

Out of School Comprehensive Sexuality Education in the Pacific

A Mapping Document



Acronyms

CIFWA	Cook Islands Family Welfare Association
CSE	Comprehensive Sexuality Education
FLE	Family Life Education
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
KFHA	Kiribati Family Health Association
MISP	Minimum Initial Services Package (SRH in Emergencies)
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NOLA	Nuanua O Le Alofa
PNGFHA	Papua New Guinea Family Health Association
RFHAF	Reproductive and Family Health Association of Fiji
SFHA	Samoa Family Health Association
SGBV	Sexual and Gender-Based Violence
SIPPA	Solomon Islands Planned Parenthood Association
SOGIE	Sexual Orientation, Gender Identity and Expression
SPC	Secretariat of the Pacific Community
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TFHA	Tonga Family Health Association
ToT	Training of Trainers
TuFHA	Tuvalu Family Health Association
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VFHA	Vanuatu Family Health Association
WHO	World Health Organisation

Cover photo: Kiribati Family Health Association youth at awareness session, 2016, IPPF/Jack Robert-Tissot

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Foreword

The importance of comprehensive sexuality education in improving the sexual and reproductive health of young people and reducing gender-based violence is well documented. Comprehensive, quality, rights-based programmes have been demonstrated to support young people to develop self-esteem and crucial life skills; empower them to make informed decisions and thus reduce rates of sexually transmitted infections, unintended pregnancies and sexual and gender-based violence. While many Pacific countries have taken great strides to provide sexuality education to young people in school, there is a lack of knowledge about the education that is provided to young people outside of school and access to quality, rights-based and gender sensitive comprehensive sexuality education is not universal across the Pacific.

The Transformative Agenda, a programme funded by the Australian Department of Foreign Affairs and Trade (DFAT) through UNFPA, identified comprehensive sexuality education as the main strategy for increasing demand for integrated sexual and reproductive health information and services in order to reduce unmet need for family planning and ultimately transform the lives of adolescents and youth. As such, IPPF with support from UNFPA, conducted a mapping of sexuality education and related programmes delivered by various groups across Cook Islands, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

A survey with organisations delivering sexuality education was conducted to understand what is currently being delivered outside of the school setting. Additionally, through online surveys, a review of existing resources and focus groups conducted with young people across the Pacific, it was possible to identify the content and programming gaps in delivering comprehensive sexuality education. It was found that while a range of organisations are delivering some form of sexuality education to young people outside of school settings, the curricula delivered are not equipping young people with adequate knowledge and skills to inform their decision making and cope with everyday challenges related to sexual and reproductive health. Organisations reported significant gaps in their curricula while young people reported receiving incomplete information or missing certain topics entirely.

It is crucial that young people are empowered to make informed decisions about their lives, by providing them with the necessary skills, knowledge and confidence. IPPF and UNFPA are committed to supporting Pacific national Governments, civil society organisations and feminist movements to ensure that every young person has the skills, confidence and knowledge to successfully navigate the challenging transition to adulthood and realise their full potential, through collaboration with multiple and diverse stakeholders in the Pacific region.

Karen Hill

Director, Programmes and
Operations, Pacific
IPPF

Dr. Jennifer Butler

Jennifer Butler
Director/Representative
UNFPA Pacific

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We thank Jack Martin, who developed the research methodology and coordinated data collection, and Katy Mackey, who synthesised the data and prepared this report.

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Executive Summary

The United Nations Population Fund (UNFPA) commissioned a mapping study, undertaken by the International Planned Parenthood Federation (IPPF) Sub-Regional Office for the Pacific, of Comprehensive Sexuality Education (CSE) programs in nine Pacific Island Countries: Cook Islands, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. This study involved 35 organisations providing CSE across the nine countries and 5,753 young people across eight countries, who took part in focus group discussions and/or responded to an online survey.¹

The objectives of the study were three-fold:

- Map the organisations providing CSE to out-of-school young people in the nine countries;
- Understand the strengths and weaknesses of the content and delivery of the CSE provided;
- Understand the needs for further support for the development and delivery of out-of-school CSE curricula.

A range of organisations reported delivering CSE across the Pacific including specialist sexual and reproductive health (SRH) organisations, government ministries, peak bodies for people with disabilities, faith-based groups, women's groups and organisations for people of diverse sexual orientation, gender identity and expression (SOGIE). All organisations surveyed reported various, significant gaps in their current CSE programs, particularly in online media, disability, services for SRH or sexual and gender-based violence (SGBV), human rights, communication and decision-making skills, anatomy and physiology, contraception, drugs and alcohol, and sexual orientation and gender identity. Of the 26 CSE-delivering organisations that answered the question on which topics were the most sensitive, 5 identified sexual orientation and gender identity as the most sensitive topic.

Organisations use a range of actors to deliver CSE, including peer educators, clinical and non-clinical program staff and guests from key population groups. All organisations provide facilitators with some form of training but this is not standardised. Positively, the majority of organisations do provide services in tandem with CSE, or refer to organisations that do. The evaluation of programs is a weak point for many organisations. The majority are making some attempt to assess the efficacy of their programs but require support to improve these processes.

The nine manuals reviewed are used by 11 of the 35 organisations surveyed. The most widely used manuals are *Sexual Health Education – A Training Manual for the Pacific* and *Adolescent Reproductive Health – Training Manual*, which were both developed in the early 2000s and are in need of updates. IPPF Member Associations also draw heavily on International Sexuality and HIV Curriculum Working Group's (Population Council) *It's All One Curriculum*, which was used to inform this mapping. More recently, Family Planning Australia and Family Planning New Zealand have developed manuals for use in Kiribati, Samoa and Vanuatu (*Marurungin Te Utu Training Manual* in Kiribati and two versions of *Sexual and Reproductive Health: A toolkit for community educators* localised to Samoa and Vanuatu).

The manuals reviewed were relatively comprehensive, although there were notable gaps. Only one manual covered information on services for SRH or SGBV or online media and technology. Only two manuals provided information specific to supporting young people with a disability in any depth and both of these included a standalone module rather than integrating a disability-inclusive focus throughout.

¹ Due to the ongoing COVID-19 pandemic, focus group discussions and the youth survey were not conducted in Papua New Guinea.

Only three manuals had an explicit focus on human rights. Coverage of sexual orientation and gender identity, gender and gender norms and relationships is also limited. Although most manuals contained some content on sexual orientation and gender identity, the it is severely limited. Content on relationships and gender norms is also in need of expansion. The coverage of relationships, in particular, was limited in several manuals to avoiding violence and refusal and negotiation skills, rather than the development of healthy relationships.

This study also surveyed the views of young people in eight countries. In total, 5,753 young people responded to the online survey, while 252 young people attended 24 focus group discussions. Participants reiterated their ongoing need for quality, comprehensive and inclusive CSE. The survey and focus group discussions collected views from diverse young people: 73% of those who completed the online survey identified as marginalised in some way.

Of the young people who reported that they had received some form of sexuality education through the online survey, the majority had received it from a teacher or a friend. Other common sources of information were nurses, adult family members and peer educators. Only 26% of participants had received information solely outside of school. The majority (52%) received information both in school and out of school. Respondents were most likely to have received information on drugs and alcohol, HIV/AIDS and sexually transmitted infections (STIs), and safe sex. However, only 26% of respondents reported receiving information on contraception or anatomy, demonstrating the limitations in the current curricula.

Additionally, 89% of participants expressed a desire for further information on sexual and reproductive health and rights (SRHR). Young people suggested that they would like to access SRHR education through peer education, which is used throughout the Pacific to provide young people with accessible information delivered by their peers. Social media and internet were also popular answers and this is an area of potential growth for CSE programs in the Pacific.

In focus group discussions, young people reported that they would like to access SRHR information online, particularly through social media; through Information, Education and Communication (IEC) materials, such as posters and pamphlets; through the media; through their parents and at home; at school; and lastly, through peer education. Young people noted several barriers to accessing SRHR information, which can be summarised into five categories: external judgements and taboos; accessibility barriers including physical barriers, cost, transport, communication barriers; lack of options to access information; internal judgement and shame; lack of trust in service providers, particularly around confidentiality.

This mapping informs the development of upcoming CSE curricula for countries in the Pacific. All organisations that took part in the study expressed a willingness to trial a new manual or curriculum, noting the need for accuracy of information and content which specifically address myths, misinformation and incomplete information. Multiple organisations expressed a desire that any future manual should be localised and developed in consultation with local partners, ahead of pre-testing.



Young people reading sexuality education materials from Reproductive and Family Health Association of Fiji, 2018, IPPF

It is anticipated that a new curriculum will be delivered by a range of actors and organisations, some of whom may not have a background in SRHR, education or human rights.

Summary of Recommendations

From this mapping, a series of recommendations have emerged.

- 1. There is a need for a positive curriculum that takes a holistic view of health and sexuality, covers the full range of topics, is incremental and promotes the development of life skills, including communication and decision-making skills.** The manuals reviewed were relatively holistic, but all organisations mentioned had significant gaps in the topics covered within their programs. Further, while the manuals utilised a range of activities, there was less attention paid to supporting young people to develop the skills needed to live happy and healthy lives. Indeed, the manuals often focused more on the negative aspects and risks of sex, with limited content on positive aspects of sexuality or healthy relationships. The development of skills should also be integrated throughout.
- 2. Any future manual or curriculum should be developed and pretested in partnership with local organisations delivering CSE already.** Content must also reflect the local context including using relatable examples and delivered in young people's native language to enhance learning.
- 3. Develop strategies to improve the recruitment and retention of diverse peer educators² and youth advocates, including in remote areas, to improve access to CSE for young people in all their diversity.**
- 4. Ensure that organisations provide sufficient training for facilitators and that they are confident and capable of delivering CSE.**
- 5. Ensure that any manual going forward includes clear support for facilitators, guidance on the importance of CSE, instructions on the delivery of sessions, as well as equipping facilitators with the capacity, knowledge and confidence to challenge myths and misconceptions.** As there is significant diversity in the types of organisations delivering CSE, many of whom do not have a background in SRHR, it is crucial that training and guidance is given to the facilitator and key terms are explained. Additionally, CSE which focusses on discussions and young people sharing their existing knowledge, presents an opportunity for a skilled facilitator to correct myths and misinformation. This should be supported through training provided by organisations delivering CSE and guidance in the curriculum itself.
- 6. Support organisations to make use of mass media, online media and online platforms to reach target populations and disseminate accurate information and reinforce learning.** This could include an online platform to deliver peer education training. Although this will not replace the comprehensive CSE package, young people expressed an interest in accessing accurate information from a variety of sources, including social media, radio, push messages on mobile phones and Information, Education and Communication materials, including materials that are

² The term peer educator is used throughout this report as UNFPA and IPPF acknowledge that this is the term most commonly used in the Pacific. UNFPA is currently reforming its peer education program and will use the term Youth Advocates going forward.

inclusive of young people with a disability and young people of diverse SOGIE. It is crucial that this information is accurate, consistent and contributes to achieving the outcomes of CSE, including supporting young people to develop the knowledge, skills, attitudes and values to understand, determine and enjoy their sexuality, both physically and emotionally. There is also potential to utilise online programs to deliver peer education training.

- 7. Expand access to CSE for young people in remote and rural areas, utilising mass media, radio and online resources to ensure continuing access to education.** Digital platforms or applications could be used, as requested in focus group discussions. Again, this is not expected to replace a comprehensive CSE curriculum, but it is crucial that young people in rural areas are not left behind due to their remoteness. This is particularly relevant in the context of increasing internet connectivity in the Pacific, while learning platforms that do not rely on a continuous internet connection could also be explored as well as integrating interactive, digital forms of learning with existing CSE curricula.
- 8. Improve the monitoring and evaluation of CSE programs, making use of a range of indicators, in alignment with global standards on measurement.** Any future curricula should include guidance on monitoring and evaluation and use the opportunity of a new curriculum to integrate rigorous evaluation at key steps (including before launch and regularly after). It is crucial that organisations assess the effectiveness of their CSE programs through validated tools. Any future CSE manual should include suggest monitoring and evaluation formats, include a baseline survey before its launch and ensure regular evaluation of its impacts.
- 9. Mainstream disability and SOGIE-inclusive content throughout curricula. Integrate information that is inclusive of young people in all their diversity throughout CSE curricula and ensure all activities are inclusive.** Currently, the majority of manuals include separate sections on sexual orientation and gender identity and disability (if those topics are included). However, this includes ensuring that young people of diverse SOGIE and young people with a disability are included throughout any curriculum. Information and services should be accessible to all young people, with friendly and appropriate (in terms of age and gender and membership of any groups as appropriate) facilitators. Adjustments should be made as necessary to ensure that young people with a variety of physical, intellectual, mental and sensory disabilities are supported.
- 10. Utilise existing best practices from UNFPA and other organisations to ensure that all CSE programs are accessible for young people in all their diversity, including young people with disabilities.**
- 11. Support organisations to integrate service provision with CSE, including through partnerships, and support service providers to improve the delivery of youth-friendly services.**

Introduction

"Every young person will one day have life-changing decisions to make about their sexual and reproductive health. Yet research shows that the majority of adolescents lack the knowledge required to make those decisions responsibly, leaving them vulnerable to coercion, sexually transmitted infections and unintended pregnancy."³



Vanuatu Family Health Association nurses explain contraceptive options, 2017, IPPF/Kathleen Prior

The United Nations Convention on the Rights of the Child states that all young people, without discrimination, have the right to access information and services that will allow them to make decisions about their health, including family planning.⁴ Comprehensive Sexuality Education (CSE) is crucial to

³ UNFPA, undated, *Comprehensive Sexuality Education*, available at: <https://www.unfpa.org/comprehensive-sexuality-education>, accessed September 2020

⁴ United Nations, 1989, *The United Nations Convention on the Rights of the Child*

enabling young people to make informed and empowered decisions about their sexual and reproductive health.⁵ The United Nations Educational, Scientific and Cultural Organization's (UNESCO) International Technical Guidance on Sexuality Education, published in 2018, defines CSE as "a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality", which equips young people with the knowledge, skills, attitudes and values to understand, determine and enjoy their sexuality, both physically and emotionally, and empowers them to "realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives."⁶

Based on a holistic view of sexuality, CSE provides information on a range of topics on the biological, physical, emotional and social aspects of sexuality, as well as supporting young people to develop life skills and nurture positive attitudes and values, and it is recognised as crucial for supporting SGBV prevention.⁷ It provides scientifically accurate information about human development, anatomy and reproductive health, as well as information about contraception, childbirth and STIs, including HIV. CSE recognises young people in all their diversity as individuals with human rights, including sexual rights, and is inclusive of young people with disabilities, young people of diverse sexual orientation and gender identity and expression (SOGIE) and other marginalised young people.⁸ CSE supports young people to develop self-esteem, an understanding of their values and crucial life skills, which promotes critical thinking, clear communication and decision-making skills.⁹ In-depth analysis by UNESCO has demonstrated that CSE has a positive impact on SRHR, notably reducing rates of STIs, HIV, unintended pregnancy, and SGBV.¹⁰

In the Pacific, a variety of terms are used to cover education programs that provide information about SRH topics, including physical and mental development, anatomy, attitudes, values, relationships, sexual behaviour, STIs, HIV and AIDS, pregnancy, contraception, gender equality, and other topics. In-school sexuality education is delivered through Family Life Education (FLE), although these programs are often not comprehensive. Research conducted by the Ministry of Education and Training, supported by UNFPA, in Vanuatu found that students lacked understanding of key FLE topics, including menstruation, and only

⁵ UNFPA, 2014, *UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender*, available at: <https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Operational%20Guidance%20for%20CSE%20-Final%20WEB%20Version.pdf>

⁶ UNESCO, 2018, *International technical guidance on sexuality education: An evidence-informed approach*, available at: <https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf>

⁷ IPPF, 2010, *IPPF Framework for Comprehensive Sexuality Education (CSE)*, available at: https://www.ippf.org/sites/default/files/ippf_framework_for_comprehensive_sexuality_education.pdf

⁸ IBID

⁹ UNFPA, undated, Comprehensive Sexuality Education, available at: <https://www.unfpa.org/comprehensive-sexuality-education>, accessed September 2020

¹⁰ UNESCO, 2015, *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review*, available at: https://www.unfpa.org/sites/default/files/pub-pdf/CSE_Global_Review_2015.pdf

50% of students surveyed knew what a condom was, despite having received FLE.¹¹ A curriculum review conducted of FLE in Samoa also revealed significant gaps in the curriculum, particularly around decision-making skills and human rights, as well as the limited support available to teachers delivering FLE.¹² In addition to the significant gaps in the knowledge shared, FLE curricula are often neither rights-based nor inclusive.¹³

Studies on SRHR knowledge of young people in the Pacific more broadly have found that there are significant gaps in young people's knowledge of key SRH issues, compromising their ability to make informed decisions about their sexuality, reproductive health and wellbeing. For example, a 2005 study on teenage pregnancy in Tonga found that the majority of young mothers had intended to abstain from sexual activity until marriage and were not prepared for the risks of sexual activity.¹⁴ In a Fijian study involving young people between the ages of 13 and 15, respondents had not heard of STIs or HIV.¹⁵ Across the Pacific, there are high rates of SGBV and it has been suggested that force was involved in the first sexual experiences of many young people.¹⁶

Despite this, sexuality education remains controversial in the Pacific, with opponents suggesting it sexualises young people.¹⁷ A survey of attitudes in Samoa found that 39% of survey respondents believed that CSE encouraged young people to have sex.¹⁸ Across the Pacific, there is a "culture of silence on sexual and reproductive health" particularly for adolescents and young people are often forced to rely on

¹¹ Ministry of Education and Training, 2019, *Baseline Study: FLE Programme In Vanuatu*, UNFPA

¹² Joiner, K., 2020, *Pacific Islands Subregion FLE Situation Analysis, Report on Phase 2: IMPLEMENTATION of the Family Life Education Programme & POLICY Report - SAMOA*, UNFPA

¹³ Eta Varani-Norton, 2014, 'It's good to teach them, but ... they should also know when to apply it': parents' views and attitudes towards Fiji's Family Life Education curriculum, *Sex Education*, 14:6, 692-706; and NZ Parliamentarian Group on Population and Development, 2012, *Pacific Youth: Their Rights, Our Future – Open Hearing on Adolescent Sexual and Reproductive Health in the Pacific*, available at: <https://www.familyplanning.org.nz/media/204645/report-pacific-youth-rights-future-2012.pdf>

¹⁴ Secretariat of the Pacific Community, 2005, *Teenage Pregnancy in Tonga, Noumea: Adolescent Reproductive Health Programme*, Secretariat of the Pacific Community

¹⁵ Seru-Puamau, E. and Roberts, G., 2009, *A pre-intervention study in the implementation of school-based family life education*, Secretariat of the Pacific Community

¹⁶ UNESCO Office for the Pacific States, 2015, *Attitudinal Survey Report on the Delivery of HIV and Sexual Reproductive Health Education in School Settings in Nauru, Niue, Palau and Samoa*

¹⁷ Hulshof, 2016, *UNICEF: Let's talk about sex: why we need sexuality education in Asia-Pacific*, available at: <https://blogs.unicef.org/east-asia-pacific/lets-talk-sex-need-sexuality-education-asia-pacific>, accessed October 2020

¹⁸ UNESCO Office for the Pacific States, 2015, *Attitudinal Survey Report on the Delivery of HIV and Sexual Reproductive Health Education in School Settings in Nauru, Niue, Palau and Samoa*

rumours and misinformation.¹⁹ Marginalised young people, including those with disabilities and young people of diverse SOGIE, are most vulnerable to discrimination when accessing information and services.²⁰

A survey of teachers' attitudes towards sexuality education found that information about reproduction and physical growth topics related to SRHR were taught in science classes, while topics related to the social and emotional aspects of SRHR, including decision-making, were taught less frequently.^{21 22} While this study found that teachers were broadly supportive of including CSE in school curricula, many respondents believed that abstinence should be the only method taught for preventing pregnancy and STIs. Abstinence-based education does not provide young people with the information or skills necessary to make informed decisions and has been demonstrated to be ineffective at reducing STIs and unintended pregnancies.²³ Additionally, teachers expressed a need for further support and preparation, particularly for sensitive and 'personal' topics such as sexual orientation and sexual activities beyond intercourse. The study found that there was a significant need for greater teacher training to address widespread misconceptions and to support teachers to reflect critically on their own values and beliefs.

In addition to improving the standard of in-school FLE, it is also crucial that CSE is delivered to out-of-school young people in the Pacific as well. Enrolment at secondary school level varies across the Pacific, from 47% and 48% respectively in Papua New Guinea and Solomon Islands to 101% in Tonga.²⁴ As in-school FLE often does not begin to cover sexuality topics until the final forms of secondary school,²⁵ without the provision of CSE to out-of-school young people, up to 53% would be left without the skills and

¹⁹ NZ Parliamentarian Group on Population and Development, 2012, *Pacific Youth: Their Rights, Our Future – Open Hearing on Adolescent Sexual and Reproductive Health in the Pacific*, available here: <https://www.familyplanning.org.nz/media/204645/report-pacific-youth-rights-future-2012.pdf>

²⁰ WHO and UNFPA, 2009, *Promoting Sexual and Reproductive Health for Persons with Disabilities*, WHO Press. and Pacific Free and Equal, 2015, *Frequently Asked Questions: Sexual orientation, gender identity and intersex status in the Pacific*, United Nations Human Rights – Office of the High Commissioner, available at:

https://www.ohchr.org/Documents/Publications/UNFE_PacificCampaignInfoSheet-Aug2015.pdf

²¹ UNESCO Office for the Pacific States, 2015, *Attitudinal Survey Report on the Delivery of HIV and Sexual Reproductive Health Education in School Settings in Nauru, Niue, Palau and Samoa*.

²² Please note: while this study focused on Nauru, Niue, Palau and Samoa specifically, it is believed that this is broadly representative of the region.

²³ UNESCO, 2018, *International technical guidance on sexuality education: An evidence-informed approach*, available at: <https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf>

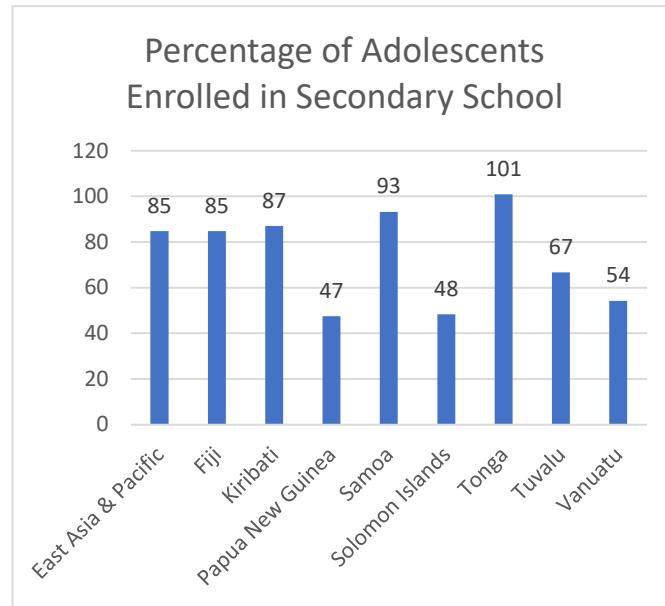
²⁴ Data from Data.WorldBank.org, accessed October 2020. Indicator: School enrollment, secondary (% gross). The World Bank summarises data from a variety of sources. The data points for Pacific Island Countries are from 2008 to 2018 and do not include Cook Islands. As this is the gross percentage of enrollment, the percentage can be over 100% indicating that young people outside of secondary school age are currently enrolled.

²⁵ E.g. Ministry of Education and Training, 2019, *Baseline Study: FLE Programme In Vanuatu*, UNFPA and Joiner, K., 2020, *Pacific Islands Subregion FLE Situation Analysis, Report on Phase 2: IMPLEMENTATION of the Family Life Education Programme & POLICY Report - SAMOA*, UNFPA.

knowledge to make informed decisions about their lives and sexualities. Making CSE available to out-of-school young people is key to addressing this gap.

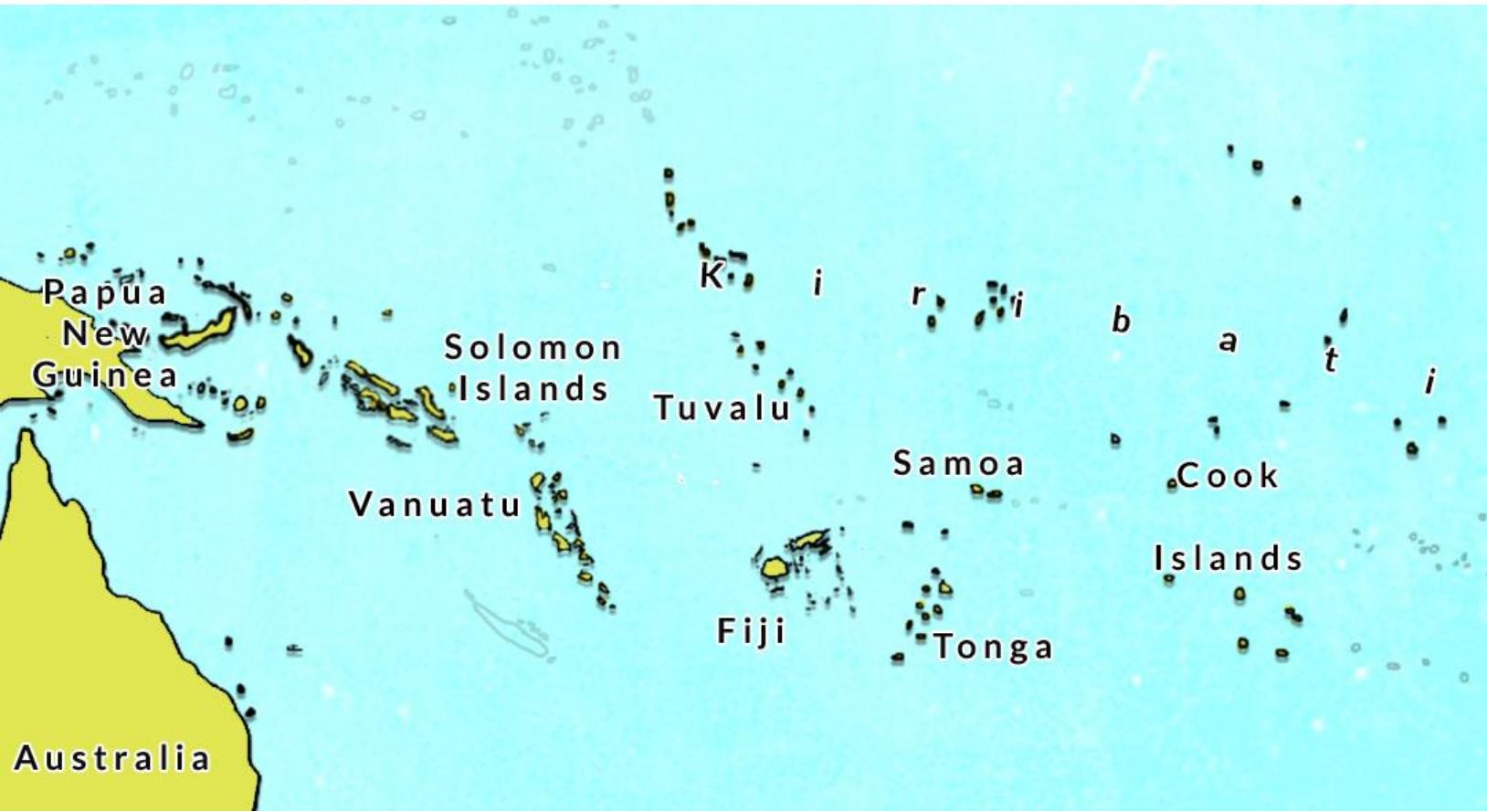
Additionally, out-of-school CSE is crucial to:

- Provide CSE when it is not included in the school curriculum,
- Provide CSE to young people who are not in school, or who do not attend school regularly,
- Complement and supplement in-school CSE, particularly if in-school CSE is not comprehensive or of high quality,
- Tailor CSE to the needs of specific groups of young people (e.g. young people with disabilities, young parents, young sex workers or young people of diverse SOGIE).



While there are many organisations across the Pacific offering some form of CSE, little is known about the curricula that are provided to out-of-school young people. IPPF, in partnership with the UNFPA, has conducted a mapping of organisations across the Pacific and the programs delivered to consolidate available information on SRH and SRHR education targeting out-of-school youth, including marginalised groups such as young people with disabilities, young people of diverse SOGIE, young sex workers and young parents.

This study aims to provide an overview of programs offering some form of CSE to out-of-school young people in the Pacific and assess the quality of education and information delivered. It is expected that this will inform future curriculum development in the Pacific and support those delivering CSE to ensure that they are providing information that meets the needs of young people.



Methods and Limitations

This mapping gathered information in four ways:

1. Organisational surveys of those providing CSE in Pacific Island countries;
2. Desk review of CSE manuals/curricula used;
3. An online survey using Survey Monkey for young people across the Pacific;
4. Focus group discussions with diverse groups of young people conducted by IPPF Member Associations.

This mapping has used the IPPF definition of young people as anyone under the age of 25.²⁶

²⁶ IPPF, 2017, *Vision and Plan for Placing Young People at the Heart of Implementing IPPF's Strategic Framework*, available at: <https://www.ippf.org/sites/default/files/2018-08/Young-people-at-the-centre-May17.pdf>

For the purpose of this mapping, ‘complete’ CSE is defined as sexuality education that covers a broad range of topics related to sexual and reproductive health and life skills, including anatomy and physiology; puberty; reproductive and teenage pregnancy; contraception; HIV/AIDS and STIs; drugs and alcohol; safe sex; healthy relationships; values and beliefs; sexual orientation and gender identity; gender and gender norms; SGBV; disability; SRH services; online media and technology; communications and decision-making skills; and human rights.

Organisational Surveys

The survey tool (available in Annex 1 – Organisational Survey) was developed by IPPF and reviewed by Family Planning New South Wales and UNFPA. A pilot test was not conducted. Overall, surveys from 35 organisations were collected, including from IPPF Member Associations. The full list of organisations surveyed is below in table 1.

The survey contained questions about sexuality education programs delivered by each organisation: what was delivered, to whom, by whom, where and how. It also provided space for organisations to share perceived gaps in their current curricula, which other organisations they were aware of delivering CSE in their country and whether they would be interested in trialling a new curriculum for out-of-school young people. The questions were based around established best practices for CSE education and covered whether the program was:

- Comprehensive (based on topics from the International Sexuality and HIV Curriculum Working Group’s (Population Council) *It’s All One Curriculum*),²⁷
- Rights-based,
- Inclusive,
- Well delivered,
- Evaluated,
- Linked to services

The surveys were distributed via email by IPPF and respective Member Associations to organisations known to be delivering in and out-of-school CSE in Cook Islands, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. The survey was only available in English.

²⁷International Sexuality and HIV Curriculum Working Group, 2009, *It’s All One Curriculum*, Population Council, available at <https://www.popcouncil.org/research/its-all-one-curriculum-guidelines-and-activities-for-a-unified-approach-to->

Table 1: Organisations Surveyed by Country

Country	Organisations Surveyed
Cook Islands	1. Cook Islands Family Welfare Association (CIFWA)
Fiji	2. Reproductive and Family Health Association of Fiji (RFHAF) 3. Ministry of Youth and Sport 4. Medical Services Pacific (MSP) 5. Rainbow Pride Fiji
Kiribati	6. Kiribati Family Health Association (KFHA) 7. Kiribati YPEER Network 8. Child Fund
Papua New Guinea	9. Papua New Guinea Family Health Association (PNGFHA)
Samoa	10. Samoa Family Health Association (SFHA) 11. Ministry of Education Sports and Culture 12. Ministry of Health 13. Ministry of Women, Community and Social Development 14. Nuanua O Le Alofa (NOLA) 15. Samoa Fa'afafine Association
Solomon Islands	16. Solomon Islands Planned Parenthood Association (SIPPA) 17. People with Disabilities Solomon Islands 18. Anglican Church of Melanesia 19. Stages of Change Women's Theatre Association 20. Ministry of Education 21. Ministry of Health 22. Seventh Day Adventist Church 23. Young Women's Christian Association
Tonga	24. Tonga Family Health Association (TFHA) 25. Tonga National Youth Congress 26. Tonga Leiti's Association 27. Tonga Red Cross Society
Tuvalu	28. Tuvalu Family Health Association (TuFHA)
Vanuatu	29. Vanuatu Family Health Association (VFHA) 30. Care Vanuatu 31. Adventist Development and Relief Agency (ADRA) 32. Mama's Laef 33. Wan Smol Bag 34. Vanuatu National Youth Council 35. Save the Children

Review of Curricula

IPPF Member Associations provided the curricula used to deliver CSE to out-of-school young people. While respondents to the organisational survey were also requested to provide their manuals, only one did.²⁸ In total, nine curricula were reviewed including:

- CIFWA's *Adolescent Reproductive Health Training Manual* (developed by CIFWA in 2009 and used in Cook Islands);
- RFHAF's *Integrated, Comprehensive & Life Skills Sexuality Education Flip Charts* (developed by RFHAF in 2008 and used in Fiji);
- *Sexual Health Education – A Training Manual for the Pacific* (developed in 2001 and updated in 2002 by Sexual Health and Family Planning Australia and used in Papua New Guinea, Tonga and Vanuatu);
- *SIPPA Volunteer Training Manual* (developed by SIPPA, revised in 2019 and used in Solomon Islands);
- *Adolescent Reproductive Health – Training Manual* (developed in 2003 and updated in 2006 by Secretariat for the Pacific Community (SPC), in partnership with UNFPA, and used in Tonga, Tuvalu and Vanuatu);
- *Good Relationships Free from Violence* (developed in 2017 by Care and used in Vanuatu);
- *Sexual and Reproductive Health: a toolkit for community educators for Samoa and Vanuatu* (developed by Family Planning Australia in 2019 and used in Samoa and Vanuatu, although the 2001 Sexual Health Education – A Training Manual for the Pacific remains the primary manual used in Vanuatu)²⁹;
- *Marurungin Te Utu Training Manual* from the Healthy Families Taskforce (the latest version was developed by Family Planning New Zealand in 2020 and is used in Kiribati).

The curricula reviewed are available in Annexes 2 – 10.

Following UNESCO's guidance high quality CSE is defined as:

- Scientifically accurate;
- Incremental (i.e. develops over time and builds on previous information learned);
- Age-appropriate and developmentally appropriate;
- Curriculum-based;
- Based on a human-rights approach;
- Based on gender equality;
- Culturally relevant and contextually appropriate;
- Transformative;
- Able to develop life skills needed to support healthy choices.³⁰

²⁸ Care Vanuatu

²⁹ These manuals are localised to the country in which they are used. Both manuals have been reviewed but they are discussed in this report as one manual as there are only small differences between the two.

³⁰ UNESCO, 2018, *International technical guidance on sexuality education: An evidence-informed approach*, available at: <https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf>

Additionally, UNFPA recommend that CSE programs are designed to elicit information from young people to promote their engagement and allow for the correction of any misinformation.

The curricula were reviewed across three criteria:

1. Coverage: does it provide comprehensive SRHR information? Key gaps are assessed against the International Sexuality and HIV Curriculum Working Group's (Population Council) *It's All One Curriculum*, developed in 2009.³¹
2. Quality of Information and Activities: is the information accurate? Is it presented in a positive and engaging way, with activities that promote engagement and the development of skills? Does it provide support for facilitators?
3. Approach: is the curricula rights-based and inclusive of young people in all their diversity, including young people with a disability and young people of diverse SOGIE?

Youth Survey

IPPF designed an online survey for young people across the Pacific, adapted from the focus group discussion guidance and organisational surveys and reviewed by UNFPA. It was not pre-tested. Overall, 5,753 young people, aged between 10 and 25, from eight countries completed the survey.

The survey was structured around three sections:

1. Demographics and Sexual and Gender Identity;
2. SRHR Information Received;
3. Needs for Further SRHR Information.

The link to the survey was distributed widely and IPPF Member Associations in Cook Islands, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu approached young people with tablets and supported them to complete the survey. Survey responses were not elicited from young people in Papua New Guinea due to the ongoing uncertainty around the coronavirus pandemic. Due to the sampling method, it is likely that these surveys predominantly represent the views of young people in urban centres on the main island of each country.³²

44% of respondents were between the ages of 21 and 25, 41% were between the ages of 16 and 20 and just 15% were between the ages of 10 and 15. There was an even split between young men and women. 1% of participants reported their gender as 'other'. When asked to specify, the most common terms used to describe their gender include 'transgender woman' or fakaleiti³³ (10 respondents), 'multi' (2 respondents), and homosexual (2 respondents).³⁴

³¹ IBID

³² In some countries, young people move between urban and rural areas frequently and thus this should not be interpreted as solely representing the views of urban youth people.

³³ A Tongan term for an individual assigned male at birth who has a feminine gender expression.

³⁴ Please note that while this refers to sexual identity rather than gender identity, it has been included here as respondents clearly felt it was important to state in respect to their identity.

Figure 1: Youth Survey Respondents by Age

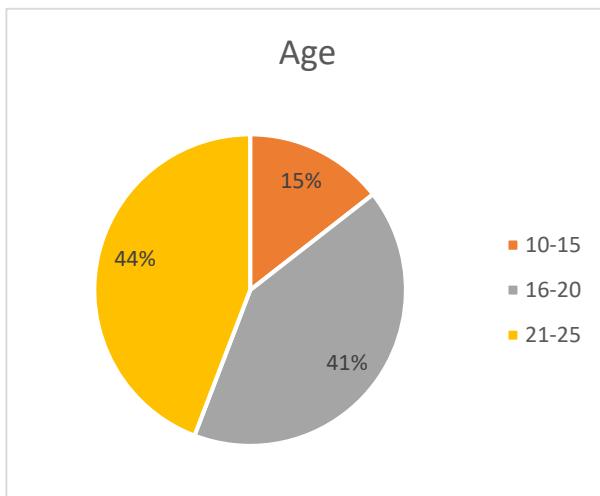
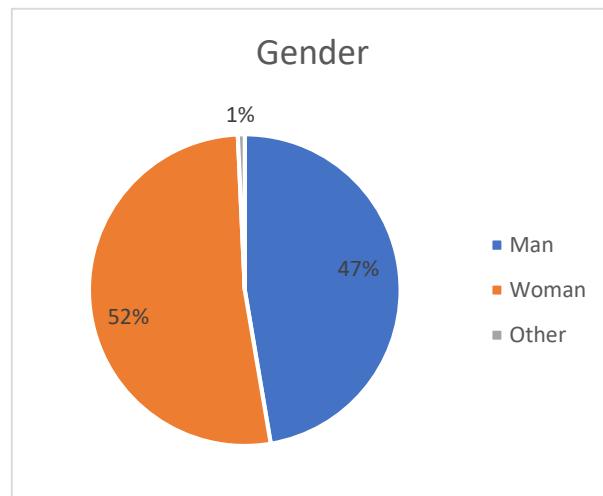


Figure 2: Youth Survey Respondents by Gender



The survey is available in Annex 12 – Youth Survey.

Focus Group Discussions

IPPF Member Associations conducted a total of 24 focus group discussions with 252 young people in Cook Islands, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu to further understand their experiences and needs in relation to SRHR. Focus group discussions were not conducted in Papua New Guinea due to the ongoing uncertainty around the coronavirus pandemic. Overall, 252 young people participated and have been included in the analysis.³⁵

Based on the IPPF Youth Manifesto focus group guide, the focus group discussion guidance was adapted, with feedback from UNFPA. The focus group discussions were facilitated by IPPF Member Association staff and volunteers, including peer educators. The question sheets and facilitator's guidance are available in Annex 11 – Focus Group Discussion Facilitator's Guide.

The focus group discussions were structured around three core areas:

1. Access to SRHR Education;
2. Access to SRH Services;
3. Unmet Needs for Education and Services.

Attention was paid to ensure that diverse groups were represented, although due to geographic and transport constraints, focus groups were only conducted in urban centres on the principal island of each country. One session was held with local transgender groups³⁶ and two with other groups for people of

³⁵ Some focus group discussions included a significant number of participants over the age of 35 and have been excluded from the analysis. 35 has been used as the cut off as per National Youth Policies across the Pacific (e.g. Fiji available at: https://www.youthpolicy.org/national/Fiji_2011_National_Youth_Policy.pdf)

³⁶ One further session has been excluded from analysis due to the age of participants.

diverse SOGIE³⁷, two with people with disabilities³⁸, two with sex workers³⁹, five with peer educators and other youth volunteers and 12 with other groups of young people. Focus groups were not limited to out-of-school young people and incorporate the views of diverse groups of young people, including in-school young people, university students, and young people who did not finish schooling.

Table 2: Summary of Focus Group Discussion Participants

Group	Participants
Total	252
Age Range	13-35
Male	87
Female	138
Other	17
<i>Number of Focus Groups by Group of Young People Involved</i>	
Young people with a disability	2
Young sex workers	2
Young people / General	12
Peer educators / youth volunteers	5
Young people of diverse SOGIE	3

Table 3: Summary of Focus Group Discussions by Country

Country	Number of Focus Groups	Total Participants	Notes
Cook Islands	2	17	
Fiji	3	30	
Kiribati	5	50	
Samoa	2	14	Two focus groups were held with those above the age of 35 and have been excluded from analysis
Solomon Islands	5	68	
Tonga	2	28	Two focus groups were held with those above the age of 35 and have been excluded from analysis
Tuvalu	2	20	One focus group was also held with those above the age of 35 and have been excluded from analysis
Vanuatu	3	25	Two focus groups were also held with those above the age of 35 and have been excluded from analysis

Limitations

There are several limitations in the methodology. Firstly, this mapping exercise was conducted during the COVID-19 pandemic which limited field work, particularly in Papua New Guinea where no focus group discussions were conducted and no youth surveys were collected. IPPF Member Associations were relied

³⁷ One further session has been excluded from analysis due to the age of participants.

³⁸ Four further sessions have been excluded analysis due to the age of participants.

³⁹ One further session has been excluded from analysis due to the age of participants.

upon to disseminate the organisational and youth surveys and to facilitate focus group discussions. This affects the sampling as respondents to surveys and participants in focus group discussions were predominantly known to the respective IPPF Member Association. The organisational survey was only available in English and several organisations did not complete all questions.

Definitions of youth vary across the Pacific, which resulted in older people being included in focus group discussions. As far as possible, those over the age of 25 have been excluded from the analysis, however 40 participants between the age of 25 and 35 have been included, due to difficulties in excluding individual participants from analysis of Focus Group Discussions and Pacific definitions of youth, which extend up to 35. Those between the ages of 25 and 35 comprise approximately 16% of participants.

With limited fieldwork due to the COVID-19 pandemic, this mapping primarily relied on a desk-based review of organisational surveys, in which organisations delivering CSE self-identify the strengths and weakness, coverage and gaps of their own programmes. As such, it was not possible to assess the quality of training delivered. The majority of organisations delivering CSE did not share their curricula and manuals, therefore this mapping has relied more heavily on their self-reporting of gaps and weaknesses than expected.

The Youth Survey was only available in English and local peer educators supported young people to complete it. This sample is therefore predominantly urban young people from the principal island of each country. As such, it is likely that their level of English and/or the national language (if multiple dialects are spoken, as for example in Vanuatu) is better than average for young people in the region, which may underestimate the importance of delivering CSE in local language.

Additionally, there was limited time for training on data collection, which resulted in incomplete data recorded for several focus groups. The focus group discussions were conducted by IPPF Member Associations with limited support and the results received from each Member Association differ. One Member Association conducted three focus group discussions but only compiled one report, several Member Associations recorded very brief notes and the last question (around diversity and inclusion) was only answered in ten focus group discussions.

This mapping was relatively broad, aiming to develop a thorough understanding of organisations who provide CSE in the Pacific. It has raised many further questions which were beyond the scope of this exercise due to its breadth. It is hoped that this will form the basis for further research.

Findings

This mapping exercise comprises four distinct sections:

1. Organisational surveys of those providing CSE in Pacific Island countries;
2. Desk review of CSE manuals/curricula used;
3. An online survey using Survey Monkey for young people across the Pacific;
4. Focus groups discussions with diverse groups of young people conducted by IPPF Member Associations.

The findings from each section are summarised below.

Organisational Surveys

A wide range of organisations, with different specialisations, deliver CSE across the Pacific including SRH organisations, government ministries, peak bodies for people with disabilities, faith-based groups, women's groups and organisations for people of diverse SOGIE. Overall, 35 organisations completed the surveys. Two did not deliver CSE⁴⁰ and the Ministries of Education in Samoa and Solomon Islands only provided in-school CSE.

All organisations expressed a willingness to trial a new manual, noting the need for accuracy of information and a reduction in myths, misinformation and incomplete information. Multiple organisations expressed a desire that any future manual should be localised and developed in consultation with local partners, ahead of pre-testing.

Curricula Overview

Out of the 33 organisations who responded and deliver some form of CSE, 28 have manuals or curricula. Of those five organisations that do not have a manual, one is in the process of developing a manual, two use resources from partners and one did not answer. Although the manuals used, either as they are or as a basis for the development of a tailored curriculum, are relatively comprehensive (see Desk Review of CSE Manuals below), all providers of CSE noted key gaps in their programs. The most commonly reported gaps were:

- Online media (27 organisations)
- Disability (21 organisations)
- Services for SRH or SGBV (17 organisations)
- Human rights (16 organisations)
- Communication and decision-making skills (14 organisations)
- Child abuse (13 organisations)
- Anatomy and physiology (12 organisations)
- Contraception (11 organisations)
- Drugs and Alcohol (11 organisations)
- Sexual orientation and gender identity (10 organisations)

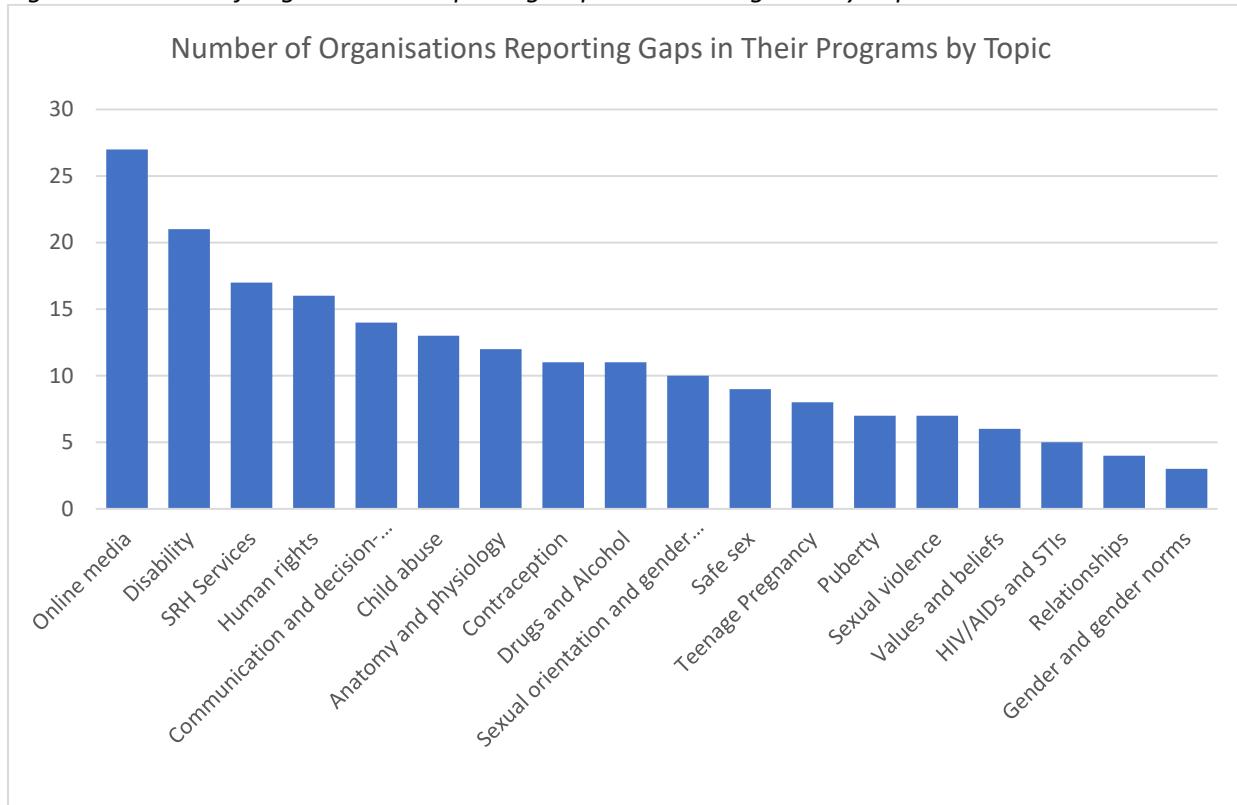


Cook Islands Family Welfare Association deliver in-school CSE, 2018, IPPF

Other areas missing from organisations' programs include safe sex (9 organisations), teenage pregnancy (8 organisations), puberty (7 organisations), sexual violence (7 organisations), values and beliefs (6 organisations), HIV/AIDS and STIs (5 organisations), relationships (4 organisations) and gender and gender norms (3 organisations).

⁴⁰ Child Fund in Kiribati deliver a life skills program that focuses on literacy and numeracy and Tonga Red Cross Society were surveyed but do not deliver a similar program.

Figure 3: Number of Organisations Reporting Gaps in Their Programs By Topic



Inclusion

There was significant variation in responses to the question ‘How do you make sure your training is inclusive?’ and respondents had varying understandings of the term ‘inclusion’. The question was deliberately broad to ascertain organisations’ understandings of the term ‘inclusion’ and the groups to which it refers. Some organisations referenced gender or disability or people of diverse SOGIE. The majority of providers are aware of the differing needs of key population groups and several work with specialised organisations to meet these needs. Six organisations did not answer this question, two gave unclear answers that related to other questions, one mentioned that ‘inclusion’ would be included in an upcoming manual and one reported that they find inclusion difficult due to the limited number of peer educators from diverse backgrounds. Several organisations provided general responses around promoting participation and inviting members of marginalised groups. Other responses included through staff training, community support to select participants, partnering with peak SOGIE and disability organisations, and providing adjustments to support young people with a disability to engage, including sign language, interpretation and involving carers.

Delivery and Training of Facilitators

Providers use a range of actors to deliver CSE, including peer educators, clinical and non-clinical program staff and guests from key population groups. All facilitators receive training, ranging from one day to two weeks, although not all organisations provided the number of sessions or days.⁴¹ Whilst it is beyond the

⁴¹ One organisation did not complete this question.

scope of this report to assess the quality and efficacy of this training, it is recommended as the focus of further study.

All participants reported using a range of activities and learning methods, including group discussions, games, one-on-one (peer-to-peer) discussions, dramas, lectures, and IEC materials. Only one organisation reported using only lecture and discussion formats. The majority made use of a wide range of activities. Many reported that the manuals used contained a range of activities while organisations also supplemented this with activity types that were not included in the manual used. There was limited use of online and offline media and providers tended to focus on classroom-style learning. Some providers made use of emerging media, including social media, although this is likely to be for ad-hoc awareness rather than 'complete' CSE. From the survey, it is unclear how extensively each activity type was used and the efficacy of each.

Geographic Reach and Coverage

Pacific Island Countries are characterised by their geographic spread, with communities dispersed across remote islands. The geographic reach and coverage of CSE programs differs by country. Broadly speaking, programs are concentrated on the main island or town of each country, although there are providers who offer education outside of these areas and IPPF Member Associations conduct regular outreach visits, incorporating CSE. However, it is unclear how frequently young people on outer islands or in remote areas are able to access SRHR education and SRH services.



*Travel to outreach,
Solomon Islands,
2015, IPPF.*

Services

The majority of providers either offer services in tandem with CSE or refer to other service providers, including IPPF Member Associations, other NGOs and government services. 13 CSE providers offer services in conjunction with their CSE program; 16 providers do not deliver services directly but refer to SRH service providers. One CSE provider neither delivers nor refers to SRH services while two others offer limited services (condom distribution and counselling for SGBV). One provider did not answer this question.

Evaluation

The majority of organisations are attempting to assess the efficacy of their interventions, using a variety of methods. The most common methods of assessing the efficacy of CSE training are pre- and post-tests and evaluation forms. Three organisations did not answer this question and one gave an unclear answer that related to another question. Two gave very general answers that did not provide details of the methods used. Providers note the limitations in the evaluation of their programs and expressed a desire to measure CSE against services uptake and behaviour change as well.

An assessment of survey responses is available in Annex 13 – Assessment of Survey Responses.

Desk Review of CSE Manuals

A thorough review of manuals shared by organisations delivering CSE was conducted. The curricula reviewed are available in Annexes 2 – 10.

The most widely used manuals are *Sexual Health Education – A Training Manual for the Pacific* and *Adolescent Reproductive Health – Training Manual*, which were both developed in the early 2000s and are in need of updates. IPPF Member Associations also draw heavily on International Sexuality and HIV Curriculum Working Group's (Population Council) *It's All One Curriculum*, which was used to inform this mapping. More recently, Family Planning Australia and Family Planning New Zealand have developed manuals for use in Kiribati, Samoa and Vanuatu.

Although all providers noted significant gaps in their organisational surveys, the manuals reviewed were relatively comprehensive, providing information on:

- Anatomy and Physiology,
- Puberty,
- Teenage Pregnancy,
- Contraception,
- HIV&AIDS / STIs,
- Drugs and Alcohol,
- Safe sex,
- Healthy relationships (relatively limited),
- Values and Beliefs,
- Sexual orientation and gender identity (limited),
- Gender and gender norms,
- Sexual abuse/violence,
- Child abuse,
- Disability (limited),
- Communication and decision-making skills,
- Human rights.

The manuals, nonetheless, contained notable gaps. Seven manuals did not include information on SRH services or online media and technology (e.g. safe use of internet and social media, pornography).⁴²

⁴² Online media is an emerging area in the SRHR space. However, the rise of social media, cyber bullying and the impact of easily accessible pornography, including the sharing of pornographic images, all have significant impacts for the SRH of young people in the Pacific. As such, it is crucial that online media is included in CSE curricula.

Disability issues were only covered in two manuals, both as standalone modules rather than integrated throughout. Child abuse was only mentioned in two manuals and there was only an explicit focus on human rights in three manuals.

Coverage of sexual orientation and gender identity, gender and gender norms and relationships was limited. While only three manuals did not cover sexual orientation and gender identity at all, the coverage in other manuals was severely limited. The same is true for relationships and gender norms: while these topics were touched on in the majority of manuals, they are in need of expansion. The coverage of relationships, in particular, was limited in several manuals to avoiding violence and refusal and negotiation skills, rather than the development of healthy relationships.

Figure 4: Number of Manuals with Gaps By Topic

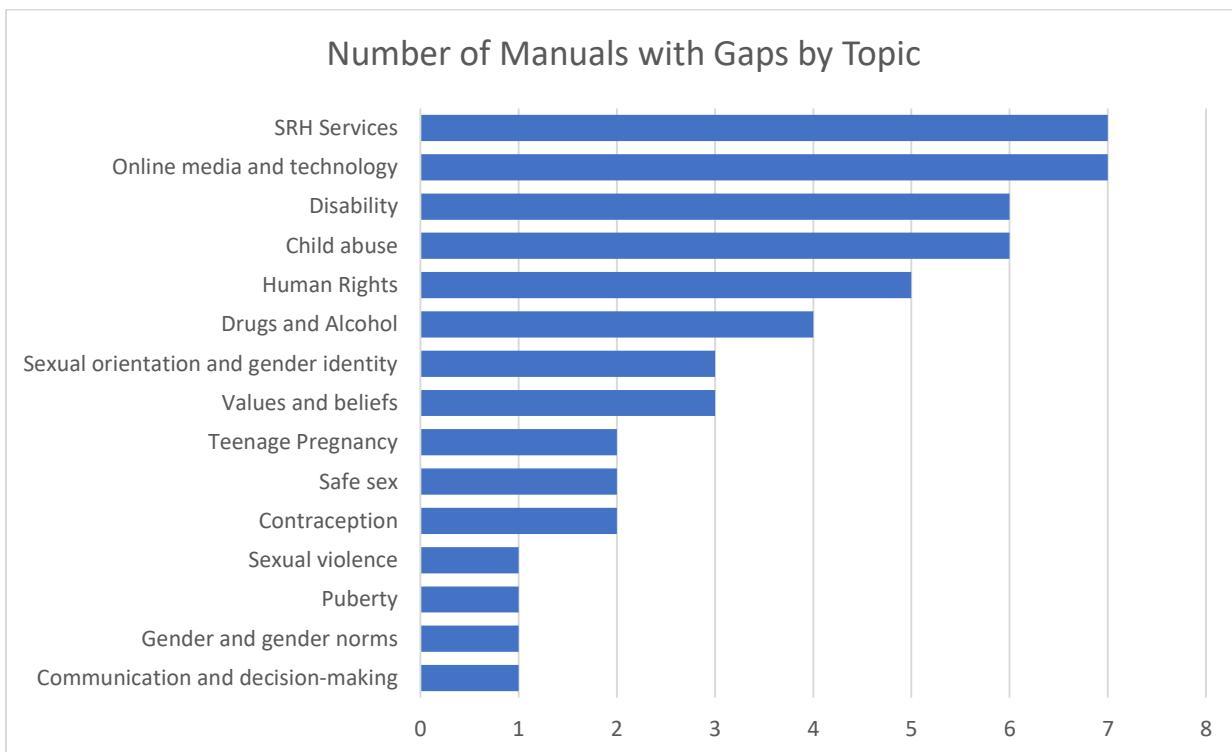
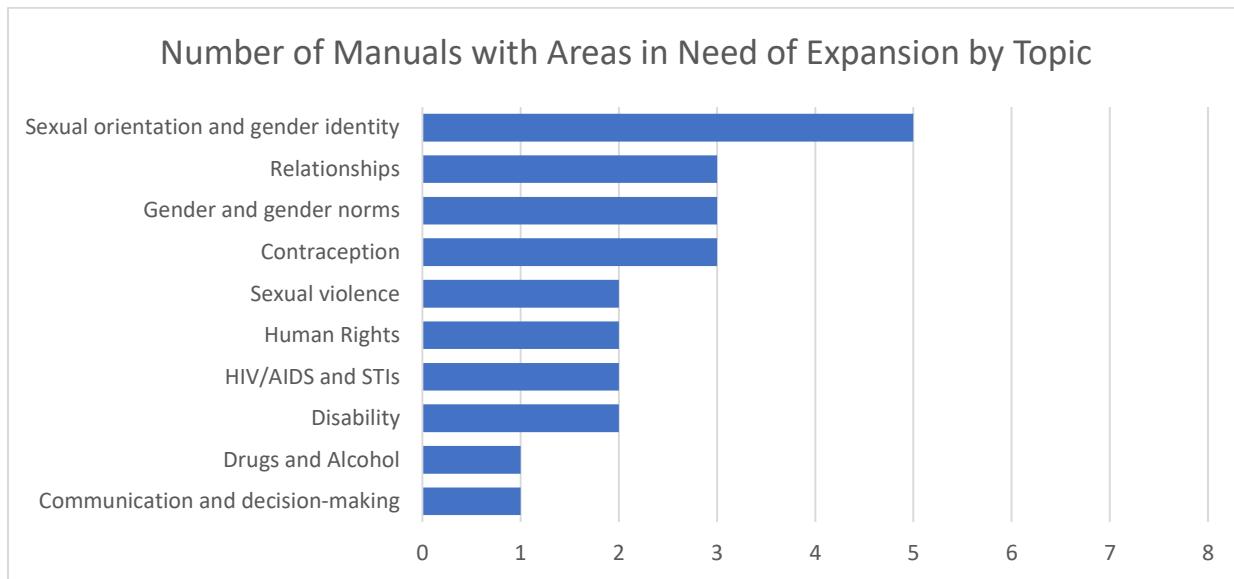


Figure 5: Number of Manuals with Areas in Need of Expansion by Topic



Notably, RFHAF's *Integrated, Comprehensive & Life Skills Sexuality Education Flip Charts* and SIPPA's *Volunteer Training Manual* do not include information on key topics such as contraception. Based on the organisations' survey responses these topics are covered in their programs, but not explicitly in their manuals.

The majority of manuals reviewed did not include information on national laws and policies around abortion or safe abortion services. Abortion was mentioned in *Sexual Health Education – A Training Manual for the Pacific* and *Adolescent Reproductive Health – Training Manual* but they did not provide accurate information as to the availability of abortion services and their legality in the Pacific and are in need of updating. Although this is a sensitive issue, it is crucial that young people receive accurate, rights-based information.

Additionally, the curricula are predominantly based around a negative view of sex and sexuality, based in fear and risk rather than viewing sexuality as a positive part of holistic health. As such, there is a lack of information on developing healthy relationships and sexual pleasure (including self-pleasure, which was only mentioned in two manuals).

While all providers of CSE reported using a range of activities and methods to provide information, several of the manuals focused on lecture styles of information dissemination rather than supporting young people to develop the skills to make free and informed decisions. However, the most commonly used manuals *Sexual Health Education – A Training Manual for the Pacific* and *Adolescent Reproductive Health – Training Manual* both make extensive use of discussions and other engaging activities.

Across the manuals reviewed, there is a relatively high level of assumed knowledge in each curriculum and basic terms (such as sex) are not explained. Three manuals did not include any support for facilitators. Five manuals provided varying levels of support for facilitators, from overall guidance on CSE and tackling sensitive subjects to module-by-module guidance and suggested scripts.

An assessment of the manuals reviewed is available in Annex 14 – Assessment of Manuals.

Youth Surveys

Of the 5,753 respondents to the youth survey, 73% identified as a member of a marginalised group⁴³, including as a person of diverse SOGIE, person with a disability, sex worker, young parent or a member of multiple groups. 48% selected ‘other marginalised group’. A write-in option was not available for this question. 1% identified as belonging to multiple groups.

Location

Responses were collected from eight of the nine Pacific islands countries that are the focus of this report. The distribution of responses broadly follows the distribution of population in the region. Notably, Kiribati is overrepresented, accounting for 18% of responses despite its small population, while Fiji is underrepresented, accounting for 14% of respondents, despite having a significantly larger population than the other countries sampled.

Figure 6: Respondents by Marginalised Group Identity

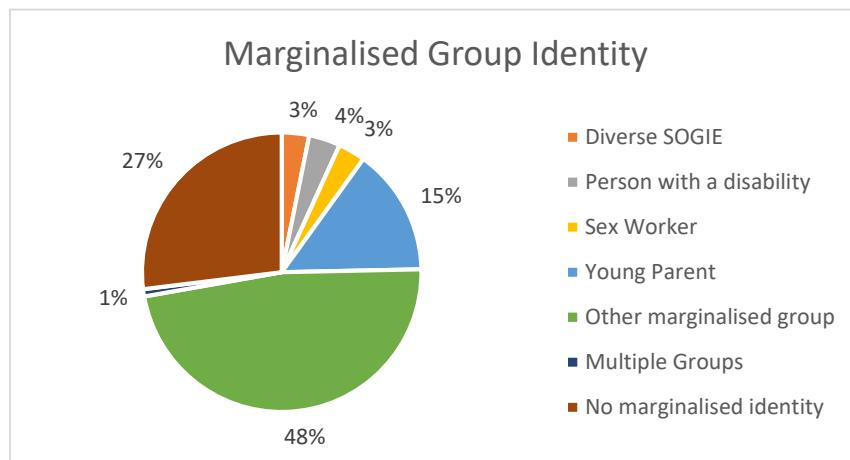


Figure 7: Respondents by Country (Percentage)

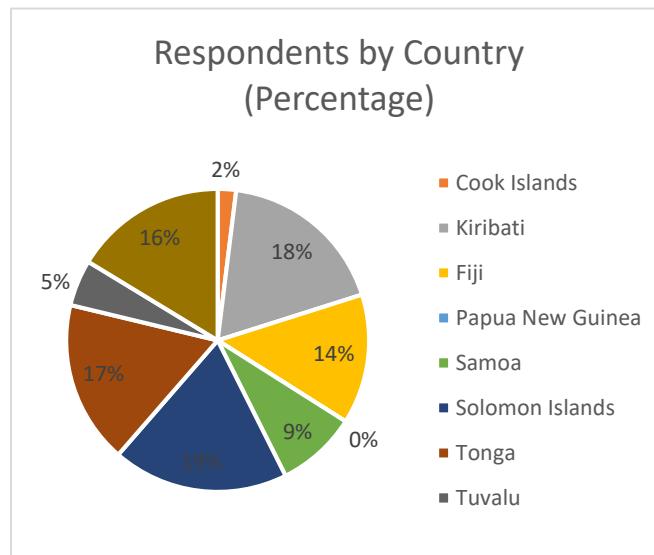
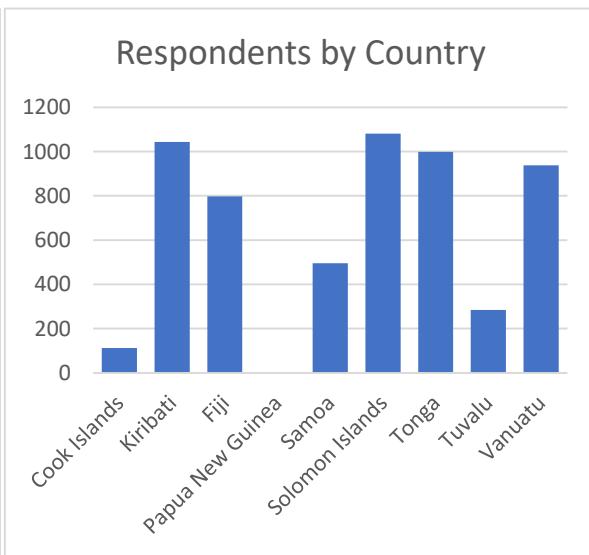


Figure 8: Respondents by Country



⁴³ Marginalisation is defined as “both a process, and a condition, that prevents individuals or groups from full participation in social, economic and political life.” (DFID, 2017, *Defining marginalised; DFID’s Leave no one behind agenda*, available at <https://www.ukaiddirect.org/wp-content/uploads/2017/03/Defining-marginalised.pdf>). In this context, it is used to refer to groups who are less able to access, or otherwise excluded from, SRH education or services, whether due to gender identity, sexual orientation, disability, ethnicity or other factors.

Education and Knowledge

60% of respondents reported that they had received some form of training on SRHR topics.⁴⁴

Respondents in Cook Islands (85%), Fiji (75%), Samoa (85%) and Tuvalu (83%) were most likely to report that they had received some form of sexuality education. Participants in Kiribati (33%) and Solomon Islands (50%) were the least likely to have received or accessed sexuality education or information.

The youngest age group was the least likely to have received any sexuality education information and younger girls were less likely to have received information than younger boys (44% compared to 52%). In the older groups, young women were slightly more likely to have received information than young men (66% vs. 63% of 21-25 year olds).

Figure 9: Percentage of young people who had received some sexuality education or information

Have you received any sexuality education or information?

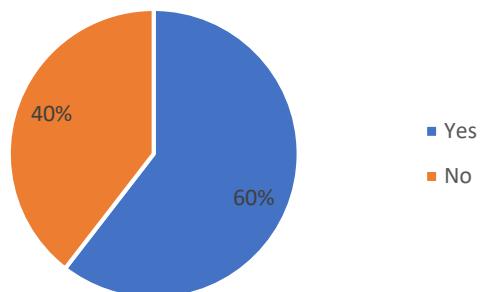


Figure 10: Have you Received Information by Gender

Have You Received Information?
By Gender

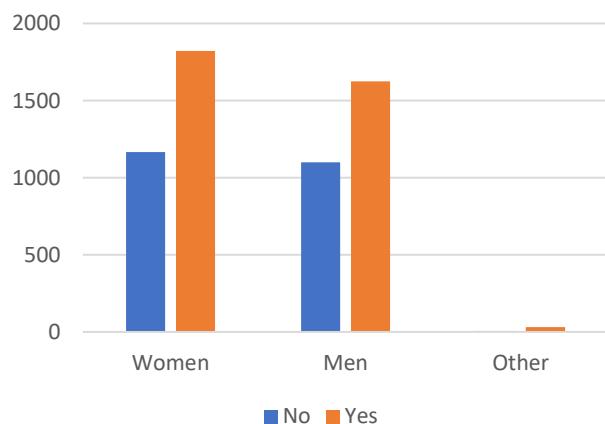
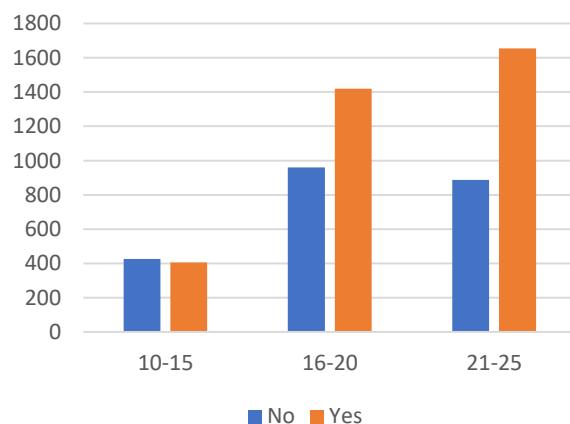


Figure 11: Have you Received Information by Age

Have You Received
Information? By Age

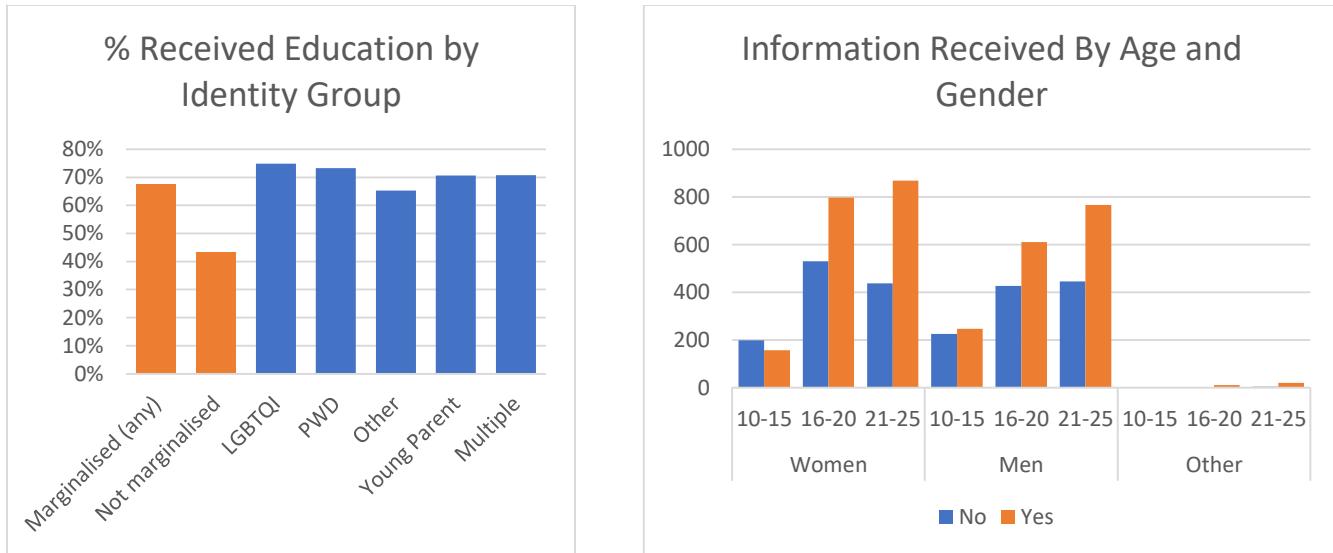


Interestingly, those who identified as part of a marginalised group were more likely to report receiving sexuality education than those who did not identify as a marginalised group. This is likely to be due to the

⁴⁴ The questions on the information were relatively broad and asked about information and education received generally, rather than specifically asking about CSE programmes (as distinct from more informal community engagement, receiving pamphlets or information and communication resources, accessing websites etc.). The questions asked were “Have you ever received any training on topics on sexuality education or sexual and reproductive health and rights?” and “Have you received information on any of the following topics?”

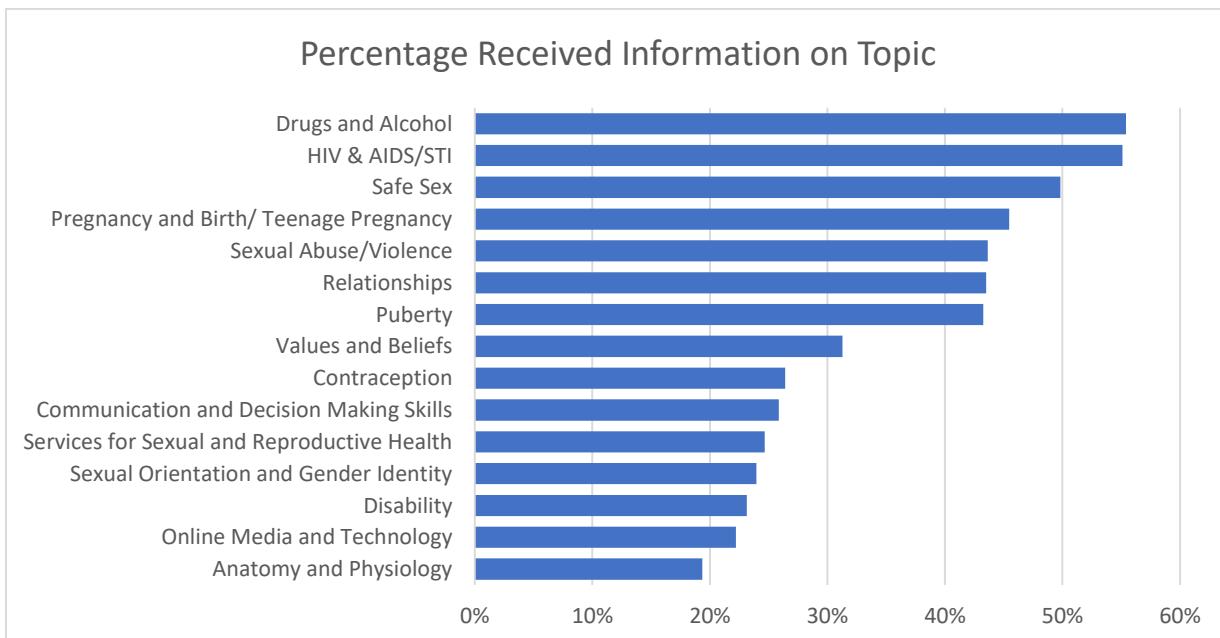
sampling method, as marginalised groups sampled were more likely to be known to peer educators because they had accessed training.

Figure 12: % Received Education By Identity Group Figure 13: Have You Received Information by Age/Gender



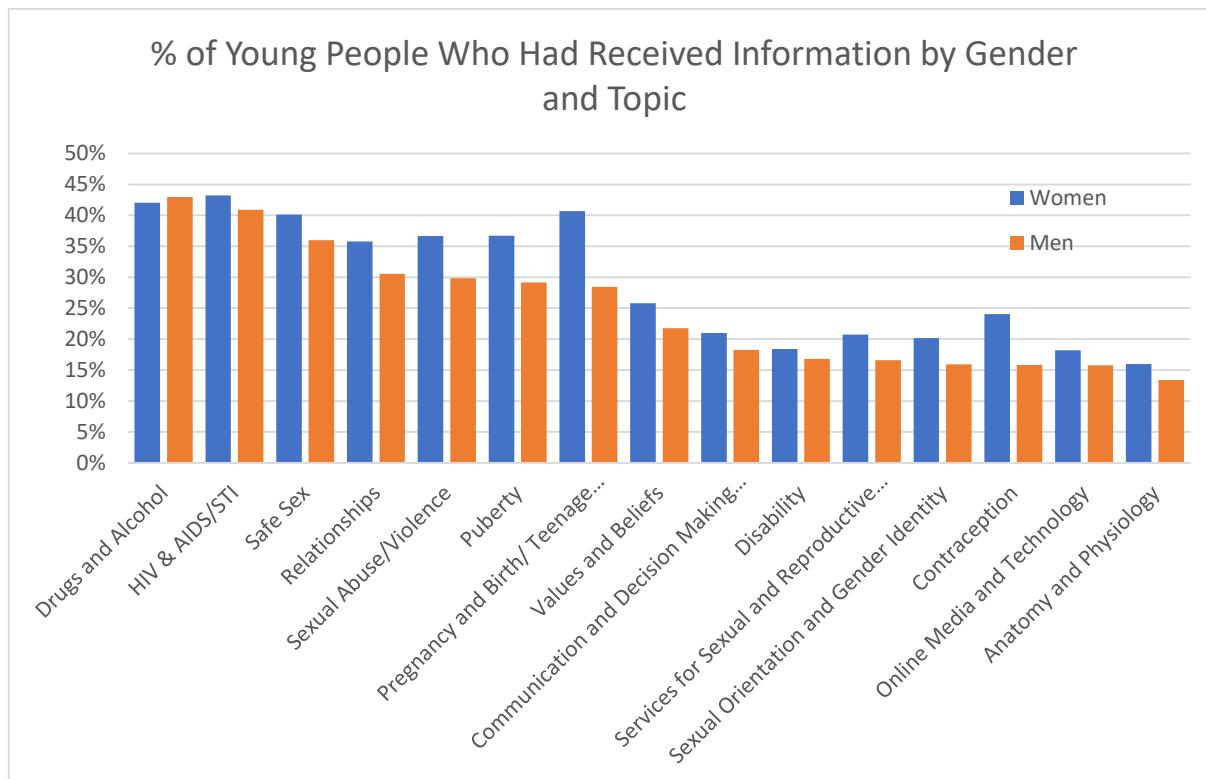
In terms of the topics that respondents had received information on, the most common topics were Drugs and Alcohol (55%) and HIV/AIDS and STIs (55%). 50% of those who had received some SRH information had received information on Safe Sex. However, only 26% had received information on contraception or anatomy, demonstrating the current gaps and limitations in the delivery of CSE, both in and out of school.

Figure 14: Percentage of Respondents who had Received Information on each Topic



There were no significant differences in the topics on which each gender had received education. Overall, slightly more women reported having received some form of information. The only area where a higher percentage of men had received information was drugs and alcohol (where only 1% more men had received information than women). In all other areas, more young women than men reported some knowledge of each area and were significantly more likely to have received information on pregnancy and, to a lesser extent, contraception.

Figure 15: Percentage of Respondents Who Had Received Information by Gender and Topic



In line with recommendations that CSE be age-appropriate and incremental, there were differences in the topics that each age group had received information on. The most common topics that the youngest age group (10-15) had received information on was Drugs and Alcohol (38%), followed by Puberty (37%) and HIV/AIDS and STIs (25%). The older age groups were more likely to have received information on sexual topics including HIV/AIDS and STIs (44% of 16-20 year olds and 46% of 21-25 year olds), Safe Sex (38% of 16-20 year olds and 43% of 21-25 year olds), and Pregnancy (37% of 16-20 year olds and 37% of 21-25 year olds).

Table 4: Percentage of each Age Group who had Received Information on each Topic

Topic Area	10-15	16-20	21-25
Drugs and Alcohol	38%	45%	42%
Puberty	37%	35%	30%
HIV & AIDS/STI	25%	44%	46%
Safe Sex	24%	38%	43%
Pregnancy and Birth/ Teenage Pregnancy	23%	37%	37%
Sexual Abuse/Violence	21%	35%	36%
Relationships	20%	36%	35%
Values and Beliefs	17%	25%	25%
Communication and Decision Making Skills	12%	20%	23%
Disability	12%	18%	20%
Online Media and Technology	11%	19%	18%
Anatomy and Physiology	10%	15%	17%
Contraception	10%	21%	23%
Services for Sexual and Reproductive Health	9%	19%	22%
Sexual Orientation and Gender Identity	9%	17%	23%

75% had received information from a teacher, 58% had received information from a friend. The next most common answers were nurse (48%), adult family member (47%) and peer educator (46%).

The majority of respondents (81%) reported receiving information through ‘awareness’ activities or training workshops, although the write in answers demonstrated the full variety of ways young people can access information. The most popular write in answers were: in school lessons, at home, in health clinics and through friends.

Crucially, only 26% of participants had received information solely outside of school. The majority (52%) received information both in school and out of school.

Figure 16: Number of Respondents by Information Source

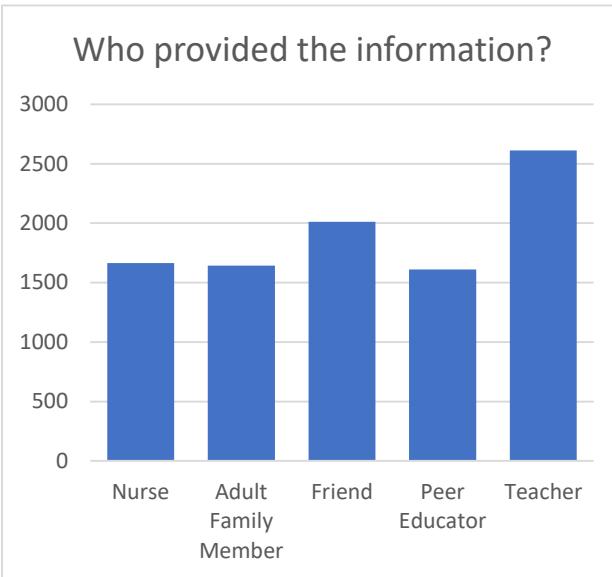
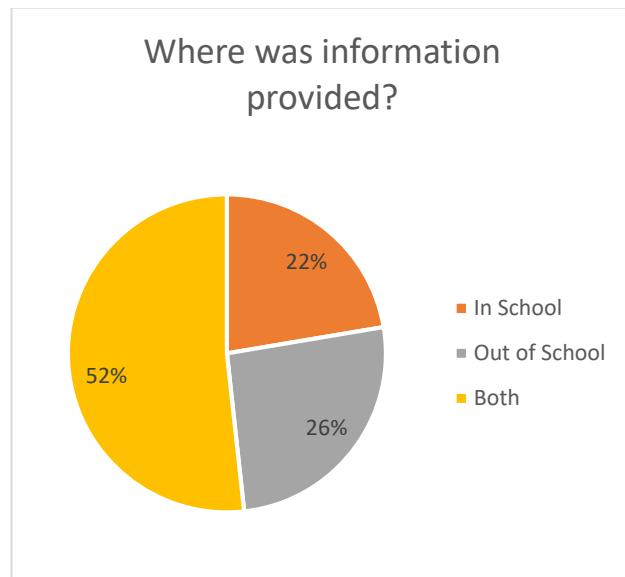


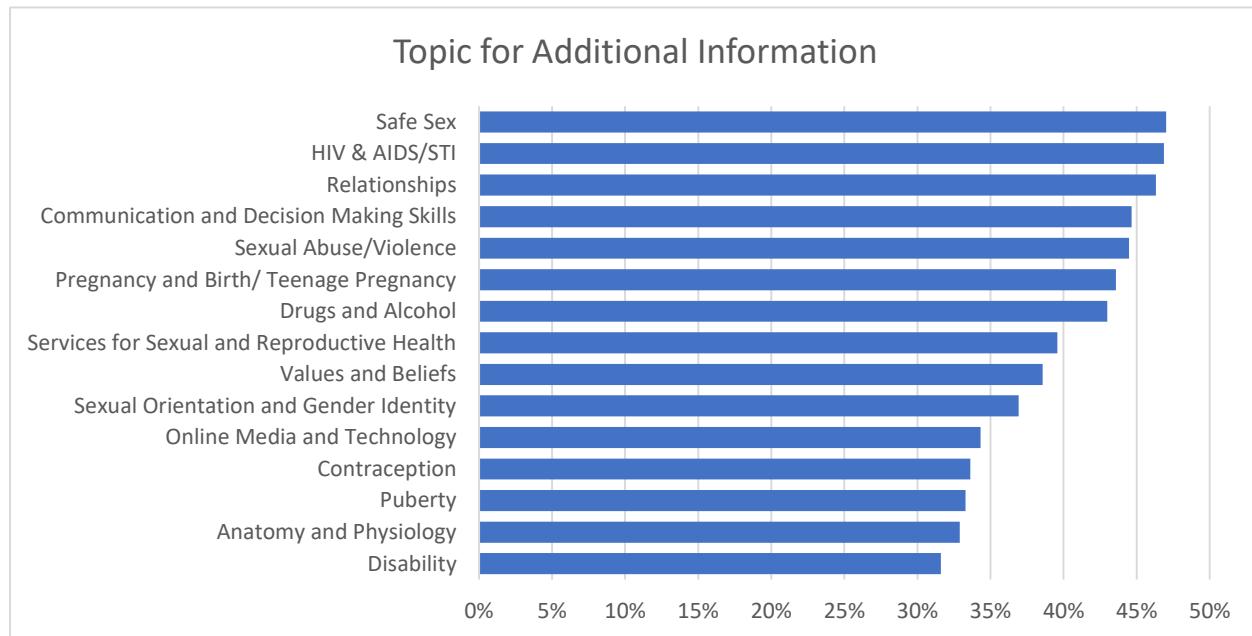
Figure 17: Percentage of Respondents Who Received Information In School or Out of School



Interest/Need for Further Information

There was significant interest in accessing further SRHR education, with 89% of participants expressing a desire for further information, demonstrating the inadequacy of information that they had received so far. Participants who had received some sexuality education were slightly more likely to be interested in receiving further information (91% compared to 85%), which indicates that the information they did receive was incomplete or of insufficient quality. Safe sex, HIV/AIDs and STIs, and relationships were the most requested topics, although there were similar levels of interest in most topics, with between 32% and 47% of respondents selecting each topic. Interestingly, the topics that young people reported having received information on were just as likely to be suggested as topics for further information as those topics that they had not already received information on. This indicates that young people did not feel that they had received sufficiently comprehensive information on any given topic.

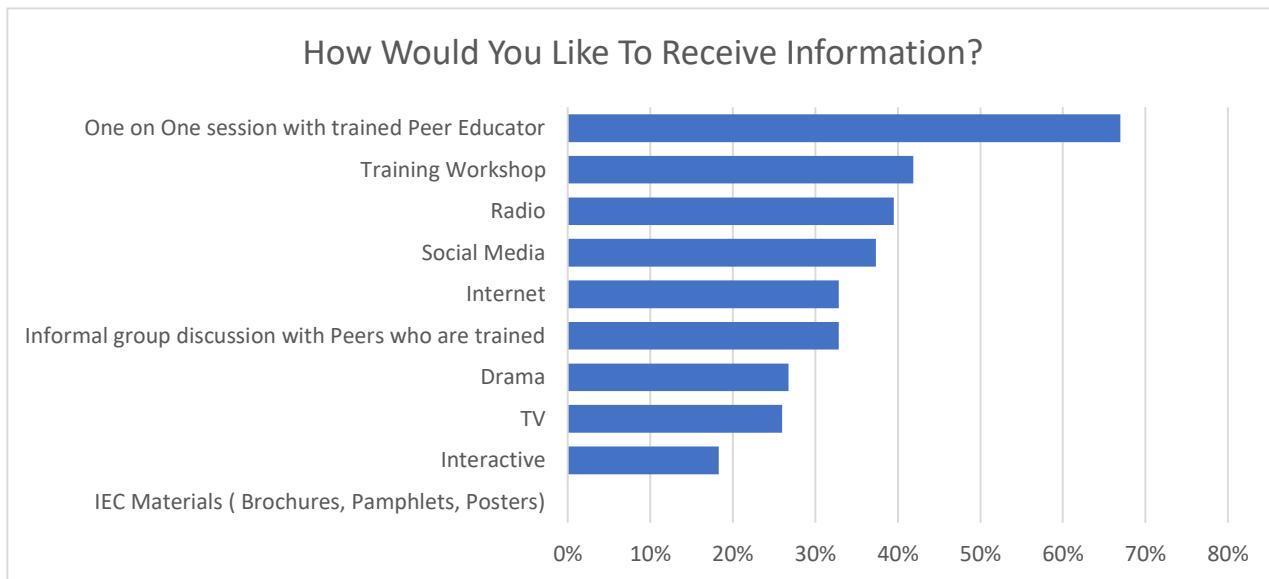
Figure 18: Percentage of Respondent who would like Further Information by Topic



Interestingly, respondents from Kiribati, who were the least likely to report having received SRH information or education were also the least likely to express an interest in receiving any. 27% answered that they were not interested in receiving information. This was followed by Cook Islands (23%) and Tonga (20%). Respondents in Vanuatu, Solomon Islands and Fiji were the most likely to express an interest in further information.

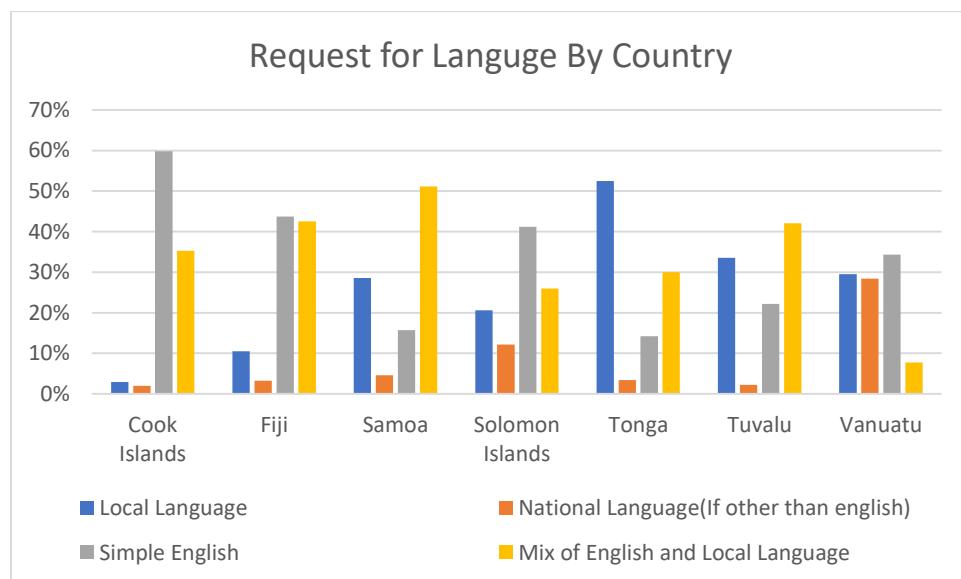
There was significant variation in responses to the question ‘How would you like to receive information?’. The most popular answers were One-on-One Sessions with Peer Educators (67%), Training Workshop (42%) and Radio (40%). Social media and internet were also popular answers. This indicates an area of potential growth for CSE programs in the Pacific, which currently focus on workshops and peer education and do not take full advantage of online and offline media.

Figure 19: Percentage of Respondents who would like Further Information by Information Source



Participants indicated that they would like to receive information in Simple English (32%), Local Language (28%) or a Mix of Simple English and Local Language (27%). A smaller percentage expressed an interest in learning in the National Language (if other than English). A majority of respondents from Vanuatu suggested information was delivered in the national language and a majority of participants in Samoa and Tonga suggested information was delivered in the local language.

Figure 20: Suggested Language for CSE By Country⁴⁵



⁴⁵ Please note that Kiribati has been excluded from the analysis of this question as there were only four responses recorded.

Focus Group Discussions

1.1 Access to SRH Education

Focus Groups participants reported accessing information from a variety of sources. Although there was variation between focus group discussions, the following sources of information were most commonly noted:

- IPPF Member Associations, both in clinics and during community outreach and awareness raising events;
- In school, including in class, from guidance counsellors and the school nurse;
- Through the media, including television, radio and newspapers;
- From health workers and at clinics and hospitals;
- At community awareness events;
- From the Ministry of Health;
- From friends;
- Online, including social media;
- From family members;
- Through IEC materials;
- From other NGOs including groups for people with disabilities and transgender people;
- Through peer education.



Young people attending a focus group discussion in Tonga, 2020,
IPPF

Additionally, young people mentioned that they were also informed through the Ministry of Education, the church, videos, workshops and music. Young people with disabilities mentioned that they also rely on their carers and sex workers mentioned relying on their employer or 'pimp'.

When asked how they would like to access sexuality information in an ideal world, young people named a range of online and offline sources. The most common suggestions across focus groups were:

- Online, including through social media and apps;
- Through IEC materials;
- Through the media, including radio, television and magazines;
- Their parents and at home;
- At school;
- Through peer education.

The most common answer was that young people would like to access information digitally, via the internet, social media, messaging apps and text messages, and games (both online and offline). IEC materials were also mentioned in several focus groups as was the media, including radio and television, generally. School was also a commonly suggested source of information in an ideal world, as was receiving information at home and through peer educators. Many young people also noted that in an ideal world,

their parents would be knowledgeable about SRHR issues and able to talk to their children without shame or stigma.

"In an ideal world, the subject would be open and more in depth and we would know more. We'd grow up with healthy relationships around us, learn in our environment and our community." [Girl, Cook Islands]

Accessibility was a key concern across focus groups. It was important to all young people that information sources were accessible for people with different disabilities.

Participants noted a range of barriers to accessing information, the most common of which, that came up in most focus group discussions, which can be summarised into five categories:

- External judgements, taboos and disapproval, including a lack of parental support;
- Accessibility barriers (e.g. physical barriers, cost, transport, communication barriers);
- Lack of options to access information (e.g. teachers and parents lack knowledge, young people do not know where to access information);
- Internal judgement and shame;
- Lack of trust in service providers, particularly around confidentiality.

Participants mentioned specific barriers for young people with disabilities, including lack of physical access for people with a disability and a lack of accessible communication for people with a disability, including the need for sign language and interpretation.⁴⁶ Cultural beliefs and taboos, religion, provider attitudes and cost were also key barriers raised to accessing sexuality information by young people with disabilities.

"If a young girl with a disability attends a training or program and goes home at the end of the day and tries to educate or talk to her parents, especially her mother about the topics discussed, the mother for sure will smack her and call her cheeky because they think this young girl does not have a right to access that information." [Person with a disability, Samoa]⁴⁷

1.2 Access to SRH Services

The barriers to accessing services were very similar to the barriers to accessing information outlined above. Inaccessibility, in terms of limited transport, the distance to clinics, access for people with a disability, opening hours and wait times, was the barrier that was cited in the most focus group discussions. Shame, cultural beliefs and taboos, cost of services, provider attitudes and a lack of confidentiality, and a lack of information or knowledge were also raised in several focus group discussions as major barriers to accessing services. Accessibility for and provider attitudes towards young people with a disability were also raised as particular barriers for those young people.

"Confidentiality - this is really important because sometimes when we come home our parents are waiting for us with a stick and asking us questions of why we went to the local health centre because sometimes the nurses know our parents." [Youth Participant, Fiji]

⁴⁶ Out of six focus group discussions held with people with disabilities, four were excluded from the analysis due to the age of participants. This analysis is based on two focus group discussions which were held with young people with a disability in Solomon Islands and Kiribati.

⁴⁷ This quote is taken from a focus group which included participants older than 35 years.

Additionally, young people mentioned religious beliefs, stigma, discrimination and peer pressure, and a shortage of health workers as further barriers.

Young people also gave definitions of what Youth-Friendly Services would look like to them. The most common suggested feature was a welcoming atmosphere and friendly, non-judgemental providers. Young people mentioned in several focus groups that ideally providers would be young and both male and female providers would be available.

Youth-Friendly Services must be accessible. For young people in focus groups, this meant accessible opening hours, including overnight and at the weekend, low cost or free services, an accessible location, including in rural communities rather than just on the main island or in the main town, and accessible for people with a disability. Young people suggested having more mobile outreach as well as reiterating that clinics must be well stocked, confidential and have a comfortable waiting area.

“... the youths, talking from experience, I felt scared and panic when I enter a room for example an office for research, I shake and felt wet on my hands and foot when I see an unfriendly and tough employee.”
[Girl, Samoa]

Participants emphasised the importance of having a fun, inviting space that was designed for and dedicated to young people, exclusively for their access. Indeed, young people suggested that a youth-friendly clinic could be integrated with a youth social club to draw young people to the clinic. Young people in many focus groups suggested having a youth centre and other activities at the clinic, including a restaurant, sports, livelihoods training, televisions and free internet.

In addition to this, young people discussed other ways to improve access. The methods most commonly mentioned in the focus groups included opening clinics in other provinces and on outer islands, as well as expanding mobile outreach and home visits; building the capacity of service providers to offer non-judgemental, youth-friendly services; building greater awareness of SRH services; and improving confidentiality. Young people were also interested in visiting clinics in school and having access to advice online or via phone. Ensuring that service providers are friendly and that opening hours are accessible, as discussed above, were raised again. Young people also suggested that clinics could provide transport and offer free services. There was also a role for parents as some young people suggesting targeting parents to encourage their children to come for services.

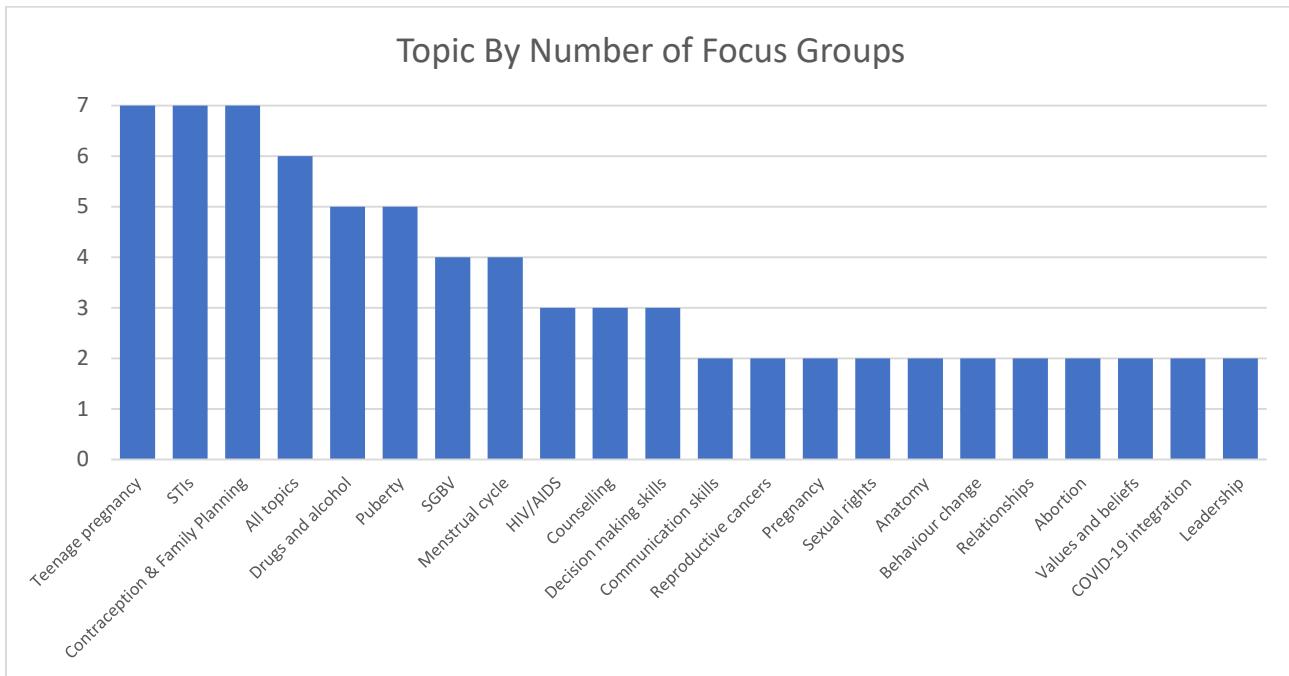
A further concern raised in response to multiple questions in several focus group discussions was the importance of clinics offering a range of contraceptives and having these options in stock, as well as ensuring their accessibility for young people with a disability.

1.3 Unmet Needs for Information and Services

Young people in six of the 24 focus groups reported requiring additional information in all areas of SRHR, while young people in only one focus group felt they had sufficient information. The most common areas that young people felt they required more information were teenage pregnancy, STIs, contraception, including condoms, drugs and alcohol, puberty, the menstrual cycle and SGBV. Other topics that were raised in multiple focus group discussions included: HIV/AIDS, decision-making skills, counselling, relationships, reproductive cancers, services, anatomy, communication skills, abortion, integration with COVID-19, sexual rights, leadership, disability, behaviour change, pregnancy, values and beliefs and leadership. Some young people also requested information about specific sex acts and sexual pleasure,

other life skills, and men's roles in SRHR (including vasectomy). The graph below shows the number of focus groups that suggested each topic.

Figure 21: Number of Focus Groups in which Young People Required Further Information By Topic



48

Young people in 16 focus groups reported not feeling comfortable talking about SRHR issues, or that they were only comfortable talking to certain people, while young people in six focus groups reported feeling confident.⁴⁹ Those who did report feeling comfortable believed that this was due to the training received and role models. Those that did not feel confident requested further trainings, while peer educators requested a certification of their role as peer educators.

Respondents in several focus group discussions stated that current SRH education programs do not meet the needs of diverse groups of young people.⁵⁰ When asked if they had faced discrimination due to their identity (for example as a person of diverse SOGIE or with a disability or as a young person), participants in eight of the 10 focus groups that responded to this question reported being excluded and facing issues accessing services and information due to the age or marginalised identity. Diverse SOGIE communities reported facing discrimination from community members, while young people with disabilities stated that they needed further accommodations to be able to access services, including a translator for those with communication issues, and for more peer educators with disabilities to be trained.

⁴⁸ Please note that RFHAF reported on all three of their focus groups in Fiji in one report and it is not possible to disaggregate this information. Therefore, these numbers should be treated as the number of focus groups in which a topic was raised out of a total of 22, rather than 24.

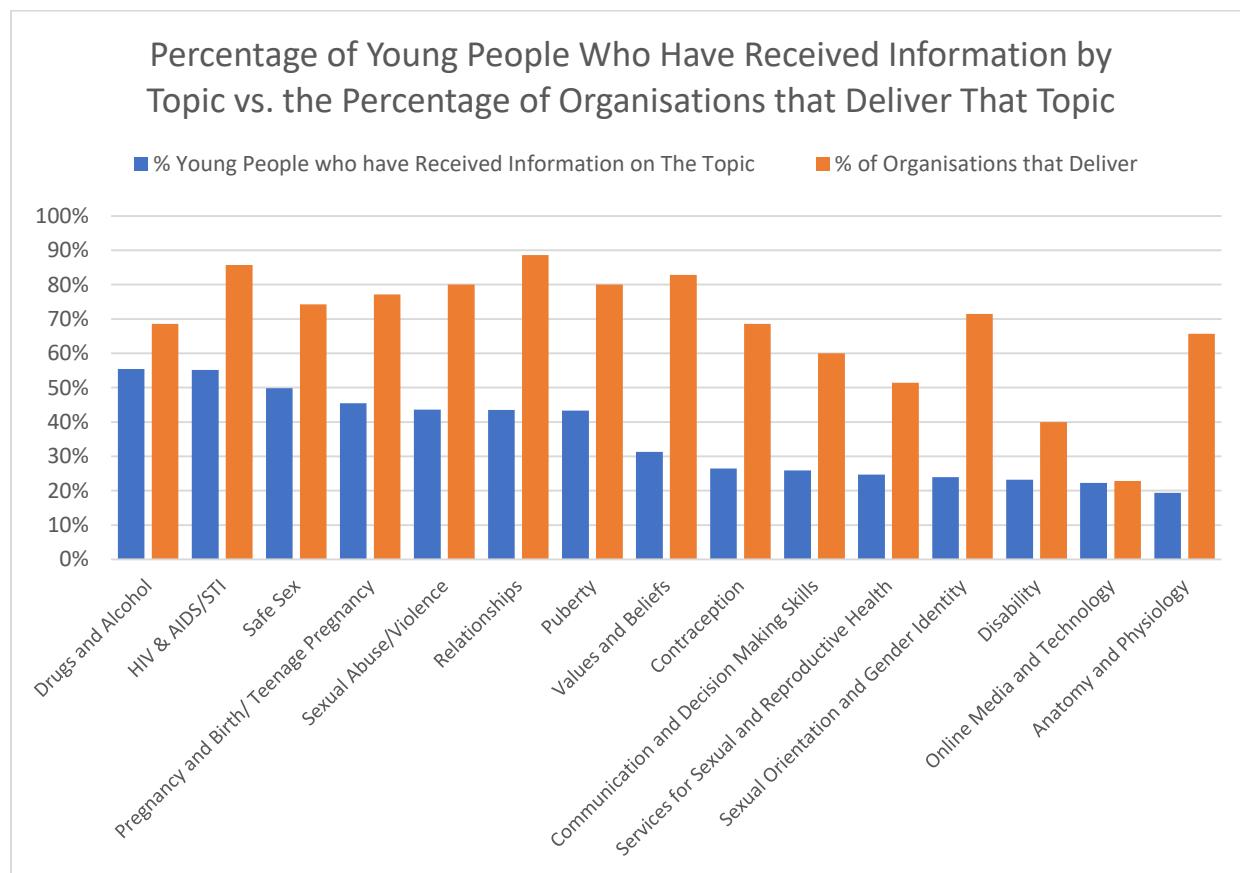
⁴⁹ Please note that this total lower than the total number of focus groups due to the amalgamation of focus groups in Fiji and one focus group did not answer this question.

⁵⁰ Please note that this question was only answered in ten focus group discussions.

Synthesis of Findings

The review of manuals, organisation's self-assessment of the gaps of their programs and the information received by young people, through focus group discussions and the youth survey, paint different pictures of how complete CSE and similar programs in the Pacific are. However, the topics that organisations reported as gaps in their programs are also often the topics on which young people reported not having received information (such as disability and online media and technology; anatomy and physiology is a notable exception to this trend).

Figure 22: Percentage of Young People Who Have Received Information by Topic vs. the Percentage of Organisations that Deliver That Topic





Kiribati Family Health Association youth demonstrates correct condom use, 2016, IPPF/Jack Robert-Tissot

Discussion

Drawing together the results and analysis of the organisational surveys, review of manuals and curricula, focus group discussions with young people and the youth survey, several key themes emerge. The organisational surveys and review of manuals and curricula create a picture of the organisations delivering CSE in each country and the quality and breadth of the programs delivered while the inputs from young people themselves, through focus group discussions and the youth survey, demonstrate their experiences of CSE, the barriers faced and how CSE programs can be improved going forward.

1.1 Content and Coverage of Topics

There are key gaps recognised by organisations and confirmed through review of the manuals but organisations also flagged further gaps that are covered in the manuals reviewed, although it is important to note that these manuals were not used by all providers and many providers have developed their own manuals which were not reviewed. Whilst 60% of young people who participated in the youth survey reported having accessed some form of CSE or information, they reported many gaps in their knowledge and expressed a desire for further information in all areas of SRHR information.

Whilst the most commonly used curricula were factual and neutral in tone, there was a focus in some manuals on a negative view of sex and sexuality, rooted in fear and risk rather than positivity, and with a limited view of health, as simply the absence of disease. There was limited content in any manuals on

developing healthy, safe and happy relationships, with the majority focusing on negotiation and refusal skills.

There was some correlation between gaps that organisations reported in their programs and the topics that young people were least likely to have received information on. Notably, content (either as a standalone module or integrated throughout the curriculum) around the inclusion of diverse young people (e.g. disability, sexual orientation, gender identity) were among the least likely to have been received. This is to be expected as these topics are relatively new additions to the CSE agenda in the Pacific and many organisations report using manuals from the early 2000s. 71% of organisations reported delivering content on sexual orientation and gender identity. Whilst this content was included in five manuals, it was very limited, which is consistent with the relatively low percentage of young people reporting that they had received information on this topic. Of the 26 CSE-delivering organisations that answered the question on which topics were the most sensitive, 5 identified sexual orientation and gender identity as the most sensitive topic.

Further, as indicated in the review of curricula above, very few young people are receiving information about SRH or SGBV services or online media and technology. Additionally, the number of young people reported having received information on Anatomy and Physiology is lower than would be expected given its inclusion in all manuals reviewed and that 66% of organisations state that it is included in their training. This could reflect the breadth of the subject and that the information provided by organisations is incomplete.

Young people were most likely to have received information on drugs and alcohol (55%). Although only 69% of the organisations surveyed shared that they included this topic, there are likely to be other providers, while this is less likely for other SRHR-focused topics, such as anatomy and physiology, which are often only delivered as part of CSE.

While the manuals reviewed were generally more comprehensive than the organisations' self-reporting would suggest (in terms of self-reported gaps), there were several topics that organisations reported delivering that had low coverage in the manuals, most notably services of SRH. The percentage of organisations delivering information on drugs and alcohol, values and beliefs and disability and SRH were also higher than expected based on the coverage of these topics in the manuals.

On the other hand, topics like anatomy and physiology and, to a lesser extent communication and decision-making skills, were well covered by the manuals reviewed but organisations struggled to deliver. This could reflect the breadth of organisations delivering CSE or similar programs, who might be less comfortable delivering anatomy information. Indeed, of the 28 CSE-delivering organisations that answered the question on which topics were the most sensitive, 13 identified anatomy and physiology as the most sensitive topic. Additionally, as this topic is often delivered during science classes in school, there may be a perception that this topic is more 'scientific' and organisations may be hesitant to deliver without a science background.

Importantly, the fact that relatively high percentages of respondents to the youth survey had received information or education on some topics does not suggest that these respondents have received a full, comprehensive and quality-assured CSE curriculum. Indeed, the distribution of topics received indicates that participants have received incomplete information, as the number of people indicating that they received information on HIV/AIDS and STIs is significantly higher than those who received

information on contraception. This is reflective of the funding situation in the Pacific, where significant funding is provided for HIV-specific interventions, through the Global Fund and other donors, rather than SRHR as a whole. As a result, large events for World AIDS Day are hosted throughout the Pacific. Further, the topics young people have received information on are also indicative of the overall approach to sexuality education: focusing on the risks of sex rather than supporting young people to develop their values and decision-making skills and make empowered and informed decisions. Drugs and alcohol were the most frequently received topic, which could be expected as it is considered less sensitive than other topics in the CSE curriculum.

Young people were less likely to have received information on key inclusion topics, such as sexual orientation and gender identity or disability. The majority of organisations delivering CSE are taking steps to include diverse and/or marginalised groups in their training. However, CSE providers demonstrated some confusion around the nature and requirements of inclusion, with multiple organisations giving unclear answers that related to other questions or very general answers. Inclusion of people of diverse SOGIE or people with a disability was also noted as a weak point in the desk review of manuals.

It is clear that more can be done to integrate inclusive information throughout SRHR curricula, to ensure that young people in all their diversity receive accurate, rights-based information and that harmful social norms are combatted. In addition to inclusive information and access to trainings, it is important that young people with disabilities are welcomed into all aspects of the training, including through inclusive energisers and activities. This is discussed further in 1.6 Inclusion, below.

It is important that any new manual or curricula is able to address these gaps and provide support for facilitators (which is discussed in more detail below). The key topic gaps in the manuals reviewed and how they can be addressed is discussed in the table below. An assessment of specific topic gaps and how they might be addressed is available in Annex 15 – Addressing Topics Gaps. The other areas that have been flagged as gaps or areas in need of updates can be supported by existing manuals or simple updates.

RECOMMENDATION 1: There is a need for a positive curriculum that takes a holistic view of health and sexuality, covers the full range of topics, is incremental and promotes the development of life skills, including communication and decision-making skills. Curricula should be comprehensive and integrate content on key inclusion topics including sexual orientation, gender identity and disability.

1.1.2 Development of a new curriculum

It is important to note that there are a range of organisations delivering CSE in various forms. Whilst some organisations deliver a comprehensive curriculum, others deliver select topics such as SOGIE inclusion, gender equality, menstrual hygiene management, SGBV and leadership skills. It should be anticipated that any new curriculum may be delivered by a range of actors and organisations, some of whom will not have a background in SRHR, education or human rights.

RECOMMENDATION 2: Any future manual or curriculum should be developed and pretested in partnership with local organisations delivering CSE already. Content must also reflect the local context including using relatable examples and delivered in young people's native language to enhance learning.

1.2 Delivery and facilitation

It is important to note that this mapping exercise centred on a desk review of curricula and self-reported experiences of CSE and it is beyond the scope of this report to assess the implementation of CSE programmes. While facilitators for all providers received some form of training before delivering training, assessing the quality of this is also beyond the scope of this report.

1.2.1 Sources of Information

Young people, in both focus group discussions and the youth survey, expressed an interest in receiving information from a range of sources. The most popular source mentioned in the youth survey was through peer education. Other popular answers included Training Workshop, and Radio, Social Media and the Internet.

The majority of providers already make use of peer educators to deliver CSE programs. UNFPA defines a peer educator as “a person of equal standing with another – someone who belongs to the same social group based on age, grade, status or other characteristics – who is trained and supported to effect positive change among other members of that same group.”⁵¹ This often refers to a person who is the same age, sex or gender as the person receiving information. In some cases, membership of a certain group is also important. Peer educators may deliver information through one-on-one conversations, group discussions, distributing IEC materials, counselling and games. Often, they make referrals to services and can support to mobilise communities during events.

CIFWA noted that recruiting a diverse team of peer educators can be challenging, stating:

“We cannot ensure that it is [inclusive] because we are very limited to the number of those [people] interested in doing SRHR work. We cannot certify them with a trainer’s certificate (from a known agency specialized in this area such as IPPF/UNFPA) to there is no incentive for young people to be interested.” [CIFWA Executive Director]

Interestingly, no respondents to the youth survey suggested IEC materials such as posters and pamphlets, as this was one of the methods raised most frequently in focus group discussions. Other methods suggested in focus group discussions include school, social media and games, parents, SMS and peer educators. Social media and the internet were mentioned as sources of SRHR information in both focus group discussions and responses to the youth survey. This is an area of potential growth for CSE programmes in the Pacific, which currently focus on workshops and peer education and do not take full advantage of online and offline media.

The language in which respondents to the youth survey thought the language should be delivered differed by country, reflecting the linguistic diversity of the region. UNFPA recommend that CSE is available in young people’s native language.

RECOMMENDATION 3: Develop strategies to improve the recruitment and retention of diverse peer educators, including in remote areas, to improve access to CSE for young people in all their diversity.

⁵¹ UNFPA Out Of School CSE Guidelines

1.2.2 Facilitation

Although it is beyond the scope of this report to assess the support and training provided to facilitators, one of the key recommendations from young people in focus group discussions was the need to build service provider capacity in adolescent SRH and the need for teachers, parents and peer educators to be more knowledge about SRHR topics. Given the number and breadth of focus of organisations delivering CSE in the Pacific, many of whom do not have a background in SRHR, it cannot be assumed that facilitators are confident in delivering this content. Additionally, CSE which focusses on discussions and young people sharing their existing knowledge, as recommended by UNFPA, presents an opportunity for a skilled facilitator to correct myths and misinformation.

This should be supported through training and capacity building for facilitators, including peer educators, and in the curriculum itself.

Across the manuals reviewed, there is a relatively high level of assumed knowledge in each curriculum and basic terms (such as sex) are not explained. Three manuals did not include any support for facilitators. Organisations stated that they offer training for facilitators, from one-day sessions to two-week training programmes. Therefore, it is crucial that curricula can be delivered with relatively little prior training and preparation. This should include an introduction to CSE, adolescent SRHR, key terms and suggested responses to common myths.

Although it is beyond the scope of this report to assess the quality of training received by facilitators, it is suggested that SRHR organisations work with identified CSE providers in-country to support the training of facilitators and provide ongoing support and mentoring to ensure they are well informed and confident.

RECOMMENDATION 4: Ensure that organisations provide sufficient training for facilitators and that they are confident and capable of delivering CSE.

RECOMMENDATION 5: Ensure that any future manual includes clear support for facilitators, guidance on the importance of CSE, instructions on the delivery of sessions, as well as equipping facilitators with the capacity, knowledge and confidence to challenge myths and misconceptions. This should include an introduction to key terms.

1.2.3 Activities

All providers of CSE reported using a range of activities to deliver information. This was also true of the majority of manuals, which provided a range of suggested activities (although it should be noted that some were more limited than others). UNFPA recommend sessions be structured to elicit information from participants to stimulate interactive discussion to unpack any myths and misinformation. A range of youth-led activities also encourages young people to be active learners and promotes promote skills development for example through role plays to development communication skills. It is crucial that skills development is a key component of any future curricula.

1.3 Involving Parents and Guardians

In the focus groups, the importance of engaging parents and the broader communities in CSE as a means of reaching young people was emphasised by young people in focus group discussions. Additionally, in SIPPAs organisational survey, the Program Youth Coordinator noted,

“Perhaps parents sometimes do not know about SRHR or CSE session and some time they might stop their children from attending CSE session or SRHR due to culture and religion. Therefore, I think it is important to consider parent education on SRHR is also needed to be included in the Manual or created a deferent manual for the parents” [SIPPA Program Youth Coordinator].

Although it is often assumed that parents are resistant to or disapproving of CSE, a study of attitudes towards SRH education in the Pacific found that parents and communities had broadly positive attitudes towards sexuality education.⁵² Greater inclusion of parents and guardians could be a significant enabling factor for CSE programs, while ensuring that the content is reiterated at home as well. Parents were not involved as part of the research and so it is beyond the scope of this report to comment on this in more detail.

1.4 Use of technology and media

Although the majority of providers use a range of methodologies during training sessions, the curricula reviewed focus around physical delivery of education programs in a classroom-style setting. In focus group discussions and the youth survey, young people recommended social media, online resources and mass media as key ways that they would like to access sexuality information. Although these data sources predominantly represent the views of young people in urban areas, internet coverage is spreading across rural areas and islands in the Pacific and represents a key medium through which to reach young people.

It is important at this point to make a distinction between a ‘complete CSE’ course, which is delivered by a qualified facilitator and provides young people with a broad curriculum of sexuality over a number of days, and one-off, ad hoc information that may be received in a number of settings. Both are important in supporting young people to develop the information and skills they need to make informed decisions, although the latter should not be seen as a substitute for CSE itself. Ensuring that young people can access accurate information that supports the development of skills and positive values through a variety of media (including online and offline) will complement broader CSE programs.

The use of technology, both traditional and emerging, is particularly important in the Pacific as the majority of CSE providers focused on the main island or town. While some providers reported that they offered CSE nationally or during outreach to outer islands, it was not reported how frequent these visits are or the coverage of CSE topics that is delivered during them. Some providers did utilise existing networks in more remote parts of their country, such as youth groups, faith-based networks and Pride Hubs (in Fiji).

Traditional and emerging media are key areas for growth among the majority of organisations surveyed. Social media, radio, television and mass media all represent ways that young people in remote communities can receive information on CSE topics. Indeed, one participant in a focus group discussion in Fiji cited Love Patrol, Wan Smol Bag’s edutainment television series that was developed in Vanuatu in 2007, as an example of an ideal way to learn about sexuality topics. There is an opportunity for organisations to explore new partnerships with media organisations and to increase their presence on radio and social media to support CSE programs.

⁵² UNESCO Office for the Pacific States, 2015, Attitudinal Survey Report on the Delivery of HIV and Sexual Reproductive Health Education in School Settings in Nauru, Niue, Palau and Samoa

It is crucial that this information is accurate, consistent and contributes to achieving the outcomes of CSE. This includes supporting young people to develop the knowledge, skills, attitudes and values to understand, and determine and enjoy their sexuality, both physically and emotionally. Messaging should also be inclusive of young people with a disability and young people of diverse SOGIE. A new curriculum or manual could support this in a number of ways, such as providing key messages for each module, definitions of key terms, myth busting guidance and engaging infographics that organisations could adapt for their social media and IEC materials. Additionally, CSE or peer educator training curricula could be made available online, either through a website where young people can proactively access accurate, rights-based information or as part of a course.

RECOMMENDATION 6: Support organisations to make use of mass media, online media and online platforms to reach target populations and disseminate accurate information and reinforce learning.

RECOMMENDATION 7: Expand access to CSE for young people in remote and rural areas, utilising mass media, radio and online resources to ensure continuing access to education.

1.5 Monitoring and Evaluation

The majority of organisations surveyed were aware of the importance of evaluating the success of their programs. The most common methods used to evaluate training was pre- and post-tests training, which is not sufficient to assess the impact of education programs. One organisation stated that they attempted to link their CSE program to the uptake of youth friendly services.

It is crucial that organisations delivering CSE in the Pacific receive support to monitor and evaluate their programs, in conjunction with any new curriculum which is launched. Any future manual should include support on how to monitor and evaluate the effectiveness of the program. This could include pre- and post-tests as well as tools to measure a range of other short-term and longer-term outcomes and overall goals of CSE programs, which are presented in the table below, adapted from UNFPA's 2015 Evaluation of Comprehensive Sexuality Education Programs: A Focus on the Gender and Empowerment Outcomes.⁵³

⁵³ UNFPA, 2015, *The Evaluation of Comprehensive Sexuality Education Programmes: A Focus on the Gender and Empowerment Outcomes*, available at: https://www.unfpa.org/sites/default/files/pub-pdf/CSE_Global_Review_2015.pdf

Table 5: Outcomes and Goals of CSE Programs, Adapted from UNFPA's 2015 Evaluation of Comprehensive Sexuality Education Programs: A Focus on the Gender and Empowerment Outcomes

Short-Term Outcomes	Longer-Term Outcomes	Goals
Increased condom and STI knowledge	More frequent use of condoms	Improved sexual and reproductive health among young people.
Increased knowledge of what to do if a person experiences intimate partner violence	Delay of sexual initiation	Gender-equitable relationships
Greater access to condoms Increase in gender-equitable attitudes	Fewer sexual partners	
Improved critical thinking skills	Greater equality of power in intimate relationships	
Increased self-efficacy to refuse unwanted sex or use condoms		
Decreased acceptance of gender-based violence		

IPPF's CSE Assessment tool suggests the following domains of change can be assessed to measure the effectiveness of CSE interventions:⁵⁴

- Knowledge on CSE content areas
- Confidence and self-esteem
- Changes related to the affective objectives for each content area
- Incidences of stereotyping and discrimination
- Critical thinking skills
- Communication and self-expression skills
- Capacity to make informed decisions
- Attitudes about sexuality and sexual rights
- Safer sex behaviour (e.g. regular use of contraceptives and condoms, decreased sexual partners)
- School drop-out rates for girls and young women
- Engagement in learning environments (including participation in classroom and academic achievement)
- Gender equitable attitudes
- Number of young people engaged as activists or advocates for SRHR
- Number of young people who access SRH services
- Incidence of adolescent pregnancy
- Incidence of HIV and STIs
- Incidence of intimate partner violence, including coerced sexual activity
- Safety of environments for young people (in schools and community settings)
- Social acceptance about young people's sexuality and sexual rights

⁵⁴ IPPF, *Inside and Out: Comprehensive Sexuality Education (CSE) Assessment Tool*, available at: <https://www.ippf.org/resource/inside-and-out-comprehensive-sexuality-education-cse-assessment-tool>

These indicators can be measured at different levels (individual, family, community, nationally) and together provide a picture of the effectiveness of CSE.

The development of a new curriculum that could be used by a range of actors also provides an opportunity for a broader evaluation of the impact of CSE in the Pacific. Before the launch of a new manual, a baseline assessment should be conducted to understand the existing knowledge, attitudes and practices. This should also be linked to key SRH indicators measured in national Demographic and Health Surveys. As well enabling CSE delivery to be evaluated effectively, this would also build a stronger case for why CSE is necessary and bring more stakeholders on board. Once launched, a new curriculum should then be evaluated regularly.

RECOMMENDATION 8: Improve the monitoring and evaluation of CSE programs, making use of a range of indicators, in alignment with global standards on measurement. Any future curricula should include guidance on monitoring and evaluation and use the opportunity of a new curriculum to integrate rigorous evaluation at key steps (including before launch and regularly after).

1.6 Inclusion

Noting the limited inclusion of content regarding people of diverse SOGIE or with a disability in the manuals and curricula reviewed, it is clear that more needs to be done to ensure that young people in all their diversity are able to access sexuality education that is relevant for them. This includes young people in rural areas as the majority of providers offer CSE programs on the main island and towns, and only provide education to young people in rural areas during mobile outreach.

There was significant variation (and some confusion) in responses to the question ‘how do you make sure your training is inclusive?’, with some organisations referencing gender, disability or diverse SOGIE, some giving unclear answers and six not answering the question. While the majority of providers were aware of the differing needs of key population groups and several work with specialised organisations to meet these needs, there was limited content on the inclusion of diverse groups of young people in the manuals. As discussed above, where this content was available, it was most often in a standalone module rather than integrated throughout. Sexual orientation and gender identity and disability were among the topics that young people were least likely to have received information on. On the other hand, 71% of respondents to the youth survey identified as a member of a marginalised group.⁵⁵ All young people have a right to access information to support them to make informed decisions about their lives and it is crucial that this information is accessible and inclusive.

RECOMMENDATION 9: Mainstream disability- and SOGIE-inclusive content throughout curricula. Integrate information that is inclusive of young people in all their diversity throughout CSE curricula and ensure all activities are inclusive.

Additionally, organisations should ensure that, as well as providing inclusive information, the trainings themselves are also inclusive. CSE-providing organisations should be encouraged to partner with peak bodies for diverse groups of young people, including young people with disabilities; to make reasonable adjustments so that diverse young people can participate fully; and to reduce stigma associated with diverse groups of young people accessing SRHR information. Young people with disabilities, in particular,

⁵⁵ This is likely to be an over-representation as IPPF Member Associations actively target marginalised groups to ensure access to services.

are often left behind by CSE programs: specific recommendations for enhanced inclusion can be found in UNFPA's 2018 report *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realising Sexual and Reproductive Health and Rights*.⁵⁶

RECOMMENDATION 10: Utilise existing best practices from UNFPA and other organisations to ensure that all CSE programs are accessible for young people in all their diversity, including young people with disabilities.

1.7 Services

In focus group discussions, young people raised several barriers that they faced when accessing SRH services, including accessibility issues such as limited transport, the distance to clinics, access for people with a disability, opening hours and wait times; shame, cultural beliefs and taboos; cost of services; provider attitudes and a lack of confidentiality; and a lack of information or knowledge. Only 13 out of 35 CSE providers deliver SRH services in conjunction with CSE. A further 16 refer to other providers. One CSE provider neither delivers nor refers to SRH services while two others offer limited services (condom distribution and counselling for SGBV respectively). Linking SRH services to CSE, through partnerships with service providers, and expanding mobile outreach to remote communities, would remove several barriers to accessing services.

Additionally, young people suggested that service providers should build the capacity of service providers to offer non-judgemental, youth-friendly services; improve awareness of SRH services; and ensure confidentiality of services. Clinics should be staffed by both women and men and have a welcoming, friendly and non-judgemental atmosphere that serves to provide a fun and inviting space designed for young people. To achieve this, clinics could be integrated with youth clubs. Clinics must be well stocked, offer free or reduced cost services and have a comfortable waiting area. Services must be accessible: in convenient locations, with transport available and evening, overnight and weekend opening hours in their clinics, and accessible for people with a disability.

RECOMMENDATION 11: Support organisations to integrate service provision with CSE, including through partnerships, and support service providers to improve the delivery of youth-friendly services.

⁵⁶ UNFPA, 2018, *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realising Sexual and Reproductive Health and Rights*, available at:

https://www.unfpa.org/sites/default/files/pub-pdf/51936 - UNFPA_Global_Study_on_Disability_-web.pdf



Vanuatu Family Health Association volunteer with sexuality education materials, 2019, IPPF/Katy Mackey

Moving Forward

CSE is crucial to enabling young people to make informed and empowered decisions about their sexual and reproductive health. These programs support young people to build the skills and confidence to have healthy relationships and make decisions in line with their values. As only 26% of young people in the youth survey reported receiving information solely in school, it is clear that accurate, inclusive, rights-based out-of-school CSE is crucial to ensure that young people in all their diversity are able to access information.

Overall, this mapping has identified 35 organisations, including specialised SRH organisations, government ministries, peak bodies for people with disabilities, faith-based groups, women's groups and organisations for people of diverse SOGIE, that provide CSE across nine Pacific Island countries. All organisations reported significant gaps in their current CSE programs, which have been explored in this mapping. The manuals reviewed also had gaps or should be updated to reflect changes in SRHR best practices and indeed the world, particularly by integrating information on the inclusion of marginalised groups and online media and technology. As the manuals stand, there is a lack of information on sexual orientation and gender identity, disability, and healthy relationships. There is a need for greater positivity in CSE curricula, which should take a holistic view of sexual and reproductive health.

Multiple organisations expressed a desire that any future manual should be localised and developed in consultation with local partners, ahead of pre-testing.

Young people reiterated their ongoing need for quality, comprehensive and inclusive CSE through a youth survey and in focus group discussions. Young people expressed a need for further information on a range of topics, with very few stating that they had received comprehensive CSE. There was a particular need for additional content to make the program accessible to young people in all their diversity, particularly young people of diverse SOGIE and young people with disabilities.

With significant gaps in comprehensive, rights based and inclusive CSE, young people across the Pacific are not fully supported to make decisions for their future, which impacts Pacific governments' ability to achieve development goals. It is crucial that organisations are supported to deliver a quality-assured, inclusive, positive curriculum that empowers and capacitates young people.

Annexes

Annex 1 – Organisational Survey

Annex 2 – CIFWA’s Adolescent Reproductive Health Training Manual

Annex 3 – RFHAF’s Integrated, Comprehensive & Life Skills Sexuality Education Flip Charts

Annex 4 – Sexual Health Education – A Training Manual for the Pacific

Annex 5 – SIPPVA Volunteer Training Manual

Annex 6 – Adolescent Reproductive Health – Training Manual

Annex 7 – Good Relationships Free From Violence

Annex 8 – Sexual and Reproductive Health: A toolkit for community educators – Vanuatu

Annex 9 – Sexual and Reproductive Health: A toolkit for community educators – Samoa

Annex 10 – Marurungin Te Utu Training Manual

Annex 11 – Focus Group Discussion Facilitator’s Guide

Annex 12 – Youth Survey

Annex 13 – Assessment of Survey Responses

Annex 14 – Assessment of Manuals

Annex 15 – Addressing Topic Gaps

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