Take into account and address the special problems young people
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Page 5: "The Policy and Strategic Plan for HIV/AIDS and Sexually Transmitted Infections 2003 – 2007 was both a policy document and a strategic plan together in one document and does not specifically mention the role of gender in HIV and STIs. Gender inequality is a fundamental cause of vulnerability to HIV. Its profound impact is on women, but also those men who adopt a transgender role or men who have sex with men also suffer specific forms of vulnerability. " Objective1: Reduced vulnerability to infection with HIV and STIs among specific vulnerable groups and the general population	
Does the Strategy highlight the importance of peer education as an intervention?	Page 5: Behaviour change and communication should be the underlying concept behind peer education. 1.1.6 Promote Peer Education: – Adopt the newly developed Peer Education guidelines – Develop/ adopt the appropriate Peer Education Training Manual – Recruit new and re-train (refresher) the existing Peer Educators following the guidelines setting standards and quality 1.1.7 Identify support /funding for peer education	

<table>
<tr><th colspan="3">Country: Vanuatu
Strategy Document: National Policy for HIV/AIDS and Sexually Transmitted Infections 2008 – 2012</th></tr>
<tr><td></td><td colspan="2">– Incorporate in Gov plans
– Encourage different organisations to adopt</td></tr>
<tr><td rowspan="10">Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy</td><td>Population
Intervention</td><td>Young people | Seafarers | Sex Workers</td><td rowspan="10">These populations are mentioned in the operational plan however none are mentioned in the national strategy.
These interventions are mentioned in the national strategy.</td></tr>
<tr><td>General public awareness campaigns e.g. WAD (Each province to hold WAD campaigns), AIDS Advocates</td><td></td></tr>
<tr><td>stepping stone approach, training people in other life skills (Communication, negotiation skills, safe sexual practices etc)</td><td></td></tr>
<tr><td>(Posters, booklets, Fact sheets, T/shirts, Comic books, Audio-visual)</td><td></td></tr>
<tr><td>Work with media to disseminate information and advocacy:</td><td></td></tr>
<tr><td>Train church leaders, chiefs, women leaders, youth Leaders to integrate HIV/STI activities into their work</td><td></td></tr>
<tr><td>Awareness raising through Schools:</td><td></td></tr>
<tr><td>Promote Peer Education:</td><td></td></tr>
<tr><td>Nationwide social marketing operation for condoms</td><td></td></tr>
<tr><td>Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs</td><td colspan="2">Page 3: “A multi-sectoral and multi-stakeholder workshop in Port Vila 27 to 30 March 2007.”

“Thus the planning process entailed: situation review and review of the implementation status of the then current plan, followed by a wide consultative process culminating in a planning workshop involving a wide body of stakeholders. “

1.1.8 Develop strategy for working with vulnerable groups implement</td></tr>
<tr><td>Does the strategy highlight the importance of training for peer workers? Refs.</td><td colspan="2">1.1.2 Community based training education - Train community groups in the stepping stone approach, training people in other life skills (Communication, negotiation skills, safe sexual practices etc)
1.1.4 Train church leaders, chiefs, women leaders, youth Leaders to integrate HIV/STI activities into their work
– addressing stigma and discrimination</td></tr>
</table>

Country: Vanuatu Strategy Document: National Policy for HIV/AIDS and Sexually Transmitted Infections 2008 – 2012	
	– promoting behaviour change – eliminating gender barriers and domestic violence 1.1.6 Promote Peer Education: – Adopt the newly developed Peer Education guidelines – Develop/ adopt the appropriate Peer Education Training Manual – Recruit new and re-train (refresher) the existing Peer Educators following the guidelines setting standards and quality

Appendix Ten

Analysis of peer education within selected regional strategies

Regional Strategy: Pacific Regional HIV Strategy Implementation Plan (PRISP) 2004–2008		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	Vision: Where people living with and affected by HIV are respected, cared for and have affordable access to treatment
	Partnership and engagement with the affected community (i.e. Vulnerable groups)	Goal: To reduce the spread and impact of HIV and AIDS, while embracing people infected with and affected by the virus in Pacific communities
	Engagement of young people and their right to access education & prevention services.	Percentage of young women and men aged 15-24 who are HIV infected Percentage of young women and men aged 15-24 with a sexually transmitted infection (by infection) (to be approved by Pacific MERG)
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Indicators: Percentage of key populations who are HIV infected Percentage of young women and men aged 15-24 with a sexually transmitted infection (by infection) (to be approved by Pacific MERG) Percentage of young women and men aged 15-24 who are HIV infected 2.b.d Improved understanding of patterns of vulnerability to HIV and other STIs in Pacific Island countries and territories obtained by undertaking targeted social research 2.d.c Country specific information campaigns in relation to HIV and other STI testing are conducted targeted to general communities and key populations 2.g.g Free condom distribution to vulnerable and other high-risk groups supported through targeted distribution centres 2.h.a Training, technical and financial support provided to programs undertaking outreach to vulnerable groups 2.H.a.1 Provide financial support to activities focused on vulnerable groups (Competitive and NAC Grants) 2.H.a.2Z Provide BCC technical support to projects focused on vulnerable groups to build capacity of implementing organisations 2.H.a.3U Support for targeted prevention among identified vulnerable and higher risk groups 2.H.a.5U Provide technical inputs to regional partners and Pacific Island countries on targeted interventions among high-risk and vulnerable populations 2.H.a.7U Provide technical advice in developing and implementing harm reduction strategies when injecting drug use emerges in the Pacific 2.h.b Training, technical and financial support provided for development of country specific BCC materials targeted at vulnerable groups 2.H.b.2A Support development, printing, distributing of behaviour change communication materials for vulnerable groups 2.H.b.3A Produce and disseminate information education and communication materials to support awareness activities and promoting condom use among seafarers	

Regional Strategy: Pacific Regional HIV Strategy Implementation Plan (PRISP) 2004–2008

Does the Strategy highlight the importance of peer education as an intervention?	1.c.g People living with HIV are supported to raise awareness and understanding in relation to HIV among communities and targeted groups 2.a.g Support and technical advice provided to establish and maintain peer support networks for people living with HIV 2.C.a.5A Identify at least one peer educator to participate in Stepping Stones workshops 1.c.d Peer education programs for young people for the prevention of HIV and other STIs are strengthened and coordinated across the region 2.C.d.3G Support adoption and implementation of national peer education strategies and activity plans 2.C.d.5P Build on national peer education capacity development programs to identify needs and issues in remaining seven countries 2.C.d.6P Establish national peer education committees to ensure recognition of importance and resourcing of peer education under national strategic plans 2.c.e Outreach to communities in relation to HIV and other STIs through theatre group presentations 2.g.d Training for peer distributors in relation to CSM designed and delivered 2.g.g Free condom distribution to vulnerable and other high-risk groups supported through targeted distribution centres 2.G.g.3G Distribute condoms through peer educators 2.h.e Peer education programs supported to prevent HIV and other STIs in vulnerable and other high risk groups 2.h.f. Out of school life skills-based education programs including HIV and other STIs supported

Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy

Population / Intervention	Young People	Seafarers	Uniformed services	IDU	PLWHA
Conduct capacity building activities for the Champions Program					
Behaviour change communication activities					
Stepping Stones Program					
Development, printing and distribution of country-specific targeted behaviour change communication materials					
Television soap opera					
Develop, pilot test, produce and integrate curriculum for life skills education					
Promote the use of both male and female condoms					

Regional Strategy: Pacific Regional HIV Strategy Implementation Plan (PRISP) 2004–2008						
	Theatre group					
	Condom social marketing					
	Seafarer community drop in centres established					
	Out of school life skills-based education programs					
	Conduct capacity building activities for the Champions Program		YES			
	Behaviour change communication activities	YES				
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs	Outcome 1c. Supportive environment for responses to HIV and other STIs improved and people living with HIV are effectively engaged according to the 'Greater Involvement of People with AIDS' principles Outputs 1c.c. Civil society and people living with HIV supported to participate in HIV strategic planning and policy development at national, regional and international levels 1.c.c.4P Support for positive people from PIC to establish support network 1.c.f People living with HIV can improve their skills in leadership, advocacy, public speaking and positive living 1.c.g People living with HIV are supported to raise awareness and understanding in relation to HIV among communities and targeted groups 1. C.i.4n. Research and develop a manual for partnerships between churches and organisation of people living with HIV. C1.C.i.13Ua Conduct a regional meeting to engage women and youth in HIV prevention in the context of faith based organisations 2.A.g.1A Forge links with non-government organisations serving people living with HIV in northern Pacific Island countries and territories through participation in Pacific Island Jurisdiction AIDS Action Group 2.G.d.2A Link peer network to other related PRSIP activities, including those undertaken by SPC					
Does the strategy highlight the importance of training for peer workers? Refs.	1.c.f People living with HIV can improve their skills in leadership, advocacy, public speaking and positive living 1.c.f.g Train AIDS additional ambassadors in public speaking and presentation skills 1.c.h Organisations of people living with HIV have the skills and funds to operate effectively 1.c.h.u Facilitate organisational strengthening, advocacy and treatment preparedness training for groups representing people living with HIV 2.c.a5 Identify at least one peer educator to participate in Stepping Stones workshops 2.C.c.3U Train and orient teachers and youth leaders to new curriculum and delivery methods 2.C.d.1G Conduct national baseline audits and workshops on peer education (coordination and capacity					

Regional Strategy: Pacific Regional HIV Strategy Implementation Plan (PRISP) 2004–2008	
	development) 2.C.d.2G Revise peer education manual and check-list for delivery of quality peer education activities 2.C.d.4G Support national CCM-approved training activities for peer education coordinators, and training and outreach support for peer educators 2.g.d Training for peer distributors in relation to CSM designed and delivered 2.G.d.3W Refresher training for Peer Leaders and Community Based Distributors 2.h.e Peer education programs supported to prevent HIV and other STIs in vulnerable and other high risk groups 2.h.e.g Conduct national training activities for and support peer educator coordinators and peer educators working with at-risk groups 2.H.e.2G Provide ongoing support for peer educators working with at-risk groups 2.H.f.1N Support peer education thorough training and capacity building

Regional Strategy: Pacific Regional Strategy on HIV and Other STIs 2004–2008		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	Affirms the protection and promotion of human rights through international human rights instruments, including regional and national commitments; seeks support for facilitation of a continuum of care and support for PLWH, and access to quality and affordable treatment, including for other STIs.
	Partnership and engagement with the affected community (i.e. vulnerable groups)	Involves affected individuals and communities at all levels of the development and implementation of services, programs and policy; is based on partnerships and a multi-sectoral approach; is based on an approach sensitive to gender and vulnerable groups.
	Engagement of young people and their right to access education & prevention services.	
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Page 20: Young people and women are the most at-risk population groups in PICTs. Most PICTs have a relatively young population, and it is important to target this sector of the population. Theme 1, Strategy: Support the development of and strengthen effective and sustainable preventative interventions for HIV and other STIs in the Pacific region, including actions to address vulnerability and risk factors. Key Action: Identify high-risk groups and target interventions (including tertiary students) Advocate for the incorporation of HIV and other issues into national and regional policies and programs on gender, youth and other vulnerable groups Theme 8: Recognising that there are vulnerable populations, interventions must target groups such as young people, women, men and transgender and other vulnerable groups. Objective To strengthen regional capacity for effective prevention and care interventions targeting vulnerability and high-risk behaviour. Strategy Encourage equitable attention to and participation of women and young people and members of other vulnerable groups, including seafarers, those involved in commercial sex, university students and men who have sex with men (including indigenous sexual identities such as Fa'afafine ne and Fakaleiti) in regional activities. Key Actions: Establish and support a regional network to identify "demonstration projects", successful processes and behavioural change communication activities that could be replicated or adapted for other PICTs in relation to working with vulnerable groups. Support organisations and others wanting to work with groups that are particularly hard to reach	

<table>
<tr><th colspan="10">Regional Strategy: Pacific Regional Strategy on HIV and Other STIs 2004–2008</th></tr>
<tr><td></td><td colspan="9">effectively, including sex workers and men who have sex with men.
Advocate for the incorporation of HIV/AIDS issues in national and regional policies and programs on gender, youth and other vulnerable groups.
Promote and support workshops and other activities that assist youth and other vulnerable groups to understand HIV/AIDS and to access safe sex materials and information to better protect themselves.</td></tr>
<tr><td>Does the Strategy highlight the importance of peer education as an intervention?</td><td colspan="9">Theme 8, Key Action Identify and map out vulnerable groups in the region in order to effectively conduct and support peer education training on HIV/AIDS.</td></tr>
<tr><td rowspan="8">Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy</td><td>Population

Intervention</td><td>PLWHA</td><td>Young People including uni students</td><td>Women</td><td>Transgender</td><td>Seafarers</td><td>CSW</td><td>MSM including Fa’afafine and Fakaleiti</td></tr>
<tr><td>Advocate and promote communication best practices, including behavioural change communication strategies, media practices, family reunion meetings and other traditional communication networks</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Formal school curricula.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Establish and support a regional network to identify “demonstration projects”,</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Workshops</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Advocacy</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Organisational support</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs</td><td colspan="9">2.1 Vision
Our Pacific region is to be a place where the spread and impact of HIV and other STIs are halted and reversed; where leaders are committed to leading the response to HIV; where people living with and affected by HIV are respected, are cared for and have affordable access to treatment; and where all partners commit themselves to these collective aims within the spirit of compassion inherent in Pacific cultural and religious values.
2.2 Goal
The goal of the strategy is to reduce the spread and impact of HIV/AIDS, while embracing people infected and affected by the virus in Pacific communities.
Page 24: “and the active participation of PLWH and affected communities in the response.”</td></tr>
</table>

Regional Strategy: Pacific Regional Strategy on HIV and Other STIs 2004–2008	
	Theme 3 Objective: To provide a comprehensive continuum of care that responds to the diverse and complex needs of people living with HIV/AIDSs and other people affected by HIV/AIDS, and to contribute to the prevention of HIV transmission. Theme 4: There is respect for human rights in relation to people living with HIV/AIDS. Based on these rights, people living with HIV/AIDS should be actively involved and supported through networks and the interface with mainstream services. Key Actions*: Involvement of HIV positive people* Identify, train, and provide ongoing support for AIDS ambassadors from PICTs. Develop and promote mechanisms in government departments and agencies to encourage the active involvement of HIV positive people at all program levels (including strategy development and implementation) on a confidential basis. *Strengthening linkages* Strengthen national and regional organisations for people living with HIV/AIDS where they exist and support the establishment of organisations for people living with HIV/AIDS where relevant. Strengthen links between PICT national and regional organisations for people living with HIV/AIDS and other networks for people living with HIV/AIDS — such as APN+, the National Association of People Living with HIV/AIDS (NAPWA, Australia) and Body Positive (New Zealand) — and global networks of people living with HIV/AIDS such as GNP+ and the International Community of Positive Women (ICW+). Theme 5, Key Actions: Develop a regional network of community-based organisations (CBOs) and NGOs, including a Pacific NGO HIV/AIDS network for improved coordination of NGO and CBO responses. Formalise recognition of regional NGOs, including the Pacific NGO HIV/AIDS network as a partner in the implementation of the regional strategy. Theme 8: Strategy Encourage equitable attention to and participation of women and young people and members of other vulnerable groups, including seafarers, those involved in commercial sex, university students and men who have sex with men (including indigenous sexual identities such as Fa'afafine ne and Fakaleiti) in regional activities.
Does the strategy highlight the importance of training for peer workers? Refs.	Theme 8, Key Action Identify and map out vulnerable groups in the region in order to effectively conduct and support peer education training on HIV/AIDS.

Appendix Eleven

Regional organisations: Survey and interview responses in summary form

Foundation of the Peoples of the South Pacific International (FSPI)

Peer education has been primarily focussed on youth, and often has been delivered in conjunction with life skills training. Consequently, many young people who have undergone peer education training have also received many important skills in communication, facilitation, and confidence building. These skills provide a valuable asset for their future participation in the community, therefore the attrition of peer educators from an organisation should never be considered a loss because the community as a whole gains from the acquisition of skills by its youth.

It would be important to conduct a longitudinal study to follow the progress of trained youth PE and observe how their broad skills are applied in future life situations and the impact it has made on their long term life choices. Consequently it is important that PE training and life skills education be combined.

Monitoring and evaluation is a constant struggle to implement. The success of programs can be measured by how clearly the voice of the vulnerable and marginalised (the target group) comes through the activities and resources developed by a program. To what extent are they represented at all stages of development and implementation? To what extent is there representation on committees and do these committees have an advocacy role and strategy for ensuring this voice is heard?

To assist with monitoring, strong use is made of youth forums, working groups, and research. Exchanges between countries of peer educators and coordinators are encouraged, and coordinators are brought together on an annual basis to share experiences. Staff of the program visit field sites each year, and participate in local forums.

Most significant change stories are very important for motivating coordinators to identify what difference they are making as they reflect upon their own work.

The Stepping Stones program conducted in Kiribati, Vanuatu and the Solomon Islands does involve a peer education methodology with men outreaching to other men according to their age groupings. It does have a HIV focus, but also includes a broader social agenda by challenging gender equity and politics.

Strategies as delivered in Chuuk, FSM, was until recently, strongly based on peer education principles with Peer educators themselves actually involved in pre and post test counselling. However in the last year the mobility of the population has led to a very high turnover and a subsequent loss of these trained PE. This was considered a significant challenge- that much of the effective work carried out falters because of the great migration of people out of Chuuk. Much of the education work in Chuuk has been confined to HIV 101 and this should broaden out to include sexual and reproductive health.

The Youth Resource Centre on Chuuk is involved in peer education training for sex workers and some MSM.

Peer education as delivered in Pohnpei is through the Red Cross and AHD program. It was noted that there may be a lack of coordination between the two programs, and generally it was observed that there was a lack of national coordination. The collaborative links between government and NGO in FSM was considered weak.

Marie Stopes International

Developed initially in Fiji, the condom social marketing (CSM) program relies upon peer distribution of condoms. Persons with previous experience in peer education (often head hunted from existing agency networks) are trained in sales and marketing skills and are designated as peer leaders. The training workshop is a two-day program dealing with the principles of CSM with refresher training on STI/HIV. A team of four peer leaders has been trained to visit villages and target persons aged 16–29 years with awareness training and condom promotion. The educators recruit teams of condom distributors from villages (or from vulnerable communities). This model was first developed in Fiji and has been implemented across other Pacific Islands. The CSM program is now implemented in Tuvalu, Samoa, Kiribati, Vanuatu, Solomon Islands, Marshall Islands, and FSM. In each of these countries Marie Stopes partners with local agencies and selects trained educators to become skilled in CSM.

A significant issue was one of gender. In each community, groups are divided according to gender for the purposes of specific training, but only one peer leader was available and required to talk with both genders. A lack of resources and staffing has meant it was not possible to send both male and female leaders. However in 2005 peers of both genders now operate in Samoa and Tuvalu

In 2008 the CSM program changed in approach. Peer educators were renamed community educators in recognition of the fact that they weren't peers within the village context. It was also realised that in many circumstances, medical professionals had more credibility and were very well accepted in villages.

Protocol officers were employed to make initial contact with the village headman and explain the program. The Village Chief would then call the community together to arrange and prepare for the community educators. Protocol Officers are selected based on their skill and knowledge in traditional ways, and the familiarity with the community.

In Tuvalu and Samoa, community educators are engaged from partner agencies (Samoan AIDS Foundation and Tuvalu Family Health Association). In Samoa the drama group has been found to be very effective, whilst in Tuvalu, TuFHA operate a youth drop-in centre with community educators as part of that centre.

Marie Stopes provides training in social marketing to partner agencies like SAF and TuFHA through which existing 'peer educators' are trained to undertake condom social marketing to 16-29 year olds.

Community educators recruit up to five condom distributors per month for each village. Distributors are provided financial incentives. Condoms are sold to distributors for 60c who then on sell them to the community for 80c. A system such as this must be carefully monitored to ensure there is no profiteering. Consequently, outreach teams visit each village a few weeks after training to monitor conduct of the distributors. As well, Marie Stopes reduced the number of distributors recruited for each village from ten to five persons as a means of keeping prices down. The community educators keep in contact with the community distributors to ensure delivery of service.

However, there is a very low level of repurchasing. It is difficult to maintain the motivation of distributors who often resort to selling condoms obtained free of charge.

Programs such as these are easy to monitor in smaller locations like Tuvalu where a single community educator can monitor condom distribution across all villages. Monitoring is difficult in larger countries such as the Solomon Islands, Vanuatu and Samoa.

A number of difficulties were identified for the implementation of peer education:

- Retention of people on a part-time allowance has been difficult and there has been a change to monthly allowances payable on submission of a report.
- Retention of volunteers is even more problematic given the level of training and capacity developed over time, only to be lost when many of the volunteers leave. (A solution has been to employ particular volunteers as community educators, further develop their skills, improve their motivation and performance, and consequently facilitate their entry into further study and career advancement.)
- Many persons have been trained in peer education across the Pacific but the high levels of migration have led to a loss of experienced persons and subsequent capacity over time.
- Many persons have received training in peer education but few have acquired experience and skills in project management. (Manuals were highlighted as an important resource.)
- A very broad definition of youth across the Pacific needs to be accounted for in program design.
- Duplication and cross-over of programs across multiple target populations, delivered by multiple agencies can create an inconsistent delivery of messages. Often there is uncertainty as to what other agencies are undertaking.
- Initial planning meetings where a number of agencies gather have been successful at fostering a collaborative spirit but often there is little follow up once various projects commence.
- Whilst there are opportunities for peer educators to come together for discussion and information sharing, it is important that decision makers meet as well to ensure that the issues and needs raised by educators can be responded to with practical support.
- Each country has its own network and mechanism for peer coordination but these systems are often very weak. (Kiribati is noted as having a good system of networking with regular meetings and progress updates).
- Referral systems are a key component of these networks with a need for close, practical links to clinical services for VCCT.
- Peer educators possess large amounts of enthusiasm and creativity, but the lack of resources can often smother this motivation.
- Ethical issues concerning the behaviour of community educators has been previously significant i.e. poor modelling of behaviour within villages (development of a code of conduct has remedied this).

Targeting of programs to those at higher risk is essential. The CSM program relies on the Village Headman to identify those at risk within a village and encourage their attendance. However, for CSM programs, vulnerable groups are identified as those who are sexually active (and not by epidemiology).

Marie Stopes has also tried to recruit sex workers and members of vulnerable groups (wheel barrow boys) to undertake training workshops and become community educators/distributors. Community educators recruited sex workers during a night outreach and invited them to a workshop. Fifteen people were invited to the training, of who eight attended. The sex workers were trained as volunteers. An important component of the workshop was the proportion of time devoted to listening to and engaging with the participants to ensure a training session that was relevant to their needs. Based on advice from the sex workers, a program was developed for the afternoon with content designed in response to participant needs.

Of the 8 who attended, one sex worker has maintained a consistent enthusiasm and has taken on the role of peer educator and distributor. He maintains regular contact with Marie Stopes and is well connected with sex worker networks.

Marie Stopes intends to repeat this model and it has provided a good methodology for other vulnerable groups. There will be some modifications in future, i.e. extending the workshop to 2-3 days to allow more time and account for the late nights spent by sex workers.

Quality assurance of education content is maintained by ensuring that community educators deliver their programs to their fellow team members for appraisal prior to delivery within a village. The educator needs to specific about the intended target group and purpose of the program, and at this point, suggestions are offered by the team as to improvements in methodology.

Successful interventions are measured by the number of re-invitations to return to a village for further education and by the number of referrals of participants to clinical services for testing. Monitoring the effectiveness of BCC beyond these quantitative measures is difficult, but community educators have received training in baseline testing. Baseline assessments of community behaviour are determined prior to a program through focus group discussions. Behaviour change is measured using significant change stories in which participants are invited a few months later to recount their impressions of whether and how behaviour has changed.

Oceania Society for Sexual Health and HIV Medicine

OSSHHM is a membership based organisation that derives its members from the health workforce in the HIV and sexual health sectors across the Pacific. There are approx 85 members. OSSHHM do not have a direct role in peer education, however some of their members work in this area.

An area of interest for OSSHHM members is the relationship between HIV peer education and the referral and access to clinical services that may result from these peer education activities. Therefore involving clinical staff in the design and overseeing of any HIV peer education initiative is warranted.

Pacific Conference of Churches

Churches should be considered a strong network for peer based training. Over the last two years, there has been emphasis on peer education within its youth program; a process whereby youth leaders come together to undergo training in HIV and human sexuality, after which the youth leaders return to their own communities and engage their youth membership. A similar process has been operating for women leaders who are also trained to provide practical care and support for PLWHA. These two programs form the platforms of the Church's HIV Strategy.

HIV is considered a cross cutting issue across all the Church programs and this will serve as the approach for 2009.

An important lesson for educators and policy makers is to convey messages without antagonising church leaders. Church leaders are highly respected within communities, and therefore diplomacy and tact are important skills when consulting and negotiating with churches. A previous program conducted in the late 90s sought to target youth with practical skills for prevention e.g. use of condoms and appreciation of sexual diversity. However this peer education program was not well accepted by church leaders or the local community Youth leaders were not properly trained to facilitate group discussion and manage delicate issues within a culturally sensitive environment. They were not equipped with sufficient facilitation skills to handle divergent views, but only trained in content. Facilitation skills training is a crucial component of peer education training. Content should be secondary as it can be easily accessed through a variety of sources.

A new contract with the SPC will seek to strengthen the Church's role. The three areas that the Church is collaborating with the SPC as part of the PRISP are:

- Promotion of care
- Training of facilitators for peer education
- Human sexuality

Facilitator workshops will now be held nationally rather than regionally or sub regionally as this can increase coverage and participation, whilst decreasing costs. Teams of master trainers have been identified within regional agencies in each country and these will be enlisted for the Church's national workshops. The Churches propose to create a data base of trainers across the region. There will be a need to review the skills and quality of these trainers and offer refresher training if required.

In 2010 a regional forum will be conducted for youth leaders to come together to share experiences, review approaches, trends, and lessons learnt. The intention is for such regional forums to be held every two years.

Facilitators and the local churches will develop local training programs with PCC input. Programs will vary in content and methodology according to local needs and culture. This variation is considered strength as training will be levelled at the needs of the local community and will allow for local input. The PCC's role will be to challenge the local programs with broader aims.

The Youth and Women's' leaders will be assembling in October to plan training, review the program design and implementation of programs, all integrated within a broader agenda.

National churches operate a Youth Department responsible for conducting sporting activities, youth rallies, Sunday Schools. Once trained, Youth Leaders will need to consider how HIV and sexuality issues can be integrated into these current youth programs. There is a need to develop a monitoring system with measureable indicators. The October forum will attempt to set a baseline for each country to commence the monitoring of activities. Baseline data will be supplied from each NAC, UNAIDS and other regional agencies and will seek to identify vulnerable populations at a national and community level. Consequently a challenge will be issued to Youth Leaders to determine how best to outreach to vulnerable groups. There will be a consideration of how the outreach to the marginalised e.g. sex workers, MSM can be linked to the Church's mission to the poor. Nonetheless, for Church programs at present, the priority is its own church membership, therefore education programs will continue to be targeted predominantly at this constituency.

The Women's Fellowship within local churches follows a similar program design to that of youth, with woman leaders trained to engage with other women. However, cross generational issues of age emerge. Other issues that are highlighted:

- A tension exists between regional and national priorities and challenges
- Youth leaders are not necessarily young- the definition of youth can be fluid and broad
- Whilst youth leaders are encouraged to consult with their youth membership, this cannot be assured
- Youth leaders are expected to return to their communities and recruit and train younger educators
- Monitoring systems need to look at systems for reporting to National Councils, and then to the regional body.

Pacific Sexual Diversity Network

The Pacific Sexual Diversity Network (PSDN) was meeting for a strategic planning exercise coincidentally in Suva at the same time as the consultants were conducting the peer education mapping activity. This opportunity presented the possibility of a face to face meeting with members of the network. The PSDN had gathered for capacity development workshops, particularly research and leadership, community mobilisation, strategic planning and operational policy development.

The network is approximately two years old and is supported by the Australian Federation of AIDS Organisations (AFAO), the AIDS Council of NSW (ACON) and NZAF for the purposes of technical support for capacity building activities, and a range of other organisations—UNAIDS, AMFAR and AusAID—with respect to funding. Thirteen members were in attendance at the network meeting.

The countries represented in the PSDN were broader than the list of ten countries involved in this peer education mapping exercise and the additional countries (e.g. PNG and Fiji) also had input into the discussion. Of the ten countries involved in the mapping exercise, the group identified that the following had 'fledgling' MSM networks in Cook Islands, Samoa, Tonga and Vanuatu. However, it might be more appropriate to describe the situation in the Cook Islands, Samoa and Tonga as community organisations rather than networks as they are relatively formal and structured. An organisation has not yet fully developed in Vanuatu but resembles more a network (i.e. a less formal, but somewhat organised, social network).

The group derived the following very specific recommendation for these countries:

- Funding that is made available for MSM education—and specifically peer education—needs to be channelled through the existing peer based MSM groups.

Additionally, the group identified these more broad recommendations:

- That the regional network—PSDN—be supported to 'scope out' and assist in the development of local MSM organisations. It was noted that this community development approach, while not direct peer education, will enable peer education to evolve within these populations over time. (An example of the Cook Islands was suggested as a specific successful case i.e. an MSM organisation had formed recently through the support and encouragement of the PSDN.) It was also noted that because of the size of (and obvious barriers for) MSM communities in smaller Pacific Island countries (e.g. Nauru, Tuvalu and Kiribati), it may be unrealistic to expect peer education to be sustained or even initiated in these countries without there being strong support from MSM regionally. In these cases, a regional rather than national program may be more appropriate.
- Using the transfer/peer based model one country can support and develop capacity of 'next door neighbour' countries.
- Utilise examples of effective MSM HIV peer education that has already occurred in Pacific other countries like PNG.
- Community development approaches that target life skills rather than HIV specifically should be supported among MSM. An example is what has happened in Tonga. (Increasing MSM visibility and HIV awareness through the vehicle of a high profile community event that builds self esteem and community cohesion, for example the Miss Galaxy Pageant.)

When asked if there is anything that PSDN specifically required in support from SPC, the following was noted:

- Need to identify MSM communities. This is very difficult. In this, PSDN can help and is most probably essential.
- Need to communicate the objectives of the PSDN both to donor organisations, and to the MSM networks in any specific country.

It was noted that in many Pacific countries, communities of MSM were organising their own networks, communities, activities in a voluntary capacity, and consequently, there now exists mechanisms to start resourcing peer education in this area.

It is noted that sometimes governments will include vulnerable populations (e.g. MSM) in their national strategies and documents but actually do nothing about it.

Secretariat of the Pacific Community

Adolescent Health & Development Program

The Adolescent Reproductive Health (ARH) Program was implemented across the Pacific in 2001 as a UNFPA sponsored program in collaboration with SPC. UNICEF established a life skills program in 2002 which took on a broader scope of adolescent development beyond ARH and became the Adolescent Health & Development (AHD) Program in 2005 by merging with the UNFPA-SPC project.

The life skills program utilised master trainers within existing NGOs and attached sexual reproductive health to their agenda. The ARH program placed coordinators in each country. Fiji took the lead implementing peer education within the MOH, employing specific peer educators in each district and specifically targeting the area of adolescent SRH. Peer educators were placed in clinics, but in the process their role often became confused as they take on a wider range of activity and responsibility.

Within the AHD Program, some coordinators are placed in the MOH, some take on a support role for lead agency NGO, e.g. Cook Islands Red Cross, and others offer technical assistance to a range of NGOs, e.g. Vanuatu.

Tonga: the AHD Coordinator is based with the Family Health Association.

Kiribati: the AHD program operates a drop in centre from which peer educators operate. The AHD, Family Health Association and KANGO have formed a Peer Education Coordinating Committee which has created a coordinated approach wherein each NGO is designated a particular target population. Workshops have been delivered to transactional sex workers.

Marshall Islands: the NGO Youth to Youth in Health works with the AHD to operate multiple peer education programs. Two peer educators are funded by the AHD. The program is very youth focussed and owned. However this creates significant issues for the Director who needs to take on a large responsibility for the program's activity and is unable to delegate much of that activity to the younger workers.

Solomon Islands: Two AHD coordinators operate from the MoH and the Planned Parenthood Association. The SIPPA-IPPF funded programs are focussed in Honiara. The Save the Children Fund, Red Cross and World Vision all conduct peer education programs. The SIPPA conducts peer education outreach to attract young people to their clinic but it is very focussed on Honiara. The Save the Children Fund has a very wide provincial reach.

Cook Islands: The Red Cross serves as the lead agency

FSM: Of the four states, there is an active peer education team in Pohnpei, and peer education has just commenced on Chuuk.

Nauru: Nothing in place

Samoa: No peer education operates under the AHD but there is a large youth program operating peer educators under the Department of Women and Social Development. As well, the Samoa AIDS Foundation and Family Health Association operate peer education services.

Tonga: Peer educators are based at the Family Health Association.

Tuvalu: The AHD is present but no peer education is conducted.

The AHD program has responsibility for operating youth centres, clinics, nurses, peer educators and has moved beyond SRH to encompass a full range of health issues. However, the overwhelming focus still remains SRH. This is achieved through a number of sub-programs:

- Supporting the creation of an enabling environment through advocacy work and policy development
- Strengthening the delivery of SRH information, e.g. development of school curriculum
- Development of youth friendly clinical services
- Strengthening project management.

A number of deficiencies were identified:

- At present there is not much coordination between partners.
- There is no consistent definition or methodology for peer education, but rather a range of different understandings.
- A Peer Education network did operate in Fiji, but now it only meets on an ad hoc basis when special events arise.
- There is no standardisation of management systems for peer education programs i.e. what constitutes support and capacity building.
- Peer educators are often trained then sent off to work with little organised for refresher training or incentives.
- There is a high turnover of peer educators.
- No consistency in standards of training and content.
- There is no coordination in the delivery of activities with multiple programs cutting across each other. Different sources of funding can create disorganisation.
- Programs submit data to their respective agencies but often there is no analysis of the data.
- There is no standardised data collection and reporting system. Reporting must be conducted according to the requirements of the donor agency, and consequently NGOs do not report to the Government.
- Evaluation poses a great challenge with each agency evaluating its own program but no central coordination. Evaluation needs to go beyond process and simple measures of attendance.
- Peer education is often location based according to community without an adequate assessment of vulnerability.
- Often the focus of peer education programs is on coverage and not specificity of targeting.
- Training workshops are often not delivered with sufficient follow-up.
- The use of labels such as sex workers can be stigmatising in particular communities that understand the concept by another term.

- There is an issue as to whether MSM are better targeted as part of mainstream service delivery or through a separate targeted program.
- There is an issue of targeting marginalised populations in smaller, often less tolerant communities.

The Red Cross was considered very organised with respect to its program.

However regional coordination may not be the way to proceed due to sovereignty issues and national priorities.

Human Development Program (HDP)

The HDP cuts across a number of agendas with most projects focussed on young people as the program works closely with the AHD. It recognises the need for broad based community education in addition to peer education.

A significant gap identified was the targeting of programs. Whilst many were targeting young people, it was identified that a number of other vulnerable groups may be missed, for example MSM, transactional sex, mobile men with money (MMM). Often sex work was not easily identifiable in many countries due to its non-commercial or informal nature.

Key issues highlighted were the:

- Management of peer education programs
- Monitoring & evaluation systems
- Retention of volunteers
- Managing peer educators.

The ad hoc nature of monitoring and evaluation processes, including the type of data collected, urgently needs to be addressed. As well, it was considered important to explore how the peer education programs are linking with other services, both health and non-health to refer their target group for further assistance beyond the PE program's mandate/reach.

More emphasis should be placed on developing the capacity of national networks because of greater relevance in country, the ability to encourage better sharing of resources, experiences and knowledge. However, it was suggested that those smaller countries where only a few organisations operated would benefit from partnering with other NGO on a regional level. Certainly the sharing of information across organisations was identified as an important task.

HIV & STI Section Head

Peer education seems to have been tightly focussed on young people. The challenge is to define who comprise the target group, who are their peers, and what defines their vulnerability. Many vulnerable groups are invisible therefore it can be very hard to recruit peers for training. Consequently, many organisations target broadly rather than specifically and as a result, BCC strategies often resort to becoming broad population rather than specifically focussed. However in larger countries, it is easier to identify and specifically target particular vulnerable communities. For smaller countries, specific populations are hard to identify, in this instance, it may be appropriate to take a regional approach.

There are fears that a vulnerable community can become stigmatised if identified within a small population such as in small islands nations of the Pacific, coupled with strong cultural and social values.

Consequently, it is easier to establish specific peer based groups in larger countries, but overwhelming community perception can negate this in smaller countries. There is a need to look at legislative reform across the region to empower vulnerable communities.

Community education is important for enhancing acceptance. Establishing regional networks for vulnerable groups has been important for communication and support. Linking small vulnerable groups with larger country networks (a model adopted by PIAF to support isolated populations across a large region) may be the most appropriate strategy rather than developing peer-based organisations within a country.

There is a need for a single framework for peer education that coordinates the multiplicity of agencies and countries. Organisations and countries develop on an ad hoc basis with no current coordinating system for assessing what is happening and its impact.

It is important that a standardised training manual be developed.

National coordinating mechanisms do exist for HIV/AIDS but are not able to focus beyond HIV. National Planning & Development Units (or equivalent) exist in each country with a mandate to look at the total of population and social issues including health. The Units could play a role for coordinating peer education programs as their broader agenda would allow them to consider the underlying social determinants in other sectors other than health impacting on various vulnerable populations.

There should be a clear link between the peer education strategy and national HIV Strategies.

It is important that there be more comprehensive peer education that addresses a range of issues in social and personal development. HIV is not a priority in many countries, therefore integrating HIV within a broader health and social agenda would be useful. National HIV/AIDS strategies are limited in terms of addressing the broader issues and needs of the vulnerable population.

Broad based peer education can provide support to vulnerable populations in all aspects of life, not just HIV.

There is a missing link between identifying vulnerable populations in country from a regional level and facilitating action on a national level to address those needs. There is a debate concerning the definition of vulnerable groups particularly with reference to sub populations of young people. This is more relevant to the high prevalence of STIs among young people- should we focus on these subpopulations or the general population as vulnerable, as young people account for 50-60% of the population in some countries.

The PRISP receives reports from regional agencies but only those identified in the Implementation Plan. This may not be adequate because reports are only being received from a limited number of agencies as referred to in the PRISP. SPC receives reports from donors they collaborate with— ADB, AusAID and Global Fund— but would have to seek out reports from other agencies. There is no system in place for formally receiving reports from all agencies.

Each agency reports directly to the Regional Office. National governments may not be aware of what is happening because of this direct external line of reporting. However, a single national framework for conducting peer education would facilitate all reporting regarding peer education and to submit to that framework and coordination mechanism that is put in place in countries.

However no peer education strategy exists at a national level therefore there is no national coordination of reporting. There is a need to get the National HIV/AIDS strategies as multi-sectoral as possible but limited resourcing is an issue.

It is difficult to determine where this Peer Education framework should be positioned- it depends on the target populations, available government resources and government departments. PE for HIV should be set within the context of human development.

It is important to define short and long term goals:

- Short term goals: developing an identified peer group, developing their capacity and ability to develop strategies and interventions.
- Long term goals: building up the education sector to conduct formalised education and legislative change to support vulnerable communities.

Need to research how current legislation can be modified to account for human rights. Parallel to legislation change is the education/awareness raising necessary for police and judiciary.

Program Development Officer HIV & STI Section, Suva

Peer education as a HIV prevention strategy was first introduced to the Pacific around the period of 1998–2000 when an intensive 3 week peer education course, funded by AusAID and delivered by AFAO and the AIDS Task Force of Fiji, was conducted on behalf of the AIDS Task Force of Fiji. The course emphasized a one to one outreach model targeting sex workers, wheelbarrow boys, and patrons in nightclubs and provided high quality training with an emphasis on communication skills, record keeping and ethics. Rigid criteria were used to assess candidates and on-site training with strong follow up was provided. The outreach project focussed on the dissemination of information, condoms distribution and referrals to health services. The outreach workers provided this service in Suva for 2 years before presenting their program at the first Pacific Islands HIV/AIDS Conference organized by the HIV Section of the Secretariat of the Pacific Community.

After the conference, a number of other organizations were keen to adopt the concept of Peer Education, and it became incorporated for example into the ARH program (later to become the AHD program). Through the AHD, the original concept of peer education as a one to one contact through outreach has evolved and adapted according to resource and local constraints. Often a group of young people would be trained in a 3 day program, graduating as peer educators and then each posted to be part of health centres, incorporated into a health centre, with an expectation to present to groups on sexual and reproductive health including HIV. Often the PE were not supported with sufficient and appropriate training, and due to resource limitations, assumed more of a coordination role. Other peer educators would be trained for two-weeks and then expected to take on a number of roles according to the demands of the NGO, health services and local community. Often peer education seems to comprise young people who reach out to a number of different vulnerable populations but without recruiting that group to become PE themselves.

A significant issue is that many program managers do not understand the methodology of peer education, nor are aware of the intense support and monitoring it requires in order to maintain quality and ethical behaviour. PE is often managed like any other project, with the development of work plans, occasional refresher training and encouraged to deliver lectures en masse. PE should be considered a transitional state for young people as they progress on to further opportunities, but many organizations have transformed it into formalized, FTE jobs. Whilst there have been forums for PE to come together for networking, there should be more effort to bring managers together.

Many NGOs have wanted to adopt peer education without fully understanding the methodology. NGOs have employed select teams of PE to go out and outreach to others, but many of those

"educated" do not become PE themselves. Consequently PE now has become a means for organizations to work with a target group rather than engaging the target group as PE.

There are differing models of PE that are often in conflict- one to one, one to group- and therefore more flexibility is needed in order to compromise with the national and social context. Essentially, one should consider that there are two components to PE, individual and group based methodologies, but each is a phase leading from one to the other. Each country needs to decide which phase is appropriate as a starting base:

- The Cook Islands do engage in individual based PE but outreach to groups on request.
- In Tuvalu PE accompany the drama group, and essentially commence as group based but once the drama is complete and the audience disperses, there are opportunities for individual contact.
- In the Solomon Islands, there is strong institutional support and a large volume of volunteers.
- In Nauru, there is not an organised structured program. An original team of PE were trained under the Regional Capacity Building program of the AIDS Task Force of Fiji and two volunteers would attend for 5 week training in Suva back in 1999, 2000 and 2001. These volunteers would develop work plans before returning, and on return, organize a 2 week peer education training for other members of the peer education team and this training was facilitated by a staff of ATFF. Otherwise the individual trained at ATFF would have a community education type work plan where they would organize to do a presentation of HIV 101 to a group and this would again be co-facilitated by the ATFF staff. Feedbacks and mentoring was a pivotal part of this capacity building process. The Health Promotion Unit within the MoH now coordinates PE. A pool of PE derived from different organisations are available on request to outreach to communities and provide individual, group, event based interventions as well as distribute condoms. The team of PE do not belong to any particular agency. It is believed that the last PE training was organised in 2005 by UNICEF as part of life skills program.

M&E should be quite simple—it is primarily a matter of maintaining a diary and record of each contact, and number of contacts. It should be possible to validate any behaviour change with observation in small communities. Verbal reports, MSC stories are helpful, though they may not be representative of community change and should not be used as standalone tools.

It should be the responsibility of the project manager to set the criteria and expectations for reporting, whilst accounting for literacy levels.

High expectations are placed on PE after limited training. Financial remuneration is important, though some MoH have employed PE on a full-time basis as volunteers.

The National AIDS Coordinating Committees should be multi-sectoral coordinating systems for HIV but PE is just one of many strategies, therefore there is a need for advocacy on behalf of PE at that level- perhaps this could be a regional role to provide expertise to the NAC.

Attempts to establish a PE regional network have faltered, despite good intentions, but motivation wanes over time to maintain email contacts. Many partners "wear too many hats in the Pacific" and access to internet remains a challenge in some settings.

Dr Rufina Latu

Peer education was introduced into the Pacific as an interventional response to the ICPD Plan of Action which called on global efforts to address adolescent sexual and reproductive health. At that time PE was a relatively new approach to providing info/education, and therefore little

expertise was available to guide its development and considerable trial and error accompanied the process. The emergence of PE as a tool for reaching young people with information on sexual & reproductive health (ASRH) commenced in Fiji in 1999 as part of its ASRH program. Because of this historical association with ASRH, PE in the Pacific has been largely considered a strategy for young people without application to vulnerable populations of other age groups. The initial training for PE involved a 6 week training course- 2 weeks of content and 4 weeks attached to organisations for practical experience. Training was facilitated by health professionals and this engendered a health focus and consequently, it became attached to the MoH. In other countries PE has largely become incorporated into other NGOs.

A weakness of current Youth-PE programs is the lack of specificity in target peer groups for which PE is targeted at. It fails to understand that young people comprise a non-homogenous population and therefore PE needs to be finely targeted at discrete groups of young people at risk. Now that this phenomenon has become more documented and better understood, the Pacific Adolescent Health and Development (AHD) has initiated a process for reorienting its program to allow for better targeting based on levels of risk and vulnerability. However until now, work plans did not reflect this targeting and the AHD program applied PE to a generalised population. Although programs were aware of different risk groups, the importance of targeted intervention was not emphasized and hence there was a tendency to merge resources and time with general community education. There needed to be clear demarcation of populations with specific targeting.

PE can be very challenging to young people, particularly with respect to engaging vulnerable communities; therefore it becomes easier to focus on schools and mainstream youth. Sometimes Youth-PE has also been implemented to fulfil work plan objectives, but it fails to meet the real challenges of using it as a tool for behaviour change. Training programs have not sufficiently empowered young people to meet these challenges, nor is there sufficient capacity built to enable organisations to target specific vulnerable populations with clear objectives for behaviour change. Essentially, organisations need to address two youth populations concurrently- the general population whose safer behaviours need to be reinforced while minimising risk behaviours, and the minority at risk populations where behaviour change is the ultimate objective in order to achieve safer behaviours.

When planning targeted interventions, a concern often expressed is the possible stigmatisation for vulnerable groups with specific behaviours (e.g. MSM). As a result vulnerable groups are targeted as part of the general community to avoid possible stigmatisation. There is a need to avoid making assumptions about what particular populations and communities want, and instead ask vulnerable groups directly as to which approach they prefer. Often the fear of stigmatisation is used as an excuse against developing specific interventions for risk groups with specific behaviours.

There needs to be clarity amongst program managers as to what they want to promote, and the need to distinguish peer education from community education. The structure of the PE program itself and how it is part of the public health program (as in Fiji) and its systems of supervision and reporting will influence the activity of PE and the direction of their work towards a greater community education focus. There are great pressures placed on PE to take on community education over and above their expectations and the training they receive. Similarly it is important that recruitment and training clarify the distinction between PE and community education by articulating TOR, objectives, reporting frameworks.

There is also confusion between the role of the master trainer and PE. The intention was that master PE (trainers) were to establish networks of PE in individual communities. However this depends on the level of capacity building and supervision offered by the AHD coordinator and what is expected of the master PE. They need support, empowerment and direction.

Master PE should be responsible for supporting community networks of PE, however this is where the system becomes weak e.g. Fiji has a good deployment strategy for ensuring PE in each division, but the delivery is weak because of a lack of support, mentoring and ongoing supervision. A feasible option that is recently been considered is to develop community based PE based in each village/community where a select group of young people from this particular community are trained and supported to provide PE to their fellow peers. Such a model will still require ongoing support and monitoring to ensure that there is adequate contact time given for actual PE work. In such situations, a decrease in the standard and quality of PE is expected as we go further out to the community level. Each community should select a PE who demonstrates the requisite skills from within its community. Capacity needs to be developed at the community level to take ownership of PE; and there needs to be acknowledgement by elders and the community that this is a strategy that is owned by young people for young people. For community receptiveness, the concept of PE should be introduced gently by people of position and authority from government and NGOs.

SPC as an organisation is now venturing into a model of integrated community-based programming aimed at mobilising community participation and resources to develop and maintain programs that address the needs of people at the grassroots level. Communities are requested to prioritise their development issues, increasing their sense of ownership and control over community resources, and become partners in the process. Issues of HIV and STIs and other health priorities are included in other development needs such as food security, water and sanitation, and housing. This approach integrates all development issues of importance and calls on partner agencies to deliver their assistance in a holistic approach. In AHD, there has been a shift to take on a more holistic approach and to think outside the box of ASRH, and to incorporate other development challenges of youth, such as education, employment and livelihood skills. As a consequence of this integrated approach, there will be growing pressure on PE to become community educators and deliver programs that they have not been trained for.

Often M&E is considered towards the conclusion of a project, when in fact a framework is needed at the outset. There has been a tendency for large amounts of activity reporting, but this activity is not being translated into outputs and linked to outcomes. Activity reporting may be fulfilling the requirements of work plans but we know little about outputs and even less about outcomes. In the coming months, each AHD coordinator will be conducting a review of their PE program in respective countries using a SWOT analysis as part of their 2009 annual work plans.

PE coordinators understand the value and process of M&E but need more technical support to constantly apply the tools to gauge results. There is a need for precise statements about how PE as a strategy will contribute to the achievement of objectives at the output and outcome level. There is a need for both raw data and the indicators for change. Essentially, there are three parameters that coordinators report on as part of their monitoring reports:

- What activities are undertaken?
- What have the activities produced i.e. outputs?
- An example of MSC stories i.e. outcomes – to add a qualitative dimension to results achieved.

These three questions provide for a simple method of M&E that allows workers and managers to demonstrate how activities are contributing to the objectives.

In general, PE as part of the AHD program is a sound approach for reaching young people by peers in view of the population distribution patterns of PICTS. However, to be more effective and cost-efficient, PE programs need to be better planned, managed, coordinated and supported. PE has to specify the exact niche within the bigger program it supports. Current country specific Y-PE

programs need to undergo reviews in order to replan, reorient its focus and redefine its role in adding value to the AHD program. Mapping out risk groups and developing evidence-based intervention activities is a crucial undertaking to embark on in view of scarce resources versus needs for greater coverage. If PE is to make tangible and measurable results, clear M& E tools are needed to document results.

The spin-off benefit that deserves mentioning is related to the impact Y-PE has on the PEs themselves at individual level. Many young people who have gone through being a PE have testified how being part of PE program has changed and shaped the whole perspective of their lives—their educational goals, career path, relationships with family and friends, and more importantly their behaviour patterns. Many have also testified that they have helped many groups of peers to refocus on their education and guided them on the right path. It is these narrative stories of PEs that need to be documented as living evidence of the impact they have contributed towards helping their peers. On record, a number of PEs have moved onto take up more responsible jobs such as nursing, health promotion assistants, project assistants, etc.

Peer education has become an employment option for many school leavers in countries of high unemployment and limited tertiary education. PE training becomes a means of gaining additional education and provides an opportunity to become a part of something greater than themselves. In this way, the greatest benefit of peer education is to the PE themselves.

UNAIDS Pacific Program

There is no sharing of information and communication between agencies is lacking. There is a fear that there will be duplication and repetition of mistakes. A directory of peer education programs would be an important aid.

There is a monthly meeting with UNAIDS— and other UN organisations—and SPC.

The NAC could bring together all the organisations—government, church, NGO, donor agencies—however this may not be really happening now. They were established to foster a multi-sectoral approach, and whilst they may inform the UN, they often bypass national governments as there is no compulsion for reporting.

The reason why NACs may not have worked is that there is no accountability processes and the lack of UN agency advocacy involvement to 'make this right'. As well, the loss of a sense in urgency re HIV infection in the Pacific has diminished the priority of the NAC.

There is a need for standards to be set for the conduct of Peer Education to ensure that educators understand their roles and limitations. Training can often create high expectations amongst young people and an over confidence in their skills and knowledge. Work plans are developed by educators during workshops but there can be little follow up to build on their enthusiasm.

Reporting of program data is a serious concern as there is no accountability from the donor agency and National AIDS Council to report to governments and consequently information tends to be siloed with little horizontal sharing.

Is culture and religion being used as 'excuse barriers'? The use of cultural reasons as 'excuses', why you shouldn't get into the 'hard questions', and the 'hard stuff' is another reason why things are not working.

How to make it work—perhaps three things that could be asked:

1. What did you do when you returned?

2. What obstacles did you face?
3. How can you help?

This is a 'quick' monitoring and evaluation mechanism as a means to assist the action to actually be done. Monitoring of peer educators should include a review of what they accomplished according to their work plan.

What mechanisms exist for young people to express their needs, share views and report back their experiences? A mechanism to achieve this could be to work it into the Youth Parliament. What are the mechanism by which young people talk about governance and monitoring and evaluation?

Is peer education is happening really being delivered? How do you assess whether the quality of education that the peer educators are giving out is correct? It is important to monitor the quality of content being disseminated by the educators- there is a danger that some educators could be giving out false information when asked questions they are unsure of.

One of the criteria for assessment would be that their involvement in peer educator actually empowers them to move further into new career opportunities and enhances their capacity as future professionals, to 'move on to better things'.

People moving onto other opportunities e.g. a full time paid job with benefits is a positive rather than a negative. Perhaps another criterion for the effectiveness of a peer education project is this capacity to develop its educators e.g. '70% of people involved have moved into the sector in paid work'. This may be mostly about young people.

Wan Smolbag program is one of the success stories. It has been very successful at engaging and generating discussion within villages. This drama group has been recruited by various agencies to perform on particular issues. They also produce films. Wan Smolbag has successfully developed capacity amongst its workers. Positive people chatting with people always has a strong effect. Also talked about *Love Patrol*. There is a drop in centre as well.

One effective example of outreach to vulnerable groups was that of an MSM needs assessment developed and implemented in Fiji. Young MSM surveyors were trained to also act as educators in the course of conducting the assessment.

United Nations Children's Fund (UNICEF)

UNICEFs primary involvement in peer education has been through its Life skills Program (Pacific Stars). Though essentially a community education intervention, the program has integrated with the UNFPA-SPC sponsored AHD program which attempts to use a peer education methodology.

However, a number of concerns and issues were raised concerning the AHD program:

- There is uncertainty as to the extent of targeting of vulnerable populations. The AHD targets a very broad range of young people (up to 30 years) but this does not coincide with the UNICEF mandate. Many of the youth friendly centres developed by the AHD are accessed by people aged 20 to 30 years whereas the UNICEF age limit is 18 with a preference for 10 to 15 years. Whilst the AHD mandate is to target all youth, HIV interventions require more strategic implementation within those most at risk. This is a particular issue for UNICEF and the organisation is keen to advise on systems and approaches to better target the AHD. However, there are discrepancies in how young people are defined. The AHD is a generalised youth program, strongly influenced by UNFPA programming. The WHO defines youth as 10-19 years, UNFPA as 15-24 years, the

UNICEF up to 18 years, and many countries include persons up to 30 years. Often a person's inclusion into the youth category is dependent on their marital status.

- There is concern as to the level of monitoring within the AHD. Whilst there is monitoring of services themselves and the numbers of persons trained, there is little monitoring of who is being targeted by the interventions. A key measure is the ability of a peer education program to access those most at risk. Relevant indicators should report on proportions of PE who derive from vulnerable groups, whether interventions are adapted with respect to time and place to target particular vulnerable populations.
- A number of resources and manuals have been developed to address peer education training and delivery but their relevance and adaptability to vulnerable groups is highlighted. A need was identified for the review of peer education manuals and their adaptability to target and involve vulnerable populations. Training materials may need to be adapted to be inclusive of vulnerable populations, and to be used by them. This will require the involvement of those most at risk in reviewing the manuals and training themselves, and consider how the timing and location of training is appropriate to the needs of the vulnerable e.g. many target groups may not be available during the day or mornings and require more afternoon or evening programs.

UNICEF is keen to redirect the AHD program so that it can focus more on the most vulnerable populations through the adaptation of certain aspects of its training and capacity. To commence this process, an exercise will soon commence to map vulnerable populations in three countries: Vanuatu, Solomon Islands and Kiribati. UNICEF will be closely working with the AHD program in these countries to develop their capacity to target vulnerable groups.

Currently, a situation may exist where a number of peer educators are recruited and employed through MoH programs but may not be age appropriate.

It may be that many national governments have been resistant to engage with vulnerable populations for fear of lack of expertise or experience, preferring NGOs to manage this component. However, governments need to show leadership and assume a greater coordination role, even in areas where it may not have expertise. The MoH needs to be multi-sectoral in its approach to ensure that even the marginalised are included in its planning and delivery.

Currently, a number of AHD coordinators are positioned in the MoH in some countries or co-opted to those departments; where they serve an important coordinating role between government and NGOs. Therefore the AHD program has a significant role in helping to shape national policy and direction, and it is important that this is done with the best technical advice possible.

Many countries are still struggling to establish a national HIV monitoring framework. There is a need to increase the support for national governments to coordinate activity and planning, and to assume more responsibility for monitoring. The AHD can provide technical support to governments to develop better monitoring systems.

National HIV/AIDS strategies need to be reviewed in collaboration with regional partners, and there needs to be a stronger definition of who stakeholders are when consultation is undertaken.

United Nations Development Fund for Women (UNIFEM)

There is a need to look at the fundamentals of peer education. It was noted that in principle, the methodology is effective however often the very people who are involved in peer education are not good models for the education they are espousing. This occurs within the initiatives with women, equity and violence. It was noted that the people that become the 'peers' need their

ongoing support. Additionally, there needs to be some strategic planning, especially with respect to recruitment, for this to work.

Peer education is effective as long as there are some very good checks and balances. There needs to be strong consideration of accountability, to whom, and the level of support required by individuals themselves.

With respect to peer education itself it was noted that UNIFEM develops tools to support the agencies that are involved in gender equity and gender based violence initiatives. There is currently no other agency providing this service. It was highlighted that UNIFEM are about to develop a project in PNG to identify women who are most discriminated against; even within women's groups e.g. sex workers, women with HIV. There are particular subsets of women that are at high risk, vulnerable and require particular assistance and support. These are the sets of women the UNIFEM is specifically targeting.

When discussing particular countries, the following organisations working with women were highlighted:

- Fiji: The Fiji Women's Crisis Centre has been running a regional program for about 20 years. This specifically involves running programs to educate people about violence against women.
- Cook Islands: A men's organisation is working on violence against women.
- Samoa: Maposaga o aiga (crisis centre but not functioning as in Fiji) and a second group called the Victim Support Group is made up of ex policewomen.
- Tonga:-Three groups that are working on violence against women.
- Vanuatu: Vanuatu women's centre.

Any delivery of peer education among women should be matched with the UNIFEM efforts to reach women who are most marginalised and who are discriminated against within women's network's themselves. It was noted particular programs should target those women who are the most powerless:

- Women living with or affected by HIV
- Women who are living on the streets

United Nations Population Fund (UNFPA)

Peer education was considered an effective methodology to employ among the most vulnerable populations and was a preferred option as it was one of the few ways to reach these hidden groups.

Whilst acknowledging that any evaluation of peer education is difficult, it can nonetheless be undertaken and should be followed through. One outcome measure that could be used to assess effectiveness of a peer education initiative is to measure changes in health seeking behaviours of the peer target group i.e. has peer educator contact with the group increased the number of occasions of service accessed by the target population?

The broader assumption is that referral and access to health services should be an integral component of any HIV peer education program. An organisation undertaking peer education could enter into a collaborative relationship with a health organisation. Essentially the peer education conducted by a NGO could become an outreach service of the health service. This not only provides an expanded range of services to the target group, beyond peer education type awareness raising and health education, it also provides a means of support and mentoring for peer educators and a base out of which they can operate.

It was noted that UNFPA works in partnership with UNICEF to support the regional AHD Program implemented by SPC.

UNFPA has also supported some pilot projects on sex worker peer education in Chuuk State FSM, Fiji, Marshall Islands (with YTYIH), Vanuatu, Solomon Is and Kiribati. In Chuuk, Kiribati, Solomon Is and RMI, sex worker peer educators attended training workshops to gain knowledge and skills on HIV/STIs, promotion/distribution of condoms and the benefits of VCT. The sex work peer education initiatives have been a response to local need. UNFPA's involvement has been technical support and a small amount of funds to run some workshops. There has also been assistance to Chuuk, Kiribati, and the Marshall Islands with technical support re grant submissions in support of sex worker peer educator programs, extending the above pilot projects.

There is quite a range of HIV prevention activities that are termed *peer education* but perhaps are not truly peer led approaches. As the country AHD projects all have youth peer educators, sometimes these peer educators access other groups such as sex workers or MSM—many of whom are young themselves and may identify with the youth peer educators. There have also been other initiatives with vulnerable populations—e.g. sex workers—where the methodology has been 'peer education' but the label (either 'sex work' or 'peer education') has not been applied as this raises discrimination and confidentiality considerations. An example of this has been Wan Smolbag, Vanuatu. This organisation provides a general user friendly/youth friendly and non discriminatory clinic. They do not conduct formal activities directed specifically toward sex workers that are identified as such, but do work with sex workers in a discrete way to encourage confidential uptake of services.

Another country that UNFPA has been involved in embryonic peer education is Samoa. This has been with a gender based violence project, which in 2008 assisted with a situational analysis of sex work. This has not yet been finalised.

The methodology adopted by Wan Smolbag may be the most effective given the context of culture. Identifying and targeting different populations—sex workers, MSM—is difficult and can be harmful in small island countries where confidentiality is difficult to maintain. As well, there is not a large pool of these groups from which to draw and train peer educators. Perhaps using "generic" peer educators from the pool of young people is the most effective means in these situations. The youth peer educators have sufficient training and skill to conduct community based outreach to people at most risk. This may not be true peer education however this may be the only way it can work in these small communities. Being labelled as a 'sex worker' may not assist any health intervention as people may be engaged in sex work very casually and don't personally identify as sex workers. They just see themselves as 'young people'.

A recommendation is that the existing efforts and methods to access vulnerable population be further supported and expanded.

World Health Organisation (WHO)

Peer education cuts across a number of sectors, therefore there is a need to strengthen peer education by linking it with other programs. Refer to paper in Lancet re highly active HIV prevention programs. Peer education needs to be linked with other service delivery e.g. clinical, counselling, education to provide a combined package that addresses a range of related health needs for that target population e.g. reproductive health, STIs, condom use. The AHP is a good example of an integrated approach, combining counselling, clinical services and education into one package.

Peer education has tended to be a standalone program, narrowly focussed on one area of intervention.

There is a critical need for a strong M&E component, otherwise impacts cannot be measured and the investment of funds cannot be matched with outputs. There is a lack of clarity about the reporting systems used by individual programs and to whom and how they report.

There is a need to measure increases in knowledge, coverage of an intervention and changes in behaviour. At present, the coverage of interventions is thought to be limited and needs to be monitored carefully.

Strategies targeting SW and MSM are very lacking:

- Lack of data and assessment
- Lack of behavioural surveys that specifically address these groups
- Challenges that data collected can be used adversely to strengthen stigmatisation and discrimination.

Structural groups such as uniformed services, seafarers, taxi drivers are already organised as collectives and are therefore easier to access and work with. It is important that these vulnerable groups are differentiated from marginalised groups such as MSM and SW. There is also an issue as to whether hierarchical organisations such as military and police truly use or need a peer-based methodology.

There is no mechanism for general HIV/SRH agencies to come together. The ARHP employs focal points in a number of countries who come together regularly as part of forums but they only meet to discuss adolescent health. A general network for peer educators should be considered.

The WHO can assist with technical advice re targeted interventions and specific clinical service delivery to vulnerable high risk groups.

There is a need to carefully define sex workers more specifically according commercial, transactional or opportunistic as each type will require particular methodologies.

Before MSM can be identified as high risk in the Pacific, there is a need to assess the extent and nature of risks and whether the cultural context of male to male sexual activity is supportive enough to militate against that risk. Studies need to be conducted

This raises the issue of the Second Generation Surveillance program and its limitations. The assessment was not targeted at sex workers or MSM as there was concern within countries that results could contribute to their further stigmatisation. Sampling and methodology within small communities is a concern as they may not be sufficient to differentiate sub populations of risk. Nonetheless, these surveys are essential for establishing an M&E system.

Appendix Twelve

Individual country based organisation: Survey and interview responses in summary form

Cook Islands: Red Cross

Peer Education is personally defined as “peers educating peers”, “networking with friends”, “pyramid effect”, “youth educating youth”

2 FTE staff and 23 volunteers work in the outer islands, 2 FTE staff and 15 volunteers work in Rarotonga. The 2 FTE staff work far in excess of their allotted 40 hours.

The program targets the following groups: marginalised young people, young people attending school, those who are transgender e.g. Fa’afafine, Fakaleiti, and MSM. There is consideration for future projects targeting backpackers, seafarers and their partners.

The organisation works closely with the Te Tiare Association to outreach to transgender and MSM. The Association was founded a year ago and has agreed to work with the Youth Peer Program.

The Organisation offers the following peer education activities: direct one-on-one education in HIV & Sexual Health; group based education; education sessions; social support activities; advocacy on behalf of the target population; advocacy for peer education as an effective intervention measure; condom distribution by peers to peers; resource distribution, resource production e.g. posters, theatre/role play education, media production e.g. HIV music video, knowledge training (in HIV & sexual health) for peer education workers e.g. HIV 101, skill training for peer education workers, training for trainers of peer educators. In addition to this, the organisation co-facilitates with the MOH to deliver training in HIV 101 and condom distribution to the general community.

Five Alumni YPE train peer educators in facilitation skills. These are experienced trainers and former peer educators who as they grow older and move on professionally, continue to share their skills voluntarily.

The Youth Peer Education Program (Red Cross) targets young people aged 15-30 years and seeks to help educate young people and increase their awareness of HIV/AIDS and STIs through active participation by youth to increase their sense of ownership. The Coordinators also work with the mental health area.

Monitoring and evaluation of each education session is principally through written pre and post test evaluations of knowledge and “blind fold” surveys. Each activity is recorded and reported on. Each PE maintains a diary of all consultations, which are submitted to the Coordinators on a monthly basis. The diaries are reviewed, and feedback is provided when interesting issues arise. A monthly newsletter is circulated throughout a wide network, highlighting particular successful activities and profiling YPE. The Coordinators compile quarterly reports for the Red Cross and other donor agencies but these do not go to the government. Funding is issued on a quarterly basis on submission of a report.

Success is measured with respect to completion of tasks indicated in the Work Plan. Indicators measured are the numbers of people reached and the changes in pre and post test knowledge.

The Coordinators report that the project is doing well. Measurement of this success is determined by the public attention attracted through the media, the credibility it has established in the community. The credibility of Red Cross provides great support for the program.

Contact is established with the target group through particular gate keepers- youth leaders, church leaders and school principals.

PE are recruited through word of mouth, advertisements in the local media, emails distributed through friend networks and posters. Interested persons apply through the Red Cross and select the particular area they wish to work in.

The Program officers (all young people) decide the type of programs delivered based on the availability of volunteers. YPE advise on the format and content, the alumni educators provide guidance but the Program Officers have the final say. Young people are involved in project design through the YPE. The pre and post test evaluations provide input from the target population in a limited way.

Through the project, the Program Coordinators have learnt that for many of the inactive youth on the islands, recreational activities, particularly sport, is important to maintain interest. In order to keep the HIV message fresh, the coordinators have organised competitions and launches to retain youth involvement. Art and poster competitions with prizes are particularly useful.

It is important to take note of language and ensure that it is directed at the level of young people, particularly accounting for local dialect. It is important to avoid terminology and keep the language at a simple level. Youth should be talked with, not at and they should be included in discussions. It is important to listen to their ideas. The use of animation can greatly assist.

Aspects of the project that have worked well have been the geographical reach of the information provided through the HIV 101 course to many of the outer islands through natural peer networks. The level of community support for the program has been strong as evidenced by community opposition to criticism from the Religious Advisory Council.

Aspects that have not worked well include cooperation with the Religious Advisory Council and their disagreements with the distribution of condoms. However, new links are being forged by potential collaboration in areas of abstinence promotion.

Resources that have been produced by YPE include posters, T shirts, and some pamphlets (though these need to be reviewed by the MOH to ensure consistency of content)

The project collaborates with other NGOs i.e. PIAF for condom distribution whilst the MOH provides training in planning and project management.

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

The coordinators believe that there is strong support for peer education by the sponsoring organisation, Red Cross, and the MOH. In fact the MOH has developed a close relationship with the program and relies upon it for condom distribution and community education.

Staff and volunteers have received two training sessions in peer education since June 08, but no other external training.

The following education and training skills were highlighted as important for an effective YPE:

- Communication skills- both oral and written;
- Empathy with the context of teaching;
- Commitment.

However the YPE are volunteers and therefore it is expected that their commitment will be fluid.

Other vulnerable populations identified in need of education include:

- Young people in the Northern Islands who are geographically isolated and make up a high proportion of the population
- Backpackers, Seafarers and fishermen- they have been identified as potentially vulnerable but no program at present.

There are plans to target these populations.

The amount and level of training received by the Coordinators and YPE was considered adequate, though at times it could be a bit too technical. All YPE have a sound understanding of the theory of peer education. A code of conduct is clear about the behaviour of YPE during their work and it is emphasized that volunteers shouldn't answer a question they don't know.

Coordination gaps were identified in so far as there was no coordinating committee of NGO across the islands. The NAC represents the views and needs of YPE to the government. There was also a lack of support from the Religious Advisory Council. The NAC filters any HIV proposals before they proceed on for further funding so this allows for a level of coordination. One youth member and one representative of PIAF sit on the committee.

The greatest need identified is human resources- for the two project coordinators, the demands of funding and reporting schedules has meant that 12 months of intended work must be compressed into 6 months before funding ends. There is a compartmentalisation of funding created by different donors contributing varying funds over the life of the one project but all requiring different reporting schedules.

Federated States of Micronesia: Foundation of the Peoples of the South Pacific – International

Strategies as delivered in Chuuk, FSM, was until recently, strongly based on peer education principles with Peer educators themselves actually involved in pre and post

test counselling. However in the last year the mobility of the population has led to a very high turnover and a subsequent loss of these trained PE. This was considered a significant challenge- that much of the effective work carried out falters because of the great migration of people out of Chuuk. Much of the education work in Chuuk has been confined to HIV 101 and this should broaden out to include sexual and reproductive health.

The Youth Resource Centre on Chuuk is involved in peer education training for sex workers and some MSM.

Peer Education as delivered in Pohnpei is through the Red Cross and AHD program. It was noted that there may be a lack of coordination between the two programs, and generally it was observed that there was a lack of national coordination. The collaborative links between government and NGO in FSM was considered weak.

Federated States of Micronesia: Ministry of Health

Adolescent Health & Development (AHD) program, commenced in 2004 specifically to address SRH issues, employs 1 FTE staff and 9 volunteers. A personal definition of peer education provided by the coordinator is "Youth to youth approach on education, counselling, planning and implementation activities. Youth participation 75% of the organisation's activity is geared towards peer education with a team of 9 PE. The program targets the following groups: Marginalized young people, Young people attending school, women, sex workers, Police personnel, Victims of rape and sexual coercion, Migrants and displaced persons, People living in rural / remote communities, Partners of seafarers. However commercial sex workers are regarded as a hidden group and outreach to school drop outs is currently minimal.

Peer education activities include: Direct one-on-one education, Group based education, education sessions (e.g. in schools), telephone information service staffed by peers, Advocacy on behalf of the target population, Advocacy for peer education, condom and resource distribution, theatre/role play education and media production, knowledge and skill training for PE, training for trainers. In addition, the project seeks to develop negotiation skills for girls who drop out of school e.g. sewing, cooking. The project is also involved in fund generating activities within Multipurpose Youth centre and in the community. Education and clinical services are integrated as part of a monthly mobile clinic.

Training of sex workers as part of a PE workshop is scheduled for this month. Previously 9 sex workers have been trained but currently two have been trained to outreach to other sex workers.

Research conducted in 2006 demonstrated that most young people were aware of the AHD program. 50% were interviewed through the clinic and an increase in condom use was identified. Measurements of teenage pregnancy rates show a drop in 2008.

The organisation is included in the National HIV/AIDS Strategy but it is not part of any formal network of HIV agencies. The Program does not feel there is sufficient support from the College of Micronesia and Red Cross, and that there is not a collaborative network in place.

The program refers young people to school Clinics for STI/HIV screening, and further to the Public Health STI/HIV clinic. Referrals are followed up through the pathology results received from the Hospital which allows the treatment regimen to be continued in school clinics.

The interviewee reported that they did not feel they had support for their involvement in peer education. The Ministry of Health was aware of the program's peer education activities. PE had received training both within the organisation and externally in the past 12 months.
The following topics were identified as important skills and training needs for PE:

- Adolescent Health refresher training course
- Well trained life skills and livelihood skills
- HIV/AIDS refresher trainings and updates
- Substance Abuse and Tobacco training
- Sexual Violence and suicidal training
- Grant writing training
- Monitoring & evaluation training
- Motivated and active involvement in youth planning and organizing meetings and workshops.

Gaps were identified in education and training for PE such as the decreased opportunity to receive in-country and abroad education and training due to limited communication and funding available for peer educators. It was also acknowledged that there were insufficient knowledge and skills practices within the peer education program to appropriately target vulnerable populations.

Peer education was considered a new concept introduced in the Department of Health Services and consequently had not yet been recognized by the Health Department. It was identified that there was less support for peer education from Public Health Programs as well as the Pohnpei State Government.

The interviewee stressed a lack of communication between peer education programs in FSM, and very little collaborative work with Public Health programs. There is a strong need for a uniform and collaborative network with standardised guidelines. Currently agencies meet once or twice a year but with no uniform plans for collaboration.

Federated States of Micronesia: Chuuk State

Three FTE staff and 3 voluntary PE are employed at the Youth Development & Health Resource Centre, commenced in 2007. 75% of the project's activities are based in peer education. The primary target of project is young people defined as 11 to 35 years, but a range of other vulnerable groups are serviced- sex workers, MSM, victims of rape and sexual coercion, seafarers, those with traditional tattoos, out of school youth, police, and young woman. PE conduct outreach to the youth populations whilst the centre integrates HIV/STI screening, counselling, as well as RH and Reproductive services as part of its operation.

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

Peer activities include:

- Direct one to one education
- Group based education
- Education in schools
- Telephone information line
- Social support
- Advocacy
- Condom and resource distribution
- Resource production of IEC materials
- Knowledge and skill training
- Train the trainer.

Plans are underway to develop theatre and role play education. As well, outreach is conducted to provide short education sessions to young people prior to sports events or at youth groups.

Monitoring and evaluation is primarily undertaken through the use of questionnaires and MSC stories. These are applied before the commencement of a program to establish a baseline. Pre and post session surveys are uses to test for knowledge. Peer educators are trained in M&E, and collect data on their activities. Demographic data is also collected through the youth centre. The youth centre combines its education services with clinical and family planning delivery. It houses a wide range of IEC materials, video and computer services (no internet access as yet). As well the centre operates a room for clinical screening and sexual assault.

The centre is accessed by large numbers of youth as there are very few facilities available in Chuuk. Success of the program has been demonstrated by the prominent feature of the centre in MSC stories. Young people interviewed have referred to their previous at risk behaviours and have identified a change. Peer educators have also been successful in referring people for STI screening and have been sufficiently trained to identify symptoms. Whilst it may be possible to follow up some referrals on Chuuk, generally such follow up is difficult because of the wide geographic spread and isolation of many of the communities.

Contact is established through outreach, and services to the outer islands are to commence this year but will only be able to occur once per year pending funding.

Target groups are involved in the design and implementation of programs.

A key finding of the project has been the greater level of outreach required to address the scattered populations and the importance of communication and listening to youth.

A particular success of the program has been both the outreach service and Youth centre which is considered to have worked well. The centre operates from Monday to Saturday, is accessed by large number of young people, even visiting from other islands, Youth groups have become very involved in sports activities.

A highlighted weakness has been the inability of the budget to keep pace with the work plan and its activities, and consequently a number of strategies are left undone.

The organisation is not linked to the National or state HIV/AIDS Plan as the 5 year strategic plan was completed before the centre and PE program developed, therefore there has been no budgeting for the centre. The centre is part of a local HIV and peer education network, but communication is difficult without internet access. The centre works closely with the Chuuk Women's' Council, the only NGO on Chuuk, the Red Cross and the AHD program which operates a school based clinic.

The centre receives support from the Chuuk state government and partners with it for assistance with outreach and resources.

In 2008, 25 new PE were trained with refresher training provided. The Red Cross has assisted with external training.

A significant gap in the targeting of vulnerable communities has been the youth populations on the outer islands who until now, have not been accessed due to a lack of resources and transportation issues. Indeed the project has only accessed 5 of the 30 islands.

A significant training issue is the inadequacy of one-off education sessions and importance of sustained, consistent messaging. The scattered populations of FSM however results in many communities only receiving annual education with insufficient time for follow up.

Communication is a significant problem with CB radio providing one of the few channels. A government radio station is inconsistent with operations. These barriers can make it difficult to collaborate with other educators.

The interviewees stressed the importance for maintaining this program. PE reporting skills were also highlighted for improvement, as delays in reporting to the SPC have caused delays in funding. Peer educators will continue their services despite the late arrival of funding; however it is critical that funding be maintained given the importance of the youth centre as the only healthy social outlet for young people in the community.

Federated States of Micronesia: Red Cross

The Red Cross currently operates HIV peer education initiatives in two of the states of the Federated States of Micronesia (FSM), Pohnpei and Kosrae. These target young people aged 15 – 24. The main aim of this project is to "increase awareness in HIV / AIDS".

The project originated from the Ministry of Health and the Ministry of Education and funding was secured from AusAID through the Pacific Regional HIV Partnership (PRHP).

There are four paid staff in Pohnpei and one in Kosrae. In total there are approximately 42 current volunteers. In Pohnpei, the peer education initiatives began in 1998 and in Kosrae these began in 2003. Two staff members work in peer education full time – one in Pohnpei and one in Kosrae.

Although the organisation was not formed specifically for peer education, this type of work is central to the ongoing work of the Red Cross in FSM. There is however, no documented definition of what peer education is. This is derived from secondary documents such as codes of conduct, confidentiality forms and position descriptions. The personal definition of peer education offered by those interviewed was of "same age to same age; same profession to same profession".

The main target population for the Red Cross' HIV peer education initiatives are young people. This includes both those who are marginalized (e.g. those who have dropped out of school) and those who are in school. Other vulnerable populations access these initiatives incidentally. These include, women, those who are transgender, those in the hospitality industries, and those in remote areas.

The range of activities that the Red Cross undertakes in peer education with young people is wide and includes:

- Direct one-on-one education in HIV and Sexual Health by peers
- Group based education by peers
- Education sessions (e.g. in schools) by peers
- Social support activities for peers (e.g. car washes)
- Advocacy on behalf of the target population
- Advocacy for peer education as an effective intervention measure
- Condom distribution by peers to peers
- Resource distribution by peers to peers
- Knowledge training (in HIV & sexual health) for peer education workers
- Skill training (e.g., in communication) for peer education workers
- Training for trainers of peer educators
- Assist with other training

The project is continually monitored and feedback is used to update the initiatives undertaken in this project. The specifics of this monitoring were not discussed in detail however the use of pre and post questionnaires and follow up visits to villages were two of the mechanisms raised.

Evaluation of the effectiveness of the project was not discussed. However, a measure that was raised was the continued mention of the project in UN (and similar) reports. Generally, those interviewed were very happy with how the project was going.

Peer educators are recruited mostly through word of mouth.

Members of the target population are not involved in the design and delivery of the project as the project activities are already set. Nor are they involved in the management or governance of the project.

A tip for other projects is the effective use of prior contact with schools and organisations where peer educators are going to visit. It is noted that this greatly 'smooths the waters' and allows more access.

An example of things that are working well was the recently revised reporting and funding route. Rather than going through the Australian Red Cross and then to SPC, FSM Red Cross now communicates directly with SPC. This was seen by those interviewed as of great benefit.

Collaboration is a key to the success of HIV peer education initiatives in FSM. As well as belonging to a regional HIV network – PIAF – the FSM Red Cross also networks with other Red Cross organisations conducting HIV peer education. Within the states of FSM there is also a collaborative framework. Those interviewed indicated that the Red Cross currently does not work in all the states of FSM, or with all vulnerable populations, as they wish to work collaboratively with other organisations undertaking similar work and source what is happening and then fill the gaps.

Those interviewed did think that the work they were undertaking in HIV peer education was supported by their own organisation and by government agencies.

While the Red Cross does make referrals for those it targets – primarily to the Ministry of Health for testing and counselling – it does not follow up those referrals to see if they were used or if the quality of the service was appropriate according to those being referred.

When discussing gaps in peer education, the lack of activity and resourcing in outer islands was mentioned.

Kiribati: Adolescent Health and Development Program

The AHD program targets young people aged 10 to 24 years but can be accessed by older clients seeking STI and HIV testing.

Peer education is conducted through training young people to be PE and work with the program in conducting promotional and awareness programs. These PE travel to communities to deliver awareness activities, training workshops for youth including life skills, advocacy seminars for decision makers, parents and elders, training of trainers and even radio programs.

1 AHD Coordinator and 11 PE are employed of which 4 are paid while the remainder are paid incentives of $20/day. 1 PH nurse is employed by the Ministry. The project primarily targets high risk youth. The peer educators are aged 20–26 years but see people over a wide range. The National Peer Education Committee conducted a mapping exercise of high risk communities to identify areas of high risk. The program is consequently targeting those communities. In addition, workshops have been held for sex workers over the last 2 years but sex worker outreach is now being managed by another NGO, KANGO. As a result, AHD program has refocussed on youth.

An M&E system was instituted in 2008. Programs were delivered to particular islands, and after 6 months, PE returned to those islands to conduct focus groups for parents,

elders and young people. Questionnaires were circulated and members of the three groups were interviewed to determine whether they had seen changes in particular individuals.

It is believed that the project has made a difference, evidenced by some changes seen in behaviour e.g. decrease in drinking, but such change has been slow. As well, numbers of persons accessing clinical services following an education session has been measured, with some increase identified.

Contact is made through the community leader, with whom the project is discussed. Youth are called together to discuss potential strategies. Young people are recruited from the community to become PE. Once trained, PE outreach to distribute condoms and provide one to one information. However, many more communities need to be outreached.

Peer educators decide on the activities to be implemented. A needs assessment of young people identified that males wanted more income generating activities and trade skills, whilst females were seeking increased domestic skills such as sewing and cooking. This demonstrated a strong desire by young people for practical skills.

The perception is that education seems to have had a real impact on some behaviour. Good collaboration has evolved with NGOs, the government and some churches. NGOs used to plan and conduct programs separately, but now there is a coordinated approach. PE is conducted jointly with other agencies, and use is made of facilitators and speakers from other NGOs. The AHD program is part of the Kiribati HIV Task Force and receives good support from sponsoring agencies and some support from government, though more funding is necessary.

The program conducts VCT itself, collecting the blood and sending it off for testing. Results return to the program so there is follow up of young people.

Every year, 1-2 PE training workshops are conducted, but there is a need to constantly retrain because of attrition. The program conducts training for other NGOs. Some PE have received training from the SPC previously in 2004 but more recently, other NGOs will incite representatives of the AHD to participate in their training.

More work needs to be undertaken to assess and identify vulnerable groups. More funding, and better qualified trainers are needed. Coordination between NGOs can be improved at times and the need for more youth friendly services was highlighted. Peer educators have a need for greater refresher training and for more opportunities to come together with other NGOs.

Collaboration between NGOs is improving. However, PE is not fully recognised by the Government, nor on its own agenda as it is directly funded by the SPC. Consequently there is no supplementary funding from the government.

Peer educators meet on a monthly basis which provides opportunities for issues of misbehaviour to be discussed. If problems persist, peer educators are seen individually.

Kiribati: Red Cross

Red Cross office employs 2 paid FTE and 1 HIV officer which commenced funding in October. 21 active PE are engaged with more available as needed.

The organisation commenced in 1979. Currently there are no formal documents e.g. constitution, volunteer policy, nor is there a formal definition of peer education. A constitution is currently under development.

The Secretary General commenced work in mid 2005, occupies both a paid and voluntary position and works approximately 40 hours per week.

A personal definition of peer education is “same age working with same age”, “one age group working together”.

The Project comprises of outreach to communities, hotels, bars on a monthly basis with condom distribution and drama productions. They also outreach to sporting events, secondary schools and work with youth groups to train up youth leaders within those groups who can then network into schools. Peer educators are provided $10 remuneration for their outreach. The peer educators are also active as first aid trainers.

The project targets marginalised youth, young people in schools (primary, secondary & tertiary), seafarers and their partners, fishing trainees, sex workers, police, transgender and MSM.. The project is currently considering targeting antenatal mothers. Injecting Drug use levels are unknown to date.

There are a high number of sex workers working the visiting ships and there is a discrete association of sex workers operating on the islands. The last Peer Education workshop conducted in October 2008 successfully invited sex workers to attend and be trained as PE. The Project is planning to repeat this exercise.

About 10 of the PE are members of the MSM and Fa’afafine community and outreach to their peers.

Monthly meetings are held for the review of activities of PE with the HIV officer. Participation in those meetings is remunerated at $10, and transport and meals are provided. Sex workers participate in these meetings.

Activities undertaken by peers as part of this project include: one to one education, group education, education sessions, social support, advocacy, drama productions, media presentations such as radio shows, condom distribution, resource distribution, content knowledge and skill training for PE, experts from the Family Health Association and KANGO provide technical training to PE re communication skills.

The drama group comprises of young people aged 18 to 28 years, mostly unemployed who outreach to communities. They request approval from the community leaders before presenting. Unfortunately outreach has been restricted to monthly episodes because of funding constraints. Integrating HIV with other peer education sessions e.g. first aid or other Red Cross programs are methods of circumventing the funding shortfall.

The target of the HIV Program is young people—marginalised, in school, church groups and community.

The aim of the project is to reduce HIV infection and reduce discrimination against PLWHA. There are about 40 diagnoses and 20 have passed away. Only 2 have come out about their status.

Monitoring and evaluation is considered one of the more difficult challenges due to the geographic spread, the number of PE, limited supervisory staff and lack of evaluation tools. Currently PE are asked to complete an activity form and report back to the HIV coordinator. The program is trying to encourage PE to conduct more one to one interventions than with general groups. In this way activity reports can be completed for individuals who can be followed up. Nonetheless forms are not very well completed due to literacy issues. Consequently, the monthly meetings are important as they allow PE to come together and tell their stories. But evaluation to date has comprised simple "head counting" of participants. There are no pre and post test evaluations of changes in knowledge, behaviours or attitudes, particularly after drama presentations. Therefore there is an urgent need to devise a suitable monitoring tool that can engender greater accountability of PE. There is a need to evaluate responses from the community, to better monitor PE activities and to collect information from the community.

Whilst the project can't measure whether it has been successful, there is an acknowledgement that greater awareness has been generated through the project. This has been identified through informal discussion with community members.

It is believed that the project contacted 3-4000 people in 2008. There is an intention to expand the PE project to the outer islands with the establishment of new Red Cross branches. It is hoped to double the numbers reach in 2009.

In order to establish contact, PE outreach to public bars, and make use of the family and social networks. Condoms are distributed through these contacts. Community education is arranged through contact with village leaders a few days prior.

Recruitment of PE is through other PE linking into their social networks. Training workshops are constrained by funding to two per year, but an additional one has been conducted due to the great demand from many young people wishing to be trained. Approximately 10-20 people are trained. The offer of financial remuneration does assist in attracting recruits.

The PE themselves decide what activities should take place. Language and literacy can make it difficult for young people to be involved in project design but Drama has provided opportunities for some input. Nonetheless any drama content needs to be checked with the HIV task force for accuracy.

With respect to the needs of young people, the most urgent are to increase awareness, to increase their sense of trust in the confidentiality of clinical services, to reduce embarrassment concerning STI testing and VCT, and to increase their sense of security and confidence in the Red Cross Project. The most important needs of the target group are to make them feel secure by stressing the confidentiality in peer interactions. There is a critical need to make the person feel comfortable and safe.

It has been hard to monitor the behaviour of PE during outreach and incidents can occur from time to time. It is important to stress the code of conduct at regular intervals, reminding PE of their commitment and public reputation. At times, meetings with the PE have involved members of the Board to emphasize with PE their code of conduct.

What has worked well has been the effectiveness of the outreach of information across the community. The deficiencies in the program has been the inability to measure the effectiveness of PE. Monitoring and evaluation has not worked well and the Program is trying harder to make PE accountable with an effective measuring tool. At present, there is an over reliance on trust.

There is a well organised network of NGO on the island involved in peer education- Family Health Association, KANGO and AHD. The network meets every month to discuss mission, vision and activities. The network coordinates activities and avoids overlapping programs by designating particular villages to particular NGOs. Each agency decides which islands will be covered and communicate with each other e.g., the outer islands will be allocated to the Red Cross following the establishment of branches there. HIV programs will be integrated with First Aid and other sessions due to limits in funding. All NGOs undertake youth peer education and pay their PE the same rate.

Referrals are made of young people to the hospital for testing. These referrals can be followed up by contacting the hospital to see if people followed up on the referral but in reality, few people go the testing. Consequently, the program relies heavily on drawing groups of young people to the blood bank and provide HIV testing through there.

Refresher training is provided to PE as required and is more flexible in its scheduling despite budget constraints. PE also attend external training offered by other partners in the network.

Elements of a good peer educator include:

- Ability to communicate messages appropriately
- Accurate knowledge;
- Good role modelling of behaviour (good moral conduct)

Vulnerable populations that are yet to be targeted include women in antenatal care (though KFHA may be targeting them already as they are better resourced with nursing staff). Outreach to PLWHA was also highlighted as it is a program not currently funded for and there was a greater need to encourage greater support and advocacy for them. Many PLWHA remain undiagnosed or living in isolation for fear of stigmatisation. Further to this, workplace policies and issues for PLWHA need to be looked at to ensure that persons are deprived of their livelihood.

No gaps could be identified in the training of PE as the current program appears to fulfil the aims of the project. There is an identified need for more refresher training.

One concern with respect to support and collaboration was the possibility of competition emerging among the partners of the peer education network the more resourced agency seeks to take on the role of lead agency.

Greatest needs identified were:

- More support for activities that were planned;
- More refresher training for current PE teams;
- More recruitment training for new PE
- Increased funding to allow for greater outreach to PLWHA
- Increased funding to allow more outreach to the outer islands, particularly with respect to PLWHA;
- Improved methods of monitoring and evaluation.

Kiribati: Family Health Association

Kiribati Family Health Association, founded in 1997, employs 5 FTE staff and 25 volunteers addresses HIV as a cross cutting issue under the IPPF Strategic Framework (5As- advocacy, access, abortion prevention, adolescents and HIV/AIDS). The organisation delivers peer education. The interviewee commented that there was no formal definition of Peer Education but it was something that was needed. A personal definition was "Capacity building of peer educators (youth volunteers of KFHA) with the sustainability knowledge and skills that will include STI's including HIV/AIDS to be able to share same information and skills to other youths for their safety. These peer educators are therefore expected to practice and live a life of what they are preaching."

About 20% of the organisation's activities are devoted to peer education, utilising the services of a Youth Officer and volunteer. The project targets:

- Marginalized young people
- Young people attending school
- Women
- People living in rural / remote communities
- Seafarers
- Partners of seafarers

MSM were recognised as very hard to identify, injecting drug users as nonexistent, and only two individuals with HIV have identified themselves.

The peer education carried out is through the Peer to Peer outreach by the Youth Peer Educators to reach out to other youths in the various communities which includes those in and out of schools.

Activities conducted include:

- Direct one-on-one education in HIV and Sexual Health by peers
- Group based education by peers
- Advocacy for peer education as an effective intervention measure
- Condom distribution by peers to peers
- Resource distribution by peers to peers
- Resource production by peers.
- Knowledge training (in HIV & sexual health) for peer education workers
- Skill training (e.g., in communication) for peer education workers
- Training for trainers of peer educators

The organisation is mentioned in the country's national HIV/sexual health strategy (though the interviewee states that no national strategies exist), is a member of the National HIV TASK FORCE, but it is not part of a peer education network. However it does collaborate with the MOH, Kiribati Institute of Technology invited as resources in the training conducted.

The KFHA is providing family planning and sexual and reproductive health services complimenting MOH health services and therefore does not need to refer to other services. There is support for peer education by the organisation and Ministry of Health. The KFHA has conducted a 'TOT" and leadership training for youth peer educators in 2008. External training has also been made available.

The following qualities were identified as integral for effective peer education:

- Moral and character training
- To know and understand themselves as human and sexual beings
- Capacity building in the area of human sexuality
- Capacity building on the STI's and HIV/AIDS and how these are transmitted and preventive measures that to be taken
- Sustainable Livelihood skills
- Negotiation and communication skills
- Training for Trainers
- Leadership training

Other vulnerable groups identified include sex workers. There had been no specific training for these groups but rather they are grouped with other community members.

Education or peer education is referring to a one-to-one sharing of information between a Youth Peer Educator and a Youth Client. Youth peer educators are only paid for their return bus fare and refreshment during their visits, which is equivalent to AUD10.00 a visit for each. The only peer education as we call it is the training that was conducted by KFHA to train peer educators on how to deliver information to others.

There was a feeling that there should there should be greater clarification on the general aim and purpose of peer education to engender a uniform understanding amongst those organizations utilizing this tool for community education.

The lack of known well trained peer educators and the outreach with information and condoms are confined to our own program only.

Marshall Islands: Youth to Youth in Health

Youth to Youth in Health (YTYIH), founded in 1986 to address SRH issues, employs 32 FTE staff and 50 volunteers. The interviewee identified a documented definition of peer education as "Peer to Peer Approach….in Marshallese our organization's name is Jodrikdrik nan Jodrikdrik ilo Ejmour (Youth to Youth in Health)" and a personal definition as "Sharing of information and skills amongst peers."

100% of the programs activities are devoted to PE, utilising the services of all staff. The following target groups were identified: Marginalized young people, Young people attending school, Women, Sex workers (commercial and transactional), Those who are

transgender e.g. Fa'afafine, Fakaleiti, Victims of rape and sexual coercion, People living in rural / remote communities, Seafarers, and Partners of seafarers. Additional groups were identified as: Young people affected by substance abuse, parliamentarians, parents, school officials and teachers, traditional leaders, taxi drivers, travellers, students going abroad for education, partner agencies and groups.

A full range of peer activities are conducted: Direct one-on-one education, Group based education, Education sessions (e.g. in schools), Telephone information service staffed by peers, Social support activities, Advocacy on behalf of the target population, Advocacy for peer education, Condom and resource distribution by peers to peers, Resource production, Theatre / role play education, Media production, Knowledge training, Skill training (e.g., in communication), Training for trainers of peer educators. In addition sports tournaments, youth field days, retreats, picnics, and alcohol free parties are conducted. A variety of videos, songs, stories, art, and music tapes have been produced.

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

The YTYIH program was established by a Marshallese woman named Darlene Keju-Johnson who worked for the Ministry of Health Adolescent Health at the time in 1986. In the 1980s the Ministry of Health was faced with the challenge of slowing down the birth rate and finding a solution to the rapidly growing population. Darlene saw that the Youth to Youth approach would work for the Marshall Islands. In 1989 YTYIH became a chartered NGO and Darlene continued her mission until she died in 1996. The program has remained the only youth program established in the Marshall Islands.

The passing of its Founder, Mrs. Darlene Keju-Johnson, embedded great sadness amongst YTYIH staff and PEs and it seemed the program also died with Darlene. However Darlene's husband, Mr. Giff Johnson, and devoted YTYIH Advisors and Peer Educators continued with their efforts and in 2006 hired a new Program Director (Julia M. Alfred). The program was revitalized and the trust of the community was regained and funding commenced. Positive feedback and success stories were routinely collected from program users and recorded and used. Program Managers wrote progress and activity reports and submitted to donors and supporters.

Success is measured by collating indicators such as Number of users by age, gender, residence, education status, employment status, clinical results, purpose of visit, number attended workshops/seminars/focus group meetings. Use is also made of "Most significant change" stories and
Pre and post test results.

The interviewee believes as the only chartered youth to youth program, the Marshall Islands has greatly benefited from its activities. Every summer another 50 YTYIH members are recruited so currently thousands of Marshallese citizens have a relationship with YTYIH since its establishment in 1986. Volunteers are peers of the of the target population.

It is estimated that more than 5,000 youths in schools and out of schools, parents, teachers, parliamentarians, community members, sex workers, seafarers, taxi drivers,

travellers were targeted in 2008. The program is primarily funded from regional donors (UNFPA, UNICEF, SPC, AusAID, and UNESCO), RMI government, private sector, and other international donors. Annually the program operates on approximately US$300,000, though insufficient given the increasing demand.

Contact is made through face to face and peer educators are generally recruited through peers, by parents, and using the media to advertise.

The Executive Director reviews all activity proposals and works with Program Managers to develop work plans. The Board of Directors regularly meet to be informed on progress, funding and policies.

After an activity, the participants are allowed time for feedback and recommendations. These are considered in the development of work plans and the program has a Project Coordinating Committee (stakeholders) who meet quarterly and at the end of the year to plan activities.

It was reported that there is still a great deal of myths and misinformation shared with young people. Access to RH/STI/HIV information and services is still very limited especially in the outer islands. One significant innovation is that YTYIH has recently opened its Ebeye Youth Centre (urban outer island) to increase access to RH/STI/HIV services and plans to expand and revitalize the outer island chapters.

This YTYIH in health one-stop-shop model is cited as an example of best practice. It reduces barriers that limit access to information and services for target audiences. It is a youth centre that provides recreational, library, computer lab, media, and tutorial services, art studio, as well as clinical services. The clinic is open Monday to Saturday from morning until 9:00 pm. It is the only clinic that provides evening and weekend RH services for the most vulnerable population groups, free of charge.

However, there are concerns. All the YTYIH staff members have been trained to become life skills trainers however, because of their youth they are subject to peer pressure and therefore don't always use their own skills to make good choices. A challenge for these young PE is their capacity to be able to model appropriate behaviour and to maintain their credibility as educators.

A significant lesson learnt is the primacy of confidentiality and trust. Consequently all YTYIH staff members must take an "oath". However as a youth organization managed and operated by young people who are still in their development stage, issues and challenges can occur with confidentiality.

The project has developed the following resources: TV shows, a movie, a book, brochure/booklets.

The organisation is included in the National HIV/AIDS Strategy, it is a part of the National AIDS Committee, and it partners with the SPC and AHD to form what it considers a peer network. The organisation collaborates with the MoH, MoE, general community and schools. The organisation refers target group members to the local hospital and clinic for testing, but is only able to follow-up those who access the clinic.

The interviewee believes that they have the support of the organisation and the MoH to be involved in peer education.

Training for PE was conducted in July/August 2008, through the 23rd Summer Youth Health Leadership Training Seminar and in November 2008 by officers of the SPC. In addition two AHD Peer Educator Trainers attended the Adolescent Reproductive and Sexual Health Workshop in Japan, a one-month course offered by JICA.

The following education and training skills were identified as critical for effective peer education:

- The Pacific Star Life skills training
- Puberty
  Reproductive health system and how it works
- Signs and symptoms of STIs and treatment
- Prevention of STI and HIV
- Contraception and available methods
- How to approach the different vulnerable groups.
- Referral and follow-up.

Vulnerable groups currently not being adequately targeted included: high school students, sex workers, trans-genders, seafarers/sailors, juveniles or young prisoners under the age of 25 years.

For the high school students, the Peer Educators' time in the school is limited by the school schedule and in some schools the information allowed to be presented is limited, especially in private schools. There was identified a need for training curriculum that can target some of the concerns of private schools (e.g. Catholic) concerning contraception and condoms. The SDA schools are considered the most difficult to work with. Peer education within church groups was considered a particular challenge. With respect to sex workers, condoms may not be accessible as some bars do not make them readily available. Some parents tell their children not to visit the youth health centre, therefore there needs to be a program for educating or motivating parents to assist their child.

The PE are seen as role models and people tend to forget that they are also young people with struggles and problems which places a lot of pressure on them when they make a mistake. The PE at YTYIH commenced their involvement as participants in YTYIH activities and were empowered to become PE. Working for YTYIH provides an environment where they can continue to develop their life skills, enabling them to cope with the problems of daily life.

There is still a lack of support from the government in terms of sharing of funds and resources. Government agencies are still very territorial and remain sceptical that an organization operated and manage by young people can be successful and produce results.

One integral component of peer education is an understanding of culture. Despite the level of training and education, PE will never gain the trust and respect of the community if they ignore their culture. There are a number of issues a young person must be aware of concerning their culture before outreaching into the community e.g. identifying the traditional leaders (landowners), the appropriate protocols and presentation of their

mission to the traditional leaders. They must know what acceptable attire is and what they should bring to them when they meet with traditional leaders.

Samoa: Samoa AIDS Foundation

The Samoa AIDS Foundation, founded in 2005 to specifically address HIV and sexual health issues, employs 10 FTE staff but no volunteers. It uses a peer based methodology.

A personal definition of peer education was "Peer education is a communication and capacity building tool where trained and motivated young people undertake formal and informal activities with their peers or other young people. The goal of which is to promote awareness, knowledge and develop attitudes and skills for young people to engage in healthy behaviour."

About 50% of all activities are devoted to peer education, utilising 4 paid staff work as Peer Educators. The program targets the following populations:

- Marginalized young people
- Young people attending school
- Personnel working in the hospitality industry
- Men who have sex with men (Gay, Bisexual and non-gay identified)
- People living in rural / remote communities
- Youth & General Public

The following activities are undertaken: direct one-on-one education, education sessions (e.g. in schools), condom and resource distribution, theatre / role play education, knowledge training (in HIV & sexual health) for peer education workers

One of the peer education projects undertaken is in the area of condom social marketing. The project has been operating for 3 years, targeting businesses and young people with the aim of promoting the use and availability of condoms to the community through a social marketing approach.

The project involves a number of strategies.

- Peer educators are trained on peer education and social marketing skills
- Peer educators outreach to interested outlets to market "Try Time" condoms
- Peer educators conduct briefings with business outlets on social marketing strategies
- Peer educators conduct village, church, in and out of school youths workshops on HIV/AIDS prevention
- Develop and disseminate IECs on sexual and reproductive Health, protection against STIs including HIV
- Introduce to hotels, motels etc as part of their hospitality services

This project was introduced by Marie Stopes International based in Fiji. It's a regional project conducted in Fiji, Samoa and Tuvalu and was favourably considered for Samoa as a capacity building project for local Peer Educators, developing their outreach skills and promoting one strategy of prevention of STIs, HIV and AIDS in Samoa.

This project is monitored with the Most Significant Changes stories as well as evaluations from the field (workshops/briefings). The following measures are used to demonstrate success for the project:

- Sale records of condoms
- Number of outreaches done
- Number of outlets selling condoms
- Number of workshops and trainings completed
- Stories of change

Respondents believe that the project has made a difference to Samoa's response to the AIDS epidemic by making condoms more available and visible in the community. Although cultural and religious taboos are a challenge in condom promotion, such projects are reported to boost the availability, awareness and access of communities to these prevention tools.

Six paid staff, peers of the target population, are directly involved in the project. There are no volunteers. The project has accessed approximately 2000 people. The project is funded by NZAID through Marie Stopes International at a cost of WST$30-40,000

Contact is made formally with the target population through workshops and informally through public outreach. Peer Educators are recruited through a formal advertising, selection (interviewing) and recruitment process.

Project activities are predominantly decided by the Donors in consultation with the Peer Educators. Members of the target population are involved in the design, implementation and evaluation of the project through monitoring and evaluation questionnaires and interviews requesting feedback on best approaches.

There is a reported demand for peer education services in the community especially among the urban population where the bulk of the population is located. The response to peer education activities is varied among age groups and geographical locations but general feedback indicates a need to make the service more available to both urban and rural settings.

The project has demonstrated the importance of approaching target groups at times appropriate to their needs, for example, approaching sex workers and out-of-school youths would be best conducted at night around nightclubs where they frequent.

Condom distribution to all hotels and motels in the urban area was considered a particular success and in need of repeating at a regular basis. It was considered important to expand the service out into the rural communities to include the growing hospitality industry in the beach fales, resorts, and bungalows.

However, the social marketing of condoms to the rural villages was not successful due to strong observance of cultural and religious codes of behaviour.

In the course of the project, it was learnt that peer education, especially in the field of HIV/AIDS, will come across cultural and religious challenges which can either hinder or greatly enhance the success of a project. Public discussions of HIV and modes of transmission will continue to be a sensitive issue but this should not be a barrier to

effective outreaching. Proper training and good communications skills with target populations will contribute to a successful campaign against HIV and AIDS.

Pamphlets, posters and banners have been developed as part of this project.

The organisation is mentioned in the country's national HIV strategy, is part of a formal national network in HIV (NGO Health Alliance, National AIDS Council) and is part of a local peer education networks comprising the Samoa Family Health Association's Peer Education and Samoa Red Cross Peer Education Programs. Peer education is conducted mainly in collaboration. Referrals are made to other clinical services but no follow-up is made. The project has the support of both the organisation and the Ministry of Heath.

Training has been conducted over the last 12 months and peer educators attended re-fresher training conducted by the Ministry of Women, Community & Social Development through its Division for Youth in partnership with the Samoa Family Health Association.

Peer Educators were selected during the recent Pacific Games held in Apia in 2007. These Peer Educators underwent intensive training by SPC trainers just before the Games in 2007. Re-fresher trainings have been conducted bi-annually since then to upgrade skills and knowledge on engaging their communities and in monitoring and evaluating their own programs. Therefore, there is confidence that SAF's Peer Educators have had ample training to carry out their work in the communities.

The following characteristics were highlighted as important for effective peer education.

- Adequate knowledge of the subject
- Systematic upgrade of knowledge and skills
- Training and facilitation skills
- Building communication skills
- Engaging communities and target groups
- Monitoring & evaluation skills
- Supervision and support in the field
- Report writing

Currently there is a noticeable but not yet identifiable group of sex workers in the country whose hidden existence (not apparent yet) poses challenges for peer education in reaching them. The public outreaches currently underway in public places around urban Apia is intended to reach some of these young people.

HIV and AIDS are concepts not only relevant to peer education training but also in project components of the Foundation. Peer Educators have a general understanding of concepts as well as appropriate translation of these concepts to the Samoan setting.

Gaps can be identified in funding opportunities for Peer Educators to continue the work that they do. Reaching often "hard to reach" communities is a challenge without proper logistics to achieve their set goals.

Peer Education is designed specifically for the requirements of each project. All other aspects of peer education including monitoring and evaluation are designed with specific donor and organisational purposes in mind. As a result, standardised data for peer

education in Samoa is yet to be realised due to this nature of project and organisational driven strategies.

There is a greater purpose served if there was standardised data collection and M&E tools used throughout service provision in the country. However, the different mandates of each organisations, target groups, organisational strengths, available resources etc do not allow for a comprehensive system to exist. As a result, gaps will always be present no matter how comprehensive the individual responses are.

One important aspect highlighted is the overlap in training and the lapse in relating funding to carry out the skills learned in these trainings. The underlying social, cultural, economic and demographic conditions do exist in Samoa, for an explosion of HIV/AIDS to occur, these conditions include a youthful population, high teenage pregnancy and STI rates, increase movements of people in, through and out of the region, slow economic growth and the consequential lack of employment opportunity.

Peer Education has a vital role to play in reaching these young people and engaging them in practices that improve their health and lifestyle conditions. SAF has already focussed on the Fa'afafine community, youth in sports and secondary and tertiary students in the past 3 years.

It is anticipated that successful programs will continue for in and out of school youths, sex workers, prisons, seafarers and police men and women for the next 3 years.

There is very little use for well trained peer educators if we don't provide the resources to facilitate the much needed programs and utilise these skills.

Samoa: Samoa Red Cross

Volunteer Management Officer
The Samoan Red Cross have recruited approximately 25 peer educators into their youth program which targets secondary school students. The program has entered the second phase of peer to peer recruitment. However the organisation is looking at expanding the program to embrace different levels of youth across the country. The educators work voluntarily but this has created difficulties for retention. The organisation is seeking further funding to provide some remuneration for its workers. The Program works closely with the Family Health Association and Samoan AIDS Foundation, in which all peer educators are trained through the same system. Despite this, each agency submits separate reports on its activities.

Health Coordinator
The Red Cross Centre employs 8 FTE staff and 20 regular volunteers who provide a range of educations services including HIV/AIDS. Whilst the interviewee was unaware of any written documentation concerning peer education or the program itself, her personal definition of peer education was:
"training people to go out and disseminate certain topics that pertain to peers"

Two FTE staff and the 20 volunteers are involved in the delivery of the HIV program. The main targets for the project include: marginalised young people, young people attending school, those who are transgender e.g. Fa'afafine, Fakaleiti (conducted by Red Cross

educators, not peers), people living in rural/remote communities, individuals living with HIV. Outreach to seafarers is only conducted informally by some educators through friendship networks.

Schools, workplaces and tech colleges are targeted. The Peer Educators used by Red Cross provide a range of training e.g. first aid, climate change and therefore are not confined to HIV. Activities undertaken by the workers include: direct one on one education, group based education, education sessions (e.g. in schools), social support activities, advocacy, condom distribution, resource distribution, theatre/role play education, knowledge training, skill training and training of trainers.

The target population are youth and the aim of the project is described as reducing the spread of HIV, STIs and unplanned pregnancies and to increase support for PLWHA. Main activities were identified as condom distribution and peer to peer counselling.

The PE work closely with educators from the Samoan AIDS Foundation and Family Health Association, and invite SAF educators to school activities. Red Cross PE receive allowances of AD $6.00 for each program they deliver and a number of programs are delivered each week.

Monitoring and evaluation was identified as a significant deficiency. PE maintain written records of their activities which are submitted to the volunteer coordinator but there is no way that the quality or accuracy of the content they deliver can be assessed as it is not possible for senior staff to be at present at all sessions. Pre and post intervention surveys assessing knowledge are used with each session.

These pre and post session surveys are the main tool for measuring the success of interventions, in addition to general feedback received from the community, and records maintained by the PE (though these cannot be validated)

It is difficult to measure the success of the project. The majority of persons utilised as PE are Red Cross volunteers and though other young people are recruited from various youth groups, it is difficult to retain these after they have received training.

Contact is made with young people at various sites where they frequent- bus depots, market places- for the purposes of condom distribution. Very little work is conducted at night. Other programs delivered through villages are organised through church letters. Letters of introduction are often used to gain access.

New PE are recruited during programs conducted in various communities. Whilst PE are involved in the planning and implementing of programs, the FTE staff make the final decision about which activities are undertaken.

One important need of the target population identified by the interviewee was that of consistency in delivery rather than relying on one off programs. It was emphasized that it is important to ensure appropriate targeting of peer with PE that are well educated and trained to deliver information.

The school programs were considered to have worked well, particularly with respect to the HIV ambassador being able to share their experiences re living with HIV. The supervised environment was also considered an advantage.

Weakness of the program is the difficulty to evaluate the quality of PE interventions and the information being delivered. Many PE have not yet completed school or have dropped out so there may be gaps in education. The need for more refresher courses was identified to address these potential gaps. It is also not possible to determine the full coverage of the PE program.

The organisation is referred to in the National HIV strategy, is part of a national network, the National AIDS Committee, and is part of the informal network of NGO involved in peer education.

The organisation refers members of the target group to the Samoan AIDS Foundation, Family Health Association and local hospital for VCT, though not many referrals are made. There is no method for following up on these referrals.

There is strong support by the Red Cross organisation for Peer Education, and the government has relied on the program to assist with its Second Generation Testing.

A couple of refresher training workshops have been conducted in the second half of 2008, covering topics such a life skills, first aid as well as HIV/AIDS. Other external sources of training on STI are offered to PE through the Ministry of Health and Ministry of Youth.

The key training and education skills identified as part of an effective PE are:

- Passion for the area
- Good understanding of the topic
- Adherence to a code of conduct.

A number of vulnerable populations were identified as not currently targeted by PE:

- Youth groups in villages
- School drop outs
- Other schools and the general teenage population.

There was uncertainty as to whether sex workers were a significant issue.

The significant gap identified in training was the need for more frequent refresher training of PE. It was difficult to identify any other needs for PE because of the absence of proper evaluation of PE activity. There was a stated need for more funding to support an increase in PE projects.

Samoa: Ministry of Women, Community & Social Development – Division for Youth (TALAVOU Program)

The Ministry of Women, Community & Social Development – Division for Youth (Samoa) employs 11 paid and 2 voluntary staff. Whilst the organisation was not started specifically to address HIV or sexual health issues, it plays a significant role in supporting other NGOs providing peer education in this area, in accordance with the output of the HIV/AIDS & STI component defined in the TALAVOU Program.

22 peer educators are involved; however program staff assist in the coordination and supervision of peer education activities rather than in their direct delivery.

The following populations are targets for the organisation's peer education initiatives:

- Marginalized young people
- Young people attending school
- People living in rural / remote communities
- General public e.g. during outreach activities and athletes during the SPG 07

The following peer education activities are conducted:

- Direct one-on-one education in HIV and sexual health by peers
- Advocacy for peer education as an effective intervention measure
- Knowledge training (in HIV & sexual health) for peer education workers
- Skill training (e.g., in communication) for peer education workers
- Training for trainers of peer educators

The Samoa National Peer Education program targets young people both in and out of school, unemployed, and employed persons aged 12–29 years of age. Commenced in 2006, the Samoa National Peer Education Program operates under Objective One of the TALAVOU Program, *to improve the self worth of Samoan youth through education and training and other capacity building measures.* Peer education aims at mobilizing young people through dissemination of information and peer consultation.

The peer education component of the TALAVOU Program supports the implementation of activities under the following output:

- Output 1.5 Increased awareness of reproductive health information by young people and enhance their capacity for responsible decision making through life skills training:
    - Media campaign – radio talk shows
    - Support for the work of Samoa Red Cross in the promotion of peer education in schools
    - Coordinate and facilitate capacity building training and refresher training for National Peer educators in partnership with Samoa Red Cross, Samoa Family Health Association, Samoa AIDS Foundation
    - Responsible for the coordination of Peer Education outreach and Safe campaign during the SPG 2007 i.e. conducted pre-campaign activities including HIV/AIDS & STIs outreach programs at vulnerable locations; organised and conducted peer education training with the technical assistance provided by SPC and refresher training on HIV/AIDS & STIs as preparation for the SPG 2007.
    - Participation of Peer educators in the implementation of the National Youth events such as the International Youth Day, National Youth Week and National Youth Parliament

The TALAVOU Program placed 3 peer educators at the Samoa AIDS Foundation who are now paid staff of the organisation. The peer educators were trained at various capacity building trainings conducted under the TALAVOU Program to strengthen their work in peer education.

The Peer Education program was included under the TALAVOU Program as part of the National Framework of Action for Youth Development. It was further strengthened with the technical assistance of the HIV section of SPC. Youth stakeholders have undertaken much of the work in HIV/AIDS & STIs; therefore the modality of peer education was included to mobilize young people in this work. This is now expanding to other social skills.

The program was initially monitored using questionnaires documenting feedback from peer educators. A plenary group reflection and evaluation was utilized at the end of the activities to reflect on achievements and map the way forward. This created a more supportive environment for peer educators. In 2008, a special sub-committee was endorsed by the Steering Committee of the TALAVOU Program to coordinate and monitor the implementation of Peer education programs; hence a close partnership has developed in terms of implementation with the Samoa Family Health Association, Samoa AIDS Foundation and the Samoa Red Cross. As a result, a National Peer Education refresher training was conducted where all existing peer educators participated with the understanding that each complimented the other's work.

The TALAVOU Program, under outputs 1.5 and 1.6 directly linked with the Peer education component, uses the following indicators to measure the success of the partnership with NGOs:

- **Indicator:** % of population aged 12-29 years with comprehensive correct knowledge of HIV/AIDS significantly increased from the baseline.
- **Baseline:** 14.3% of population aged 15-25 years with comprehensive correct knowledge of HIV/AIDS-STIs. (HIV Second-Generation Surveillance Report, 2005).
- **Target:** Focus districts & villages identified where there is a greatest concentration of vulnerable young people and existing youth services available.
- **Target:** Undertake analysis of existing services and support offered and published directory of services for young people.
- **Target:** At least one HIV/AIDS-STIs awareness campaign conducted in Samoa by end 2011.

In terms of information coverage and mobilizing young people, peer education was noted to be making a difference. This should be seen in the context of a lack of paid staff to conduct outreach and inaccessible services for some populations. However there is yet to be undertaken a thorough impact assessment of how much difference peer education has made to the lives of the target population.

There are no direct program staff specifically designated for the peer education program, however under the Ministry's structure, Objective One of the program, which includes the peer education, is the responsibility of the Social Services unit (3 staff members)

Paid staff are peers of the target population. Throughout 2008, it is estimated that 60% young people between the ages of 17–25 (1314) and 23–25 age category (773) were reached by the program.

Contact is made with the target population through direct face-to-face consultations. Peer educators are recruited through open invitations extended to Youth Directors of

different Church denominations and selected from amongst participants attending National events e.g. Youth Parliament.

Decisions concerning activities are made by the Program's sub-committee which meets to discuss activities with the input and feedback from peer educators. Members of the target population are involved in the project through feedback or evaluation sheets.

Despite the work of this program, it was acknowledged that more work was needed in the community with more innovative approaches. It was stressed that it was also important to utilize the existing opportunities and networks to disseminate information through leaders and decision makers.

It was noted that there was much strength in working with NGOs through a partnership model rather than competition among peer education programs. This partnership also allows the pooling of resources to support peer education through the provision of training and minimal remuneration for peer educators. Each partner NGO is responsible for different locations around the country but all seek to achieve planned targets. The TALAVOU Program strongly supports NGOs to conduct peer education with respect to capacity building, refresher training and networking. As yet a standard remuneration to compensate for time and commitment of peer educators is yet to be established.

However, many people have yet to understand the concept of peer education, though there is a gradual acknowledgement of its importance as an effective tool.

Important lessons learnt in the course of this program include:

- Working in partnership with NGOs and key Government Ministries to create supportive environments for peer educators.
- Inclusion of peer educators in the design, planning, implementation, monitoring and evaluation process.
- Ongoing capacity building in areas needed.
- Continuing the peer education work at the level of youth group, village and affiliated organisations.

The organisation is mentioned in the national HIV/sexual health strategy, is part of a formal national HIV network (National AIDS Coordinating Committee), and is a partner in the peer education network comprising the Samoa Family Health, Samoa Red Cross and Samoa AIDS Foundation.
The program is a collaborative effort of a number of NGOs i.e. Samoa Red Cross, Samoa Family Health Association, Samoa AIDS Foundation and Young Women Christian Association (YWCA), Adolescent Health Development Program (Samoa).

The program refers clients to the Ministry of Health for technical assistance and available social services e.g. contraceptives and condoms but there is no capacity for follow up of these referrals. There is strong support for peer education by both the organisation and Ministry of Health.

Training for staff and volunteers has been conducted in the last 12 months re HIV/AIDS & STIs and life skills training. One staff member attended the Regional Peer Education Manual consultation.

The following education and training skills were identified as significant for an effective peer educator:

- Introduction to peer education: roles/responsibilities, procedures, processes, accountability
- Life skills training- leadership skills, communication skills
- Facilitation skills training
- Basic information on sexual and reproductive health training
- Time management
- Simple report writing

Other vulnerable groups that are yet to be targeted include young offenders at rehabilitation centres and under probation and street vendors.

Education and training is currently regarded as ad-hoc given that training needs of peer educators are identified by each partner NGO. The focus of training for peer educators is in the area of HIV/AIDS, STIs, Sexual and Reproductive Health and life skills. The intention is to expand the peer education program to other social skills.

With reference to the partnership of existing peer education programs, there was a misunderstanding re expectation of roles and responsibilities of peer educators and what peer education programs can offer. Some partner NGOs expected peer educators to possess more technical knowledge concerning sexual and reproductive health. However the understanding that peer educators are trained not as technical experts but as channels of correct and relevant information is one that needs to be standardised.

There is yet to be formal recognition of the importance of peer education by various sectors. There are challenges in securing adequate resources to support and coordinate peer education work. The work of existing peer educators is voluntary and it is difficult to retain peer educators over time. There needs to be a collaborative effort in terms of implementation to avoid competition and duplication of activities and coverage in the community. In this respect, the TALAVOU Program within the National Framework of Action to Youth Development is currently coordinating training in support of the peer education program. However a more coordinated peer education program is imperative.

Solomon Islands: Planned Parenthood Association (SIPPA)

The Solomon Islands Planned Parenthood Association (SIPPA) employs 16 paid staff and 60 volunteers. The organisation was established in 1972 to specifically address sexual health issues. The organisation provides peer education services. The organisation provides peer education services and has a peer network called Community Based Educators and Distributors (CBED), which follows guidelines provided by International Planned Parenthood Federation (IPPF). It has specific programmes targeting peers especially in the area of sexual and reproductive health, based mainly on situation analysis or findings.

A personal definition of peer education provided by the interviewee was that it is an education tool allowing people from similar group ages, gender and society to educate each other.

Almost 90% of the program is devoted to peer education targeting youths. Approximately 8 staff and all of the 60 volunteers are involved in the project. The organisation targets the

following: marginalized young people; young people attending school; women; sex workers (commercial and transactional); people working in manufacturing industries, logging and fishing; people working in the hospitality industry; police personnel; MSM; victims of rape and sexual coercion; migrants and displaced persons; people living in rural / remote communities; seafarers; individuals living with HIV.

The following activities are provided: direct one-on-one education; group based education; education sessions (e.g. in schools); advocacy on behalf of the target population; condom distribution by peers to peers; resource distribution by peers to peers; media production and use by peers; knowledge training (in HIV & sexual health) for peer education workers; training for trainers of peer educators; and mobile musicians. The In school programs targets secondary schools to make young people aware of sexual and reproductive health for the purposes of developing a healthy prosperous nation and to enable behavioural changes to avoid risky behaviour such unsafe sex. The project engages in a number of activities including video shows, questionnaires, dissemination of information through presentation, debating and group work

The project has been operating for seven years and developed from International Planned Parenthood Association and Family Planning Australia with SIPPA staff developing it further. The project predominantly targets young people enrolled in school as they are able to reach a large number of the target population during each workshop.

Monitoring and evaluation include:

- Follow up visits to visited school
- Pre and post test surveys
- Feedback from teachers and students

Indicators used to measure success of the project include:

- Increase number of students accessing SIPPA services and youth centre
- Increase number of phone calls enquiring about SIPPA services and services in the youth centre
- Increase number of condoms distributed

The interviewees believe the project is going well given the increasing number of clients accessing SIPPA services over recent years. However, it was noted that there were opportunities for improvement such increasing efficiency and greater outreach to more young people living in provinces. Five paid staff and 20 volunteers are directly involved in the Project. The volunteers are peers of the target population. Throughout 2008, 10 secondary school in Guadalcanal and 6 provincial secondary schools were reached, a total of 2000 + young people.

The project is funded by International Planned Parenthood Association (IPPF) and Australia Nongovernment Cooperation Program (ANCP) at a cost of AUS$23,000.00. Access is made with the client group through written contact with school principals informing them of the program.

Peer educators are recruited through a process of initial consultation with community leaders who nominate candidates from their community. At other times young people approach the program themselves and request to join the peer education network.

Ideas for activities are developed by both staff and peer educators with the assistance of teachers particularly with respect to the kind of approaches and topics appropriate to their students. This depends entirely on teachers' perception and their analysis of their school situation

Students are not really involved in designing the project, although teachers do have an input. The young people help to implement and evaluate the program through actively participating in the workshop, asking questions and giving feedback.

Important lessons learnt in the course of the project was the importance of a non-judgemental attitude by educators, the priority for easy and free access to sexual and reproductive health services, the need for sustainable programs rather than short term programs. Preparation is necessary to ensure that program runs effectively. Peer educators are critical during workshops or awareness programs as they are best skilled to lead active participation by youth.

Characteristics for working appropriately with this target population include:

- Flexibility
- Have Fun
- Non judgemental
- Friendly
- Listening to questions properly and giving thoughtful answers

A particular success of the program is the outreach of peer educators to schools instead of the need to bring students to SIPPA. Principals and staff are consulted as to the appropriate topics for discussion and a program is designed for student needs.

Weaknesses of the project include:

- Time constraints make it, difficult to convey information to students
- Poor quality facilities at schools and the surrounding environment can make it uncomfortable to discuss some issues
- Inadequate teaching materials

At this stage the resources that are being used are those already available from stake holders and developed by SIPPA in the previous years

The organisation is mentioned in the country's national HIV/sexual health strategy, is part of a formal network in HIV and / or sexual health (SIPPA is a member of the SINAC network), and is a partner in the Stepping Stones peer education network.

SIPPA is responsible for its school programs but other organizations can assist if requested especially on specific topics.

Persons are referred to other agencies in cases where the client was uncomfortable with SIPPA service, if there was a shortage of drugs or in cases beyond SIPPA capability. Referrals are followed up using a standard referral card where the provider can state what findings and services were provided to the client

The project has the support of the organisation and the Ministry of Health.

Training has been conducted in the last 12 months e.g. CBED training for youths for 10 days. Monitoring and evaluation training has been provided for staff and volunteers involved in peer education. External training was provided through the stepping stone program.

The following characteristics were considered integral to an effective peer educator:

- Good Public speaking
- Good Communication Skills
- Good listening skills
- BCC
- Enthusiasm
- Continuous education for peer educators
- Counselling skills
- Computer skills

Single mothers aged 18–25 years, young sea farers, taxi drivers, hotel workers, men sex with men, disabled youth were all identified as vulnerable groups not fully targeted by peer education programs.

Gaps identified in education and training for paid and voluntary peer educators include computer skills, counselling training and formal education on Sexual and Reproductive Health. There are some gaps in the delivery of awareness programs e.g. SIPPA peer educators rarely operate in private homes, street corners, bus stations or social clubs. Rather, the program concentrates mostly on schools, churches and workplaces.

SIPPA requires greater collaboration with other NGOs and MOH as it was noted there was not enough support from SIPPA to other provinces apart from where it operated provincial clinics (due to funding restraints).

Solomon Islands: Ministry of Health

The MHMS AHD Project of the Solomon Islands commenced in 2001 to specifically address adolescent sexual health issues and employs one FTE paid staff. The AHD coordinator has occupied the position for 5 years and defines peer education as " Educating, sharing information with same peer groups. Educating friend. Someone around the same age. Someone you can confide in."

80% of the project is devoted to Peer Education. The project targets marginalized young people, young people attending school, women, and people living in rural / remote communities. Activities include one to one and group based peer education, education sessions, condom and resource distribution, knowledge and skill training and training for trainers of peer educators.

Two Peer Education programs are conducted:

Out Of School: 29 community PE aged 19–37 years and nominated by the community, were trained in 2008 for the Central Islands Province. This group was directly trained under this project. All were volunteers. The program was directly monitored by the Training Officer responsible for the AHD program at the provincial level and who reports to the AHD National Program. Report forms are compiled by the PE who report to the

provincial AHD program. The PE not only deals with youth issues but also family planning motivators. In addition Church leaders were trained to work along and give support to this group of PE.

Other provinces too have seen the benefits of training PE and are considered adopting the program. A follow up training is scheduled for April 2009 at which the number of remaining PE can be determined. The program has been considered particularly successful in its promotion of vasectomies across the province.

Those PE currently attached to the Youth Friendly Clinic are being paid by SIPPA.

In School: 40 PE were trained from 11 Schools in Honiara but these have not been followed up as yet.

The organisation is included in the National HIV Strategy, is part of a national HIV network and collaborates with other non government agencies in the delivery of Peer Education and school education. The project refers its client group to youth friendly clinics and reproductive health centres but is unable to follow up on these referrals. The interviewee did not feel there was ongoing support for peer education by the organisation as conducted both in schools and out of schools/community. After initial training, there ideally should be support for the PE to integrate within a variety of NGO or faith based organisations as volunteers with regular follow up and refresher training after 6 months. However, in reality, refresher training is only provided after 1–2 years and only if funds were available. Funding for training is not allocated from the Ministry of Health but has to be arranged within the project. Consequently, no training had been conducted in the previous 12 months.

The following qualities were identified for effective peer education: trained in life skills, good communication skills, competency in peer to peer relationships, good listening skills, creativity, problem solving, decision making, knowledgeable on RH, ASRH and HIV issues, good interpersonal relationships and willingness to work as a team.

Sex workers, street kids and those with multiple sexual partners were identified as vulnerable populations currently not receiving peer based services. There was an identified gap in the availability and range of training resources appropriate for addressing different target groups. Currently the program is using different training manuals and each NGOs relies on its own curriculum. The length of training programs varies greatly between 1 week to 1 year, and often with no set time limits. There was an emphasis on the need for uniform training resources and programs.

Solomon Islands: Oxfam

Oxfam Solomon Islands employs 14 FTE staff and 12 volunteers. Peer education was defined by the interviewee as, *a Group or people with similar interests, ideas or need*.

60% of the project is focussed on peer education, utilising the services of 2 FTE staff. The program also supports 6 out of 10 partner NGOs under the NAC grants program with youth peer programs. The project targets marginalized young people, young people attending school, women, people working in the hospitality industry, people living in rural / remote communities and individuals living with HIV. Its activities include:

- Group based education by peers
- Advocacy on behalf of the target population
- Advocacy for peer education as an effective intervention measure
- Condom distribution by peers to peers
- Resource distribution by peers to peers
- Theatre / role play education by peers
- Media production and use by peers
- Skill training (e.g., in communication) for peer education workers
- Training for trainers of peer educators

The Project is referred to in the national HIV strategy, is part of a national and regional HIV network and is a part of a peer education network, i.e. Stepping Stones Network and Development of National Youth Peer Education Strategy for HIV Prevention. The project delivers peer education in collaboration with other NGO and support partners through the NAC Grant Program and the National Stepping Stones Network.

The project refers clients to medical services and attempts to follow up on these referrals through stakeholder meetings and reports. The project enjoys the support of the organisation and the Ministry of Health.

Within the past 12 months training has been conducted with partners:

- Monitoring & evaluation
- BCC training
- Stepping Stones Community Facilitators Training
- Project design management training.

The following characteristics were identified as important for an effective peer educator:

- BCC
- Information training
- Project design & management
- Monitoring & evaluation

Whilst the interviewee identified a number of vulnerable groups (sex worker/MSM/Youths) in the country, they did note that there were organizations with programs to address their needs.

Whilst it was recognised that there was very good peer training for youth peers, it was identified that a greater focus needs to be placed on other vulnerable groups. A good focus had been placed on age group peers and consequently greater attention was needed for other vulnerable groups (sex workers, MSM). Greater coordination of peer programs was also highlighted.

Solomon Islands: World Vision

World Vision, founded in 1981 in the Solomon Islands, employs 25 active volunteer peer educators. Peer education is defined as “an Effective behavioural change strategy: Peer education typically involves using the members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the

individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level, by modifying norms and stimulating collective action that leads to changes in programs and policies."

40% of the program's activities are directed towards peer education with a total of 50 staff and volunteers. The following groups are targeted: Marginalized young people, Women, People working in manufacturing industries, logging and fishing, People working in the hospitality industry, Migrants and displaced persons, People living in rural / remote communities, People getting traditional tattoos, and taxi drivers. The program provides one to one direct peer education, group based education, education sessions, telephone information by peers, condom and resource distribution by peers, theatre/role play education, media production, and the training of community facilitators for the Stepping Stones Program.

Three particular programs were highlighted: Stepping stones; Peer educators network (youth to youth) and the Taxi network, targeting the community, young people and clients of taxi services respectively. These projects have been operating for 5 years and seek to reduce risk taking behaviours amongst youth and high risk group in Honiara to HIV & STI infection

A number of activities are included in these projects:

- Conducting KAPB surveys
- Development of peer educators training program
- Training of peer educators
- Conducting community awareness programs
- Taxi network
- Holding annual youth festivals including involvement in the World Aids Day campaign
- Working with church leaders: advocacy amongst church congregations to HIV response
- Condom promotion & distribution
- Promotion of SRH services
- Designing and development of IEC materials including radio & TV spots
- Advocating against stigma and discrimination amongst PLWHA

These projects were developed by the Program Officer, World Vision Solomon Islands as consequence to the increase of movement amongst the general population especially the unemployed youths, to Honiara, increasing their vulnerability to HIV & STI. Surveillance data has demonstrated an increase in STI despite the current low prevalence rate of HIV, with young people comprising one of the most sexually active populations.

Monitoring and evaluation is conducted through a number of means:

- Indicator tracking table
- Monthly, quarterly , six monthly & annually narrative report
- Most significant change stories
- Quantities of condoms distributed
- Structured questionnaires: KAPB
- A full concluding narrative report

Success of the Project has been measured through the following outcomes:

- At least 25% increase in number of youth reporting regular practice of an ABC method
- 75% of target beneficiaries can identify 2 prevention methods
- 20 Peer educators Trained
- 1,000 High risk groups receive information on HIV and STI prevention
- 3 World AIDS Day Events held
- HIV-STI Awareness Program developed for Radio/Television
- 1 set of IEC on STI developed
- 10,000 people receive IEC on STI and HIV
- 20 Pastors participate in Channels of Hope Training
- At least 400 congregants participate in seminars on HIV &STI

The interviewee believes that project is progressing well and will achieve significant impact for its target group. Though it is in its first year of operation, a number of anecdotal reports of behaviour change have been collected.

5 paid staff and 46 volunteers are involved in the program, with a number of them drawn directly from the target group. It is estimated that 26000 people have been reached through radio programming, World Aids Day campaigns and IEC materials. The Program is funded by AUSAIDS through World Vision Australia with a budget of $540,000.

Contact with the target group is made directly, whilst peer educators are recruited through advertisements and selected via an interview process. The program office decides which activities are undertaken but the target group are involved through structured surveys and focus group discussion, participation in PLA training and by provide MSC stories as part of the overall evaluation.

During the course of this program, a number of social and physical needs have been identified within the target group, increasing their vulnerability to HIV. However, the consistent application of projects such as these was considered significant in achieving positive outcomes.

Examples of activities that were considered to have worked particularly well were:

- Conducting Stepping Stones program within communities—3 months
- Conducting PLA for target communities—3–5 days
- Conducting mapping exercise for stakeholders—1 day

The Stepping Stones program was highlighted as a particularly effective approach for Pacific communities as it provided a culturally and religiously sensitive and appropriate channel for discussing SRH issues. The SS approach creates an environment for peers to discuss these issues within their own peer groups.

Resources produced as part of this program include:

- Condom dispensers & condom dispenser stickers
- Calendars
- STI picture cards
- Key tags
- Hand bands

- Bags
- Radio spots

The organisation is included in the national HIV strategy, is part of a HIV network within the country, and is also part of the Stepping Stones network within the Solomon Islands. Delivery of interventions is sometimes conducted in collaboration with others. Clients are referred to other agencies for STI management, and follow-up is provided for those PLWHA undergoing treatment and care. The peer education program is strongly supported by both the organisation and the government. Training has been provided to peer educators within the last 12 months, both internally and external to the organisation.

The following skills were considered essential for an effective peer educator:

- M&E – developing an M&E framework for its activities
- Counselling skills – to support PLWHA
- Stress management
- Report writing
- BCC skills
- Facilitation skills
- Human rights training in support to PLHWA

A significant gap was the development of an M&E framework for the activities undertaken. Sustainability was also considered a weakness in that there was still a need for the community and target group to take the leading role of ownership for peer education. There was also an identified need for community resources and support tools to sustain programs for communities and peer educators.

Solomon Islands: Save the Children

Casper Supa

SCF conducts its HIV/AIDS Prevention Program as two concurrent arms- a clinical services project and a Peer Education Outreach project. The Peer Education project employs 3 FTE staff and relies upon 224 volunteer PE.

The organisation had previously documented a definition of peer education but as the project evolved and changed its approach, so did its understanding of peer education. Previously the strategy of the project was to train one PE per community to serve as a focal point. However, due to varying effectiveness and capacity, the current methodology has been to train large groups of young people to deliver PE in their communities.

Peer education is personally defined as a “method whereby friends and motivated young people take on formal or informal activities with peers”, “similar age and background”, “strategy for disseminating education”.

60% of the HIV Program is devoted to PE, targeting marginalised young people, other youth at risk (defined as 14-29 years), sex workers and MSM. Peer education activities conducted include:

- Direct one to one education
- Group based education
- Condom and resource distribution

- Theatre and role play
- Knowledge and skills training
- Train the trainer training.

The wider age range for youth is used in SI as a means of attracting more motivated and active volunteers.

The HIV Program was commenced in 2007 and its primary aim is to increase safer sexual behaviours amongst most vulnerable groups through outreach and networking with stakeholders. Its activities mostly comprise of outreach to locations of vulnerability, condom promotion and distribution amongst peers, involving young people in a range of key awareness activities targeting vulnerable groups e.g. targeting night clubs, advocacy through volunteers, involvement in recreational activities e.g. sport events, and training of volunteers.

The outreach to sex workers is particularly highlighted as an example of effective peer engagement and delivery. Key sex workers are identified in a location, invited to training and skilled up to deliver peer based education to their networks of sex workers. Approximately 50 sex worker peer educators have been trained. Training is specifically designed and organised for sex workers in comfortable venues.

In contrast, MSM peer educators are trained in combination with other youth and volunteer PE. This is considered important as MSM have not formed separate networks within the community (like sex workers) and the current belief is that MSM should not be separated out from the general community.

Monitoring and evaluation is a significant concern for the program. Monitoring young PE—a very mobile population—is considered difficult. Methods of monitoring include asking PE information about their activities and the completion of written reports which are submitted to the project officers and collated at the community level. Forms are completed for each contact.

Indicators measured include the number of people participating in activities, gender, aim of activity, outputs of the activity.

However it is difficult to determine if the program has made an impact. Long term changes are determined through most significant change stories. Once a month, project staff organise focus groups of the target population and interviewed individually about behaviour in the previous 6 and 12 months. This is considered an effective tool for monitoring gaps and needs.

The perception of the interviewee is that the project has made a difference in addressing needs and that there is evidence for some behaviour change. Important some of the target group members have become facilitators in their own right. There is a strong sense that the project is targeting those most at risk.

In 2008, records indicate that 2509 young people and 3249 adults were reached by the project (401 children aged less than 18 years but this data overlaps with adolescents). However, there is no individual data maintained for MSM and sex workers and these are currently included with the general community statistics.

Contact is made with the vulnerable group through peer to peer outreach. Peer educators are recruited from specific areas. When a pattern of risk behaviour has been identified in an area, a meeting is organised with the vulnerable young people of that area. Training is organised and offered, and following training, an invitation is made for the youth to become PE. These interested persons are offered more training and given time to decide if they would like to become PE. This period of consideration is important as PE are volunteers and are only compensated on particular occasions for their time. Otherwise, they are unpaid.

Young people are engaged in project planning and implementation. Target young people are mobilised in the selected areas, brought together to brainstorm ideas and organise activities they would prefer and what would be involved in implementation. They are involved in the implementation of the activity and provide evaluative feedback. Following the delivery of activities, members of the target group are brought together to review results and recommend modifications. Sex Workers are offered separate meetings for this planning and review.

An important lesson learnt is that what often the target group wants can conflict with the expectations of the donor agency or program plan. There is a need at times to modify the program as conceived by the funders so that it is relevant to the target group. This requires skill to be able to satisfy the needs of both parties. Often the needs and desires of young people will change.

Another important lesson highlighted is the need for PE programs and other interventions to target a particular group rather than the whole group or general population. In the Solomon Islands, there is a need for greater specificity in targeting strategies given the great diversity of interests and needs in communities. Non-homogenous communities cannot be blanket targeted.

One of the great successes of the program has been its ability to enable peers to become good educators and facilitators of education to others. A significant weakness is the limited ability to identify behaviour change and monitor the impact of programs.

Resources that have been produced include IEC materials, posters, and stickers. These are usually produced by the project staff with recommendations from target focus groups.

The organisation is included in the National HIV/AIDS Strategy, is part of a national HIV network (Solomon Islands AIDS Council), and is part of a peer education network. The program works closely with World Vision who target the general population of young people with their team of PE.

PE refer clients to two government clinics that they work closely with. They also train nurses to become more youth friendly. However, they are not able to follow-up the progress of these referrals. Recently a card system was introduced to assist referred young people with access to clinical services by providing notice to nurses that this is an urgent referral. The card system will allow measuring of percentage referrals completed. However more advocacy is required for the implementation of the card system. At present, there are not a significant number of persons following up on referrals.

At present, the PE project receives strong support from both the organisation and MoH. Over the previous 12 months, a large amount of training, mostly refresher training has been delivered to PE. They also receive training from other organisations and at a national level.
Key education and training skills identified for an effective PE include:

- Effective communication training
- Effective Peer Education training
- Information training
- BCC skills
- Monitoring and evaluation skills
- Public speaking skills

There is concern for some vulnerable groups that are currently not being accessed by PE. In particular, the program is not reaching the whole province and the majority of islands. The project is focussed on the main island. There is a priority to target the islands close to the PNG border, those islands with logging communities and isolated communities.

A gap in training concerns the resources and manuals used for training. Training materials currently in use need to be reviewed, and adapted to better suit the literacy levels of PE.

Whilst there is a strong understanding of the theory of peer education, there are challenges for newly recruited PE. There are also issues concerning poor role modelling by PE. The organisation provides feedback on appropriate behaviour and reinforces the importance of positive behaviour and responsibilities. PE meet weekly in their respective communities to discuss activities and this provides opportunities for behaviour review.

There is a need to be able to collaborate with other NGOs that are capable of catering for new strategies, particularly income generating activities for young people and sex workers.

Other issues identified include the retention of PE and the inevitable loss of skills and capacity as they grow older and become married, and the difficulty with implementing particular activities at times on schedule.

Eric Houma
This Peer education project targets young people aged 14-29 years (as defined in the Solomon Islands) and seeks to improve the capacity of young people to address social issues, thereby raising the capacity of the country for the future. The project operates in 6 provinces including Honiara, and works within target communities based on particular criteria. Target communities are selected according to specific risk indicators- youth population, teen pregnancy rates, sexual abuse rates, proximity to logging camps.

A team of 30 FTE youth outreach workers (youth themselves aged 20-25 years) travel to designated communities for 3 out 4 weeks. Each worker is responsible for 3-5 communities and will spend up to a week in each community. In each community, the worker will form a youth group of about 20 people, train them as volunteers, and enable them to develop their own TOR, activities and youth leaders. When selecting such volunteers, a criteria is used so that motivated young people, keen to enact social change and aware of issues are recruited.

The youth groups then develop a community profile, collecting data with the assistance of staff. Issues are identified (e.g. unemployment, substance abuse, pregnancy, child abuse), and strategies developed. Surveys are conducted house to house or through focus groups. Activities are developed by the youth group based on the assessment-drama, talks by health staff, sports activities and community development.

Monitoring and evaluation is through collecting MSC stories. Training is evaluated by asking peers to tell stories. Staff conduct monitoring against particular indicators and report to the donor. Staff visits to each community each month allow them to monitor the activities of the youth group, and the cycle is repeated monthly.
From the youth group, about 10 persons are selected for more intensive training as PE, equipped with skills in communication, M&E, and facilitation and these volunteers maintain records of activities and report to staff.

All youth group members are trained in basic education but it is these 10 that are selected for the more intense PE training, making it easier to monitor activities. The PE are unpaid, but future planning is considering a project where PE are paid a stipend. Retention is an important issue as PE need to be recruited and trained quite regularly to replace those who leave. Extensive training and up to 6 refresher trainings are offered per community.

Overall, the project is reported as successful. A recently conducted evaluation of each community has looked at impact and has identified high levels of knowledge amongst young people and positive feedback from communities and other stakeholders.

Weaknesses identified related to the high staff turnover rate and the need to retrain; the difficulty applying this community methodology to urban areas where mobility is high and there are not the same social networks.

Measuring the impact of the project is difficult because funding has been annually, though it has now secured funding for the next 5 years.

A gap in training was the difficulty to follow-up PE after training and monitor the quality of information, and the further follow up of their contacts. It was important to get PE to more thoroughly document these contacts. Another concern was the need for more consistent information. Standardised training manuals could address this.

The organisation works closely with the provincial government and a network of NGO. Youth stakeholder meetings are facilitated by the government on a monthly basis and a strong collaborative network has developed. Some training gaps have been highlighted in the area of technical support for income generating programs and to provide more occupational based training to young people. There is also a concern for duplication of programs and some competition is emerging between organisations working in the same area though collaboration is addressing these.

Vulnerable groups that have yet to be targeted include single mothers, who find it difficult to become involved in training, and the elders within the community. Older persons miss out on information because trained youth PE do not engage them because of age differences.

The project refers to other services for counselling and testing and draws on external technical advice as needed. Staff work closely with the clinics, and though follow up of individuals is not possible, monthly testing data is reported back.

With respect to conduct issues, the criteria used to recruit PE assists in ensuring a high level of motivation and responsible behaviour. However, when issues arise within communities, elders are involved to assist with problematic behaviours.

The next phase of the project will focus on sustainability and work closely with the provincial government to develop youth policies within the Ministry of Youth. Youth policies will assist provinces to organise action plans developed by young people.

Young people are demanding for greater income generating projects and this advice has been adopted by the organisation. The long term plan would be to assist community youth groups to become CBOs in their own right and receive funding directly.

Solomon Islands: Adventist Development Relief Agency

The Adventist Development and Relief Agency (ADRA) operates across both the Solomon Islands and Vanuatu. It employs 5 FTE staff and 20 volunteers for its HIV project based in the Solomon Islands. ADRA began operations in 1986 with the HIV project commencing in mid 2001. Though the organisation provides Peer Education, there does not appear to be a formalised definition of the methodology, however, the interviewee provided a personal definition: “Youth from the same age group share information that affects them and receive information that will elevate them addressing their needs”.

75% of the HIV project is committed to peer education relying on the services of 3 FTE and 20 volunteers. The targets of its peer education activities are marginalised youth and youth in schools. Peer education activities include direct one to one, group based, and school based education sessions, advocacy on behalf of the target group, resource distribution and production, knowledge and skill based training of PE, and train the trainer programs.

The program is referred to in the national HIV/AIDS Strategy, and is part of a HIV network, SINAC and INGO, but it is not part of any peer education network. It collaborates with other organisations to facilitate training, and refers members of the target group to for condom supply and VCCT through Oxfam, Save the Children, SIPPA and clinics.

Follow-up of these referrals is attempted through phone calls and stakeholder meetings.

The program appears to be supported by both its parent organisation and the government. Training has been conducted for volunteers in the previous 12 months but not for staff. No external training has been accessed.

The following education skills were identified as important for an effective PE:

- HIV/AIDS Facts & confidentiality
- Communication skills
- Youth leadership

- Youth and vulnerability

- Peer pressure
- Self-esteem and value
- Ways of conducting outreach
- Negotiation skills

Unemployed youth were identified as a vulnerable group currently not accessing peer education. Gaps in training were identified for mainstreaming, policy development, content of HIV/AIDS and skills in transferring information. Further gaps within the program were identified in the general understanding of behaviour change and in formulating budgets.

Solomon Islands: Integrated Community Program (ICP), The Church of Melanesia

Inclusive Communities Program, Anglican Church of Melanesia, founded in 2004, employs 14 FTE staff and 14 volunteers. Whilst not specifically set up for HIV and sexual health issues, the organisation is involved in peer education. The project defines peer education as "people of same gender and age groupings (e.g. Girls aged 13–19 or women aged 20–45 or boys age 13–29 etc)" A personal definition of peer education was described as" Peer education is for those who are of same gender, age groupings, may be ethnic groupings, same village groups, wantoks etc. Who are affected by same problems, e.g. teen pregnancies, wives, husbands, teenagers both male and female, elderly people etc."

10% of the project is devoted to peer education as an extracurricular activity. All the staff and volunteers are involved in peer education. The project targets: marginalized young people, women, people living in rural / remote communities and those in traditional leadership roles (chiefs).

The project undertakes the following peer education activities: group based education by peers, training for trainers of peer educators, and use of the Stepping Stones program at the community level and within prisons.

The organisation is not mentioned in the national HIV/sexual health strategy, but is part of a national network of HIV services with Oxfam and part of a church network for peer education. It collaborates with other organisations—ADRA, Oxfam and World Vision—and refers to other services and clinic if requested. However follow-up of referrals is not undertaken. The organisation supports the peer education program but it was reported that the MoH was unaware of this activity. In the previous 12 months, refresher training was undertaken in the Stepping Stones method and there has been access to external training through Oxfam on the use of the Stepping Stones training manual and with ADRA as part of the trial of the HIV Community Development Manual.

The following characteristics were identified as important for effective peer education:

- Facilitation skills
- Communication skills
- Familiarity with training manuals
- Ability to network with other people to ensure consistency in information
- Ability to give out right information

- Counselling skills for those needing one on one sessions
- Ability to refer on if not sure about any information
- Ability to consult, communicate, collaborate and coordinate with others involved in HIV peer education.

There were identified gaps in education and training, a lack of resource materials, lack of funding to keep the volunteers motivated, and lack of support from organisations for voluntary workers. There was also reported a lack of technical support and a need for greater capacity building of the team to increase its effectiveness.

There was also a need for support in the reproduction of resource materials, and for additional funding and greater collaboration with other NGO to effectively use existing networks network to carry peer education to the grassroots even remote areas of Solomon Islands.

There was a need to understand and work within the unique context of the Solomon Islands—its culture, wide geographical settings, and religious approaches to peer education. There is a priority for greater availability of services in rural areas. Many services are currently urban based and consequently many of peer education programs do not reach the vulnerable in the rural areas. There is also a need for more collaborative effort on the part of Ministry of Health and to develop an inventory of peer education and other relevant service providers and distribute this to all stakeholders involved in peer training programs.

Tonga: Tonga National Youth Congress

Tonga National Youth Congress, founded in the 1980s, employs 4 FTE staff and 6 volunteers. The organisation undertakes peer education. Though there is no documented definition there is an understanding of the strategy used and this is verbally communicated. However the national per education committee set up in 2007 by different organisations conducting peer education has developed a formal definition.

The interviewee defined p*eer education* as people of the same age group who have relations with each other and they have something in common e.g. age, interests etc and at the same time they are educating each other through story exchange and at the same time they are learning in their talking with each other.

50–55% of the program's activities are committed to peer education. The project employs one coordinator and 20 peer education volunteers who receive a stipend when they do outreach with $10 for their transportation and meals before doing the outreach. This is monitored by the number of confirmed peer educators who participate in the outreach.

The project targets the following populations:

- Marginalized young people
- Young people attending school
- Women (young women 15–34 years)
- Sex workers (commercial and transactional)
- Those who are transgender e.g. Fa'afafine, Fakaleiti
- Men who have sex with men

- People living in rural / remote communities

Peer education activities include the following:

- Direct one-on-one education in HIV and Sexual Health by peers
- Group based education by peers
- Condom distribution by peers to peers
- Resource distribution by peers to peers
- Resource production by peers e.g. HIV brochures/pamphlets & newsletter
- Skill training (e.g., in communication) for peer education workers
- Training for trainers of peer educators

Peer education community outreach targets 50–85% of the total population and has been operating for about three-years, to increase awareness in the community by disseminating information through peers.

The focus of peer education within the project is to reach youth through peers using small discussion groups or one-to-one interactions and seeks to change behaviour. The peers are located in different areas where they are accessed by local youth and are offered referrals for further information and services e.g. the Tonga Family Health Association and hospital for clinical issues and testing, the Centre of Women and Children for domestic violence. The project was established some years ago after surveys indicated that young people trusted their peers more than parents and family.

M&E of this project is through peer education reports during bi weekly peer meetings. There is also some post-session testing at every outreach to test newly gained knowledge.

Indicators used to measure the success of the project include:

- The number of outreach requested from the community
- Frequency of youth drop in for information
- Number of condoms distributed.
- Referral drop in as a result of the peer education.

Three paid staff and 25 volunteers are engaged in the project— all are peers of the target group. In 2008, it is estimated that 70–85% of youth, 30% of the Women Caucus and 20% of the LGBTI population have been accessed. LGBTI peers are used to access this specific population. The project is funded through PRHP to the cost of $30,000.00.

Contact is made with the target population through peer education, town officers, the Tongatapu Youth Congress and youth presidents. Peer educators are recruited through an application process and interviewed to determine if their geographical locations are suitable for the network of peer educators. Their role in the community necessitates good relationships with their peers.

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

The project has emphasized the need for accurate information about STIs, HIV/AIDS to be addressed in an appropriate manner. It is important that the target population be carefully studied to determine their daily schedule and location. Opportunities need to ensure that they can express their opinions and their preferences for topics.

A particular success of the project has been designing it around times that are appropriate for young people. Outreach is conducted on week days at 8–10pm after they have completed evening activities. Young people are informed that there will be a kava circle, which in rural areas is the means of social gathering for the youth. These kava circles provide the venue for dissemination of HIV and STI information.

Attempts to establish a support group for LGBTI people were modified in recognition that the most appropriate organisation to facilitate this was a partner organisation, TLA, which has responsibility for training in this area. Appropriate clients are referred to this organisation, and the TLA has assumed a greater role in directing activities for this target group.

An important lesson is good communication as an essential in any peer education project. Resources have been produced as part of this project:

- Brochures
- Newsletter
- IEC
- Posters/radio program

The organisation is referred to in the country's national HIV/sexual health strategy, is part of a national HIV network (CCM/NSP committee), and is part of the National Peer Committee. The project collaborates with other national peer educators. It refers clients to TFHA and local hospitals and follows up on these referrals through its clinic. The project has the support of the organisation, but it was reported that the Ministry of Health may not be as fully aware of the scope of peer education within the project, particularly in areas that move beyond the traditional concept of youth peer education.

Refresher training has been conducted for peer educators in the previous 12 months and some peers have been involved in the national peer education training.

Those qualities identified as important for effective peer education include:

- HIV/AIDS basic information
- Good counselling skills
- Decision-making skills
- Good listening skills
- Public speaking skills
- Communication skills
- Moral education (non-judgemental attitudes, understanding the differences)

Vulnerable populations identified in need of peer education were hut dwellers, taxi drivers, bar nightclub owners. An identified gap has been identified in the lack of initiative and motivation at times to share knowledge amongst their peers (taxi drivers etc). There is some misunderstandings of the concept of peer education amongst young

educators in that their expectation is that information should only be shared with their friends and not to the wider group of peers.

Tonga: Tonga Family Health Association

The Tonga Family Health Association, established in 1975, employs 12 FTE staff and 15 volunteers, and specifically addresses HIV and / or sexual health issues using a peer education methodology. The TFHA use the guidance notes and definition provided by the IPPF as its definition for peer education. The interviewee personally defined peer education as, *a process whereby those of the same societal group or social standing are educating each other.*

30% of the project is involved in peer education, using 30 staff and volunteers. Its targets include:

- Marginalized young people
- Young people attending school
- Sex workers (commercial and transactional)
- Those who are transgender e.g. Fa'afafine, Fakaleiti
- People working in the hospitality industry
- Police personnel
- People living in rural / remote communities
- Seafarers

The project conducts the following activities:

- Direct one-on-one education in HIV and sexual health by peers
- Group based education by peers
- Education sessions (e.g. in schools) by peers
- Social support activities for peers (e.g. meet for a community meal)
- Advocacy for peer education as an effective intervention measure
- Condom distribution by peers to peers
- Resource distribution by peers to peers
- Theatre / role play education by peers
- Media production and use by peers
- Knowledge training (in HIV & sexual health) for peer education workers
- Skill training (e.g., in communication) for peer education workers
- Training for trainers of peer educators

The TFHA Peer Education Program specifically targets adolescents (10–19years), both in-school and school drop outs. One of the most effective strategies in involving adolescents/young people is peer education. The project has been operating for 6 years and aims at empowering youth with accurate information, equipping them with life skills, encouraging them to access YFS and referring their peers who need further counselling. The project provides for:

- Condom distribution
- Role play education (Filitonu Drama Group)
- Training of peer educator trainers

This project was developed through the Adolescent Health Development Project which was known as the ASRH Project.

Tonga Family Health Association is an affiliate member of the IPPF and is guided by its 5As Framework.

The project is monitored on a daily basis as well as through quarterly reporting of its activities to both the donor and TFHA. Evaluative activities include Focus Group Discussion and exit interviews of young clients accessing the YFS. Indicators used to measure the success of the project include:

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

The interviewees report that the project is well monitored and evaluated annually with an increasing number of youth accessing the services as a result of the peer educators' referral network

The project employs one paid person (not a peer of the target population), and 24 youth peers as volunteers. It is estimated that a quarter of the target population has been reached.

It has been funded through the AHD Project at US$3000. Contact is made with the target population through the network and youth stakeholders whom the project works with when dealing with the target population.

Peer educators are recruited under a volunteer scheme of TFHA who are engaged in volunteer training before recruiting them using the selection criteria in line with that of IPPF.

Activities are selected in consultation with TFHA, youth stakeholders and the donor. The target population are the potential stakeholders of this project and they participate in the design of the program in consultation with the Youth Advisory Group. Proposals are presented to the AHD Project stakeholders for endorsement and included in the annual work plan of the AHD Project for funding. Involving the target population in the design phase has lead to the success of the intervention effort.

There is an urgent need to implement the program to the outer islands as according to the national census the target population is denser.

A particular success of the project has been the conduct of needs based assessment of the target population as well as risk mapping exercises in the target areas. This is important to repeat in each locality since different areas have different levels of risk and referral networks.

It is important to develop a profile of each target population hence contributing to the effort of developing targeted interventions. Amongst other lesson learnt over the years:

- Interactive training improves project outcomes
- Many young people prefer to receive RH information from peers rather than from adults

- The involvement of peer promoters significantly increases referral for contraceptive services at the TFHA Clinic

Resources have not been developed as the project has been using existing materials due to a lack of funds for development of advocacy kits.

The organisation is referred to in the national HIV/ sexual health strategy, is part of a regional network in HIV/sexual health (TFHA implement the HIV/AIDS CDO Grants and is an affiliate member of IPPF), and is a partner in a peer education network (IPPF Peer Education Network). Peer education is conducted in collaboration with other youth stakeholders. Clients are referred within an existing network and referrals are followed up through a referral and card system used by the clinic coordinator. The project has the support of the organisation and the Ministry of Health.

Training has been conducted three times annually i.e. volunteer training followed by refresher training of trainers. Some of the trainees have attended peer education training offered by Tonga National Youth Congress.

Qualities deemed important for effective peer education include:

- A demonstrated interest in working with peers
- Communication skills
- Presentation skills
- Have similar experience with those of the target population
- Able to keep confidentiality
- How to handle resistance from their peers
- A good planner and how to develop session plan
- Basic Counselling Skills and when to refer a clients

An identified gap is the inability to pay peer educators. Most are working on a voluntary basis as there is insufficient funding to reimburse them. In addition there is an identified need to handle the high turnover of peer educators but as yet there is no plan to address this.

There is a gap in understanding the importance of confidentiality and when to refer clients/peers. The role of peer promoters has not yet been clarified to some due to the high turnover in Tonga at the moment. The community at large needs to be mobilized to offer support and to accept the peer educators and their role in disseminating information and desired behaviour change.

Peer education was considered a very cost-effective intervention.

Tuvalu: Family Health Association

The Tuvalu Family Health Association (TuFHA), commenced in 1989 to address SRH issues, employs 9 FTE staff and approximately 30 volunteers. The organisation uses a formal definition of peer education documented in its national strategy.

The interviewee defined peer education as, *the term peers means one of equal standing with another. So in this case peer education is communicating and exchanging ideas and*

knowledge with your own peers and in this case is youth. Peer education can be done on different approaches like one to one basis and community outreach.

Approximately 30% of the organisation's activities were based in peer education, utilising 3 FTE staff and 9 volunteers. The program targets the following groups: marginalized young people, young people attending school, women, people living in rural / remote communities, and seafarers. Peer education activities include: direct one-on-one education, group based education, education sessions (e.g. in schools), advocacy for peer education, condom and resource distribution, resource production (IEC materials) by peers, theatre / role play education, media production and use, and skill training (e.g. in communication) for peer education workers.

The organisation is included in the National HIV/AIDS Strategy, is part of a formal HIV network, but not a peer education network. The program does collaborate with the Red Cross and MoH in the delivery of services. It refers the target population to the TuFHA clinic or MOH, and attempts to follow up these referrals through condom distribution. Whilst the program felt it had the support of the organisation for its peer activities, it was believed that the government was not aware of the peer education program.

Training for PE has been organised by TuFHA in the previous 12 months, and was facilitated by the one of the peer educators from Fiji and doctors from MOH. The visiting trainer had come to Tuvalu to review PRHP project and assisted in training the peer educators (volunteers) for a short period. No external training has been organised.

Significant education and training skills for effective peer education were identified as:

- BCC skills
- Negotiation skills (condom use)
- Communication skills
- Leadership skills
- Facilitation skills
- Pacific Star Life skills
- Basic information on STI/HIV, Teenage Pregnancy, contraceptive methods
- Reporting and monitoring skills

While the interviewee acknowledged that there was no survey to assess whether there were unidentified vulnerable groups yet to be targeted, it was felt that peer education had made extensive reach into the public sphere through radio programs and community outreach.

A number of education and training gaps were identified:

- Lack of Pacific life skills
- Insufficient information on SRH issues such as teenage pregnancy, STI/HIV
- Limited exposure to other peer education programs or ability to exchange with other peer education programs at the regional level.
- Lack of a peer education network.
- Insufficient incentives offered to peer educators.

The proper recruitment of peer educators was highlighted as critical for ensuring a right understanding of peer education. The interviewee identified a lack of support from

Government and compartmentally of different NGOs leads to duplication of activities in this small country.

Vanuatu: World Vision

World Vision Vanuatu, commenced in 1982, employs 40 FTE and 30 volunteers and specifically addresses HIV and sexual health issues using a peer education methodology. The organisation uses youth volunteers as peer educators for a range of social health issues. A personal definition of peer education described it as, y*outh at the age between 10–19 telling and informing other same age group about health or any issue affecting social life.* 100% of the project is devoted to peer education, involving 3 FTE staff and 15 volunteers. The project targets: marginalized young people including school drop outs, young people attending school, women, sex workers (commercial and transactional) people living in rural / remote communities, people getting traditional tattoos, individuals living with HIV.

The project provides the following peer based activities:

- Direct one-on-one education in HIV and sexual health by peers
- Group based education by peers
- Education sessions (e.g. in schools) by peers
- Social support activities for peers (e.g. meet for a community meal)
- Advocacy for peer education as an effective intervention measure
- Theatre / role play education by peers
- Knowledge training (in HIV & sexual health) for peer education workers
- Skill training (e.g. in communication) for peer education workers
- Training for trainers of peer educators

The Traem blong stopem HIV/STI long Tanna project targets school drop outs and the community. The project has been operating since 2005 and seeks to increase youth access to HIV/STI services and improve the quality of those services. It also seeks to facilitate the participation of the people of Tanna in health awareness. The clinic facilitates a biannual capacity building workshop, the clinic nurse provide confidential services and trains 30 peer educators. The peer educators conduct health education seminars and review and update the peer educators training program.

World Vision has been working very closely with youth in Tanna to advocate for gaps which the Health Department are not able to reach.

The project is monitored and evaluated by:

- Conducting baseline KAP surveys at midterm/end of project
- Consultative meetings with peers
- Couples meetings and discussions

Success is measured by determining the knowledge of STIs, self knowledge of HIV status, the number of cases of STIs treated at the youth clinic, attendance of youth at trainings and the how far peer education reached into communities.

The interviewees reported that the project was going well with its training and awareness but that not many other activities had enabled its further development.

The 3 FTE staff employed by the project are not peers of the target group. The 15 volunteers participating in the project are peers. In 2008 the project reached an estimated 3000 youth.

Contact with the peer group is achieved through awareness raising in communities via meetings and training programs, area counsellors, chiefs and consultative meetings. New peer educators are recruited by their educators. Selections are conducted during community awareness at community level and the community decide. The project logframe sets up activities with the collaboration of young people and the Health Department.

The target group is involved in the design and implementation of the project through group discussions, questionnaires, consultative meetings, individual peer contacts and youth to youth counselling. The project has demonstrated the efficacy of youth activities such as drama and singing groups, festivals and cultural activities rather than dissemination of information alone.

The project has had a number of particular activities work well

- Training of peer educators
- Drama group
- Funds secured for the development of other HIV/STI activities

A particular weakness has been the use of peer educators without funds or allowances to sustain their ongoing peer education. Schools must continue with the peer education without any long term support. Appropriate funding is required to support the peers providing education as many leave the program when allowances are not given. Proper funds allow for more creative activities and facilitate young people to lead with activities.

The project has generated leaflets and posters.

The project is included in the country's national HIV /sexual health strategy, is part of a formal HIV network (member of National HIV Committee) and part of a peer education network with other NGOs and the government. The project collaborates with the Vanuatu Family health association, other NGOs and Health department. The project refers people to the youth clinic and follows up on those cases receiving treatment. The project receives support from the organisation and the Ministry of Health.

The organisation has conducted training for its staff and volunteers in the last 12 months

- 6 for peer educators
- 1 for nurses at dispensaries and clinic
- 1 for Nurse Aid at Aid post
- 2 for committee members.

Other external training has been accessed with the Tanna Rural Health HIV / STIs program.

The following qualities were identified as important for effective peer education:

- Communication
- Counselling

- Methodology of presentation of HIV status
- Educator skills
- Decision making
- Management
- Listening skills
- Program Planning

Vulnerable populations currently not targeted by peer education include: Taxi drivers, hidden kava drinkers, girls sex workers and school children (high schools).

Currently there are gaps in having adequately trained full time peer educators, the right level of educated young girls and boys, and trusted young married couples. The theory of peer education often develops weakness in the implementation of activities through lack of funding. This lack of funding can impair the work of volunteers.

Further gaps in support and collaboration of the project were identified in the need for:

- Funds for peer education
- Funds for special drama group
- NGO to work together with Government policies

The interviewees raised an important ethical issue with regards to engaging young people as peers. It is important that youth peer educators are not used or exploited merely as a means to fulfilling the objectives of the project design. Engaging young people should be an end in itself by mobilizing their skills to develop their own good character.

Vanuatu: Wan Smolbag

Wan Smolbag Theatre, established in 1989 to specifically address SRH issues, employs over 116 persons, with 5 FTE and 1PTE volunteers. There is no set definition for peer education but they are working with the Ministry of Health to harmonise the peer education program in Vanuatu in order to maximise its effectiveness as a tool to fight HIV. A personal definition of peer education was described as, *helping someone to access information and services they need to help them have a better choice for their life*.

Approximately 15% of the organisation's activities are devoted to peer education, employing the services of 17 staff and volunteers. The following target groups are addressed: marginalized young people, young people attending school, women, sex workers (commercial and transactional), those who are transgender e.g. Fa'afafine, Fakaleiti, people working in the hospitality industry, military personnel, police personnel, men who have sex with men, people living in rural / remote communities, seafarers, partners of seafarers.

The type of peer education services delivered include:

- Direct one-on-one education in HIV and sexual health by peers
- Group based education by peers
- Education sessions (e.g. in schools) by peers
- Social support activities for peers (e.g. meet for a community meal)
- Advocacy for peer education as an effective intervention measure
- Condom distribution by peers to peers

- Resource distribution by peers to peers
- Theatre / role play education by peers
- Media production and use by peers
- Knowledge training (in HIV & sexual health) for peer education workers
- Skill training (e.g., in communication) for peer education workers
- Training for trainers of peer educators

The organisation is referred to in the National HIV/AIDS Strategy, is part of a regional HV network (NAC, PIRMCCM) and coordinates with other peer education organisations (NCYC & Haulua) as well as the MoH. The organisation refers persons to KPH, VCH, and VFHA but has no system of follow up. The delivery of peer education within the program is supported by both the organisation and the government.

Peer educators have received in-house training in counselling within the previous 12 months but has not accessed any other external training.

A number of education and training skills were identified for effective peer education

- Skills to approach strangers and engage them in conversation
- Listening skills
- Ability to put people at ease
- Thorough knowledge of their topic
- Ability to answer questions
- Ability to refer if not able to provide immediate assistance
- Honesty
- Good role modelling of appropriate behaviour

The main gap identified for training of PEER EDUCATORS was the lack of opportunities for ongoing refresher trainings for the peer educators already in the field. The ability to update knowledge was considered critical. Otherwise, the organisation reports that it is receiving good support in most areas, including financial.