Ministry of Health

Sexual and Reproductive Health and Rights Needs Assessment

Vanuatu

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Resilient nations.

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Abbreviations.

ABR	Adolescent birth rate
AIDS	Acquired Immune Deficiency Syndrome
AFPPD	Asian Forum of Parliamentarians on Population and Development
APSP	*Association Partage Sante Pacifique*
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive prevalence rate
FLE	Family Life Education
FP	Family planning
GBV	Gender based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HDI	Human Development Index (UNDP)
HIV	Human Immunodeficiency Virus
HSS	Vanuatu Health Sector Strategy 2010-2016
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IMR	Infant mortality rate
IUCD	Intrauterine contraceptive device
M&E	Monitoring and evaluation
MAF	MDG Acceleration Framework
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
MOH	Ministry of Health
NGO	Non-Government Organisation
PAA	Vanuatu Priorities and Action Agenda 2006-15
PMTCT	Prevention of mother to child transmission [of HIV]
PoA	Plan of Action
PICCT	Provider-initiated confidential counselling and testing [for STIs and HIV]
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health [Committee]
SPC	Secretariat of the Pacific Community
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
TFR	Total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary confidential counselling and testing [for HIV and STIs]
VFHA	Vanuatu Family Health Association
VNSO	Vanuatu National Statistics Office
VWC	Vanuatu Women's Centre
WHO	World Health Organization

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Executive Summary.

The Republic of Vanuatu (Vanuatu) has endeavoured to incorporate gender and rights into its national and provincial sexual and reproductive health (SRH) programs. This report reviews Vanuatu's rights-led approach to health and social development, and presents the results of a detailed Sexual and Reproductive Health and Rights (SRHR) Needs Assessment. The work was commissioned by the national Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Committee, funded and supported by the New Zealand Ministry of Foreign Affairs and Trade, UNDP and UNFPA, and was conducted by Chris Hagarty, the Vanuatu Reproductive Health Consultant, on behalf of the Ministry of Health.

The SRHR Needs Assessment, conducted in November and December 2014, comprised a comprehensive desk review and analysis of data, followed by provincial consultations with health service managers and providers, and key informant interviews with national public health program managers, NGOs, service providers and technical advisers. Consultations were guided by UNFPA's *SRHR Needs Assessment Tools for SRHR, and HIV* (Appendix 3), and collected information on family planning, prevention and management of sexually transmitted infections (STIs), HIV, and gender based violence was verified through a number of site visits to health facilities.

Commitment to rights-based health and social development: Vanuatu remains committed to upholding the human rights of its citizens, and particularly those most vulnerable, such as females, children and young people. This has been documented through the National Constitution, and signing of a range of international conventions and treaties, including the *Convention on the Elimination of All Forms of Discrimination Against Women* (1995), the *Convention on the Rights of the Child* (1993), the *Convention on the Rights of Persons with Disabilities* (2007) and a number of conventions under the auspices of the International Labour Organization.

Special commitments have been made towards upholding the SRHR of Vanuatu's citizens through promotion of gender equity and equality, and these commitments have been documented within the International Conference on Population and Development (ICPD) Plan of Action, the Millennium Development Goals and most recently through the Moana Declaration 2013 and the *Pacific Sexual Health and Well-being Shared Agenda 2015-2019*. At the national level, the *National Population Policy 2011-2020*, the *Vanuatu Priorities and Action Agenda 2016-15* and the *National Reproductive Health Policy 2008* together prioritise gender- and rights-based approaches to:

- Safe motherhood: improved delivery of quality antenatal, perinatal, postpartum and newborn care.
- Promotion and delivery of quality family planning services.
- Improved delivery and access to SRH services for adolescents.
- Prevention and management of sexually transmitted infections (STIs), including HIV.
- Addressing of gynaecological morbidities, including abortions, cancer, infertility and menopause.
- Prevention and management of cervical cancer.
- Prevention and management of sexual violence and violence against women.
- Establishment and maintenance of Reproductive Health Commodities Security.

At the core of these SRHR priorities is the commitment to ensuring all individuals and couples have the right to make informed decisions about the number, spacing and timing of pregnancy, and that they are provided with the information and means to do so, in order to choose and maximise their potential to develop as individuals, and within households and communities.

A young and growing nation: As a country with a dispersed landmass and population (76% of whom live in rural and remote areas), there are significant challenges for a health system working to limit and respond to rising fertility, which places a considerable economic and development burden upon households (and on young women in particular, who make up 58% of the population under 25).

Health Priorities and Status: Health status of the population is characterised by stabilising child mortality in recent years (Infant Mortality Rate: 15/1,000 live births), however concerted efforts to reduce maternal mortality (such as ensuring a skilled birth attendant is present for the majority of deliveries) are yet to be having a significant statistical effect (Maternal Mortality Ratio: 86-110 maternal deaths per 100,000 live births).

Prevalence of HIV remains low, however there is evidence of a significant and rising prevalence of STIs, especially amongst young people.

Vanuatu has one of the highest rates of contraceptive prevalence in the region, thanks to a suitable mix of family planning commodities and methods available to meet the specific needs of individuals and couples, however use of contraceptives is not uniform throughout the country, nor amongst specific age groups. For instance, Vanuatu experiences one of the highest adolescent birth rates (amongst women aged 15-19) in the region (66 live births per 1,000 women; 77 in rural areas). Despite the comparatively high rates of contraceptive use, approximately 20-30% of married/partnered women in Vanuatu who either do not want, or wish to delay child bearing, are unable to access contraceptives.

Gender equity and equality: These are poorly reflected within most aspects of society in Vanuatu, with females faring considerably worse than their male counterparts on most development indicators. There is insufficient political and decision-making representation from women at the national and sub-national level, and women's SRHR are significantly neglected. Physical and sexual violence against women, experienced by nearly two-thirds of the female population, is present throughout the country, in both urban and rural communities, and a woman's decision to use family planning and contraceptives is often made under the real fear of physical and/or sexual violence from her partner.

Findings - Policy: Vanuatu has a comprehensive policy platform upon which to plan and implement gender- and rights-based advocacy and deliver health services which promote and uphold SRHR. The *Vanuatu Health Sector Strategy 2010-2016* and *Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010* articulate the SRH and gender equity and equality priorities of the Vanuatu Health Sector, and set goals, objectives and activities through which to guide programs. *Evidence-Based Guidelines in Family Planning for Health Workers* serve as an excellent, clinical resource for health workers implementing SRH services.

A *National Strategic Plan for HIV and STIs 2008-2012* exists to guide the national HIV response, and links with prevention and management of STIs, especially in relation to vulnerable youth. Likewise, there is significant cross-over of HIV prevention and management within the *National Reproductive Health Policy*, however to date there has been no attempt to develop a combined SRH and HIVSTI Policy and/or Strategy, nor indicators and reporting mechanisms with which to truly integrate programming and reporting.

The *Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010,* the *Evidence-Based Guidelines in Family Planning for Health Workers* and the *National Strategic Plan for HIV and STIs 2008-2012* are outdated and require review and revision to incorporate updated priorities and processes, and to facilitate more integrated programming.

System: A number of development partners support SRHR programming in Vanuatu through funding mechanisms and technical assistance. The Ministry of Health (through funding from recurrent Government revenue and Australian Government bilateral aid) leads policy development, oversight and program coordination, including training and staffing. UNDP, UNICEF, UNFPA, UNAIDS, SPC and GFATM each provide a mix of financial revenue and technical assistance to programming, protocol, policy and strategy development, data analysis and training.

Multi-sectoral steering committees and working groups comprising Ministry of Health and other government personnel, representatives from United Nations agencies, NGOs, other civil society groups and/or affected communities and stakeholders are engaged to provide technical and/or managerial oversight of SRH and HIV responses and interventions in Vanuatu. Examples of these coordinating mechanisms include the RMNCAH Committee, the National AIDS Committee, the Vanuatu Country Coordinating Mechanism (for GFATM) and the MDG Acceleration Framework Expert Working Group.

Monitoring and evaluation remains a challenge for the National HIV/STI and Reproductive Health Programs. The national Health Information System does not provide sufficient detail to support Program reporting against strategic indictors and targets, and there are neither integrated data collection systems for the HIV/STI and Reproductive Health Programs, nor specific indicators for capturing integrated services. The two Programs have each devised additional monthly reporting processes for completion by clinic staff and collection and compilation by provincial and national program coordinators. National reports are often delayed and generally reflect data gaps.

Service delivery: Higher level health facilities such as Hospitals and Health Centres are providing a comprehensive range of reproductive health (including family planning) and HIV/STI services, especially if designated as Voluntary Confidential Counselling and Testing (VCCT) sites. Approximately two-thirds of Dispensaries are providing the minimum suite of SRH and HIV services, however staff shortages are impacting on the remaining third as administering of family planning commodities require a trained, registered nurse. Aid Posts are reported as not sufficiently meeting their SRH and family planning promotion and referral responsibilities, however it is suspected that this may reflect a flaw in Village Health Worker Program reporting mechanisms, which limit provincial managers' awareness of Aid Post activities.

Comprehensive, essential HIV services (including pre- and post-test counselling for HIV and STIs) are widely available from the designated VCCT sites, but not from most other health facilities in the country, mostly attributable to the very low prevalence of HIV. Treatment of opportunistic infections and post-exposure prophylaxis are not offered from any clinics other than the Vila Central Hospital and the Northern Provincial Hospital (notably not reported as available from Tafea Provincial Hospital, despite confirmed HIV cases in the province), however all facilities could be suitably equipped should they have clients requiring this in future.

Almost all health facilities in the country provide condoms for STI and HIV prevention, and most offer antenatal and newborn clinics which deliver basic awareness for prevention of HIV among women of child bearing age. Only the Kampusumhed Clinic in Port Vila (operated by Wan Smol Bag) provides targeted information and promotion of services to specific, vulnerable groups, such as men who have sex with men and sex workers.

There are few reported cases of women presenting to government medical facilities with prolonged bleeding or other post-abortion complications, however these are generally managed at provincial hospitals.

There are no established forensic protocols, guidelines or systematic processes for receiving, examining and reporting presenting cases of gender-based violence and sexual assault (including rape). Sexual assault examination and testing kits ('Rape Kits') and post-exposure prophylaxis for HIV and STIs are not available in provincial hospitals or clinics, but are available within some units of the Vila Central Hospital, which has a private and confidential waiting room for women who have experienced gender-based, domestic or sexual violence, and a dedicated nurse for arranging referrals to doctors and counsellors (a joint initiative with the Vanuatu Women's Centre).

Well-resourced and managed peer education and outreach programs are implemented by Vanuatu Family Health Association and Wan Smol Bag, delivering SRH awareness, condom promotion and distribution, VCCT and clinical services to rural communities across all provinces. CARE International also delivers SRH awareness targeting girls.

Conclusions and recommendations: Major challenges to improved SRH service delivery and status exist across the country, such as under-staffing, outdated policies, strategies and clinical guidelines, inadequate reporting mechanisms, systems and processes and under-resourced commodities distribution systems. Significantly improved legislation, policy and political and social commitment to gender equality and equity at all levels will need to be seriously addressed before real gains in SRHR are made. Section 4 of this report provides a summary of key recommendations from this SRHR Needs Assessment.

1: Introduction.

In keeping with its commitment to rights-based development across all sectors, the Republic of Vanuatu (herewith referred to as Vanuatu) has successfully incorporated gender and rights into its national and provincial sexual and reproductive health (SRH) programs (inclusive of safe motherhood interventions, family planning and prevention and management of sexually transmitted infections – STIs – including HIV).

This report provides a review of Vanuatu's rights-led approach to health and social development, and SRH in particular, and presents the results of a detailed Sexual and Reproductive Health and Rights (SRHR) Needs Assessment undertaken to review the Ministry of Health's progress against its international commitments.

The SRHR Needs Assessment was commissioned by the national Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Committee (renamed from 'Maternal, Newborn and Child Health Committee' to reflect an expended mandate for technical and quality oversight of SRH activities), in May 2014[1]. The activity, funded by the New Zealand Ministry of Foreign Affairs and Trade through UNFPA's Pacific Regional Sexual and Reproductive Health Programme, was carried out by the Vanuatu Ministry of Health in the final months of 2014.

This report constitutes part of a comprehensive, consultative National Reproductive Health Program review to inform a revised Reproductive Health Policy and Strategy for Vanuatu in 2015.

1.1: National commitment to rights-based health and social development.

Since achieving independence in 1980, Vanuatu has remained committed to upholding the human rights of its citizens through its Constitution, which enshrines the protection of all people, and specifically directs efforts towards the "…advancement of females, children and young persons, members of under-privileged groups or inhabitants of less developed areas"[2].

The Government of Vanuatu has actioned its commitment to the fundamental principles of the Universal Declaration of Human Rights through its signing and/or ratifying a number of international conventions/treaties which prioritise individuals' rights in the establishment and upholding of laws, legislation and practices in all areas. These include the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW - 1995), the *Convention on the Rights of the Child* (1992), the *Convention on the Rights of Persons with Disabilities* (2007) and a number of conventions under the auspices of the International Labour Organization.

[1] Personal communication; Lorna Rolls, UNFPA Pacific Sub-Regional Office; 14th January 2015; with confirmation from Apisai Tokon, National Reproductive Health Program Coordinator; 12th February 2015.
[2] Parliament of the Republic of Vanuatu, 2012; *Constitution of the Republic of Vanuatu*; source: parliament.gov.vu/Constitution.html, accessed 6/1/15.

Of particular relevance to health and social development, Vanuatu was an original signatory to the 1994 Plan of Action (PoA) of the International Conference on Population and Development (ICPD). This commitment seeks to reduce poverty and hardship and promote economic and social development through multi-sectoral engagement which upholds the rights of couples and individuals (women in particular) to make informed, voluntary decisions about the number, spacing and timing of planned pregnancy. The PoA extends beyond recommendations for access to services and family planning information and commodities, to uphold gender equality as the key element for improved health, including reproductive health, of a nation.

The PoA therefore advocates for cross sectoral engagement beyond health, to the justice, education and a number of other key social sectors in order to:

- Advance gender equality and empowerment of women.
- Eliminate violence against women (also referred to as gender-based violence).
- Eliminate discrimination.
- Achieve full, equal participation of women in civil, cultural, economic, political and social life.
- Enable women to control their fertility.

The PoA also informed the development of the Millennium Development Goals (MDGs), which likewise advocate strongly for rights- and gender-based approaches to poverty alleviation at the national level. Table 1.1 presents the MDGs with particular relevance to population health and social development. In 2012, with support from UNDP, Vanuatu identified MDG5 - Target 5B (*achieve by 2015, universal access to reproductive health*) as requiring significant additional technical support and resourcing to accelerate progress ahead of the 2015 deadline. The initiative, known as the MDG Acceleration Framework (MAF), commenced with a detailed, multi-sectoral needs assessment in 2012, followed in 2014-15 by implementation of rights-based initiatives across three components:

- Improved delivery of quality, evidence-based reproductive health services (including family planning).
- Incorporation of Family Life Education (FLE) into the national school curriculum.
- Establishment and maintenance of quality, comprehensive youth-friendly SRH services[3].

Table 1.1: MDGs with particular relevance to population health and social development.

MDG3	MDG4	MDG5	MDG6
Promote gender equality and empower women	Reduce child mortality	Improve maternal health 5A: Reduce by ¾ … the maternal mortality ratio 5B: Achieve … universal access to reproductive health	Combat HIV/AIDS, malaria and other diseases

These international commitments, conventions and plans of action were more recently re-affirmed by the Government of Vanuatu's signing of the Moana Declaration in 2013[4], and the subsequent *Pacific Sexual Health and Well-being Shared Agenda 2015-2019*[5], which re-commits to the upholding of SRHR. The

[3] Government of Vanuatu, 2013; *Vanuatu MDG Acceleration Framework: Improving Access to Reproductive Health Services*; Port Vila; Government of Vanuatu and UNDP.
[4] Pacific Conference of Parliamentarians for Advocacy on ICPD beyond 2014, 2013; *Moana Declaration: Outcome Statement of Pacific Parliamentarians for Population and Development*; Suva; UNFPA, AFPPD and IPPF.
[5] SPC, 2014; *Pacific Sexual Health and Well-being Shared Agenda 2015-2019*; Suva; SPC.

latter serves as a revised framework for strategy and policy development which prioritises integrated sexual health and reproductive health services, and will support the Government of Vanuatu to further develop its already established series of sectoral, rights-based policies for health, education and justice, informed by a *National Population Policy* (currently established for the period 2011-2020), and the *Vanuatu Priorities and Action Agenda 2006-15* (PAA). Together, these guide the implementation, measurement and reporting of rights-based actions towards national development priorities.

1.2: Sexual and Reproductive Health and Rights (SRHR).

One sectoral policy which has been heavily influenced by the ICPD PoA, the *National Population Policy* and the PAA, is the *National Reproductive Health Policy 2008*, which utilises a strong gender- and rights-based lens to guide the development, implementation, monitoring and reporting of interventions designed to improve reproductive health of Vanuatu citizens[6]. The identified, strategic priorities of the *National Reproductive Health Policy 2008* include:

- Safe motherhood: improved delivery of quality antenatal, perinatal, postpartum and newborn care.
- Promotion and delivery of quality family planning services.
- Improved delivery and access to SRH services for adolescents.
- Prevention and management of STIs, including HIV.
- Addressing of gynaecological morbidities, including abortions, cancer, infertility and menopause.
- Prevention and management of cervical cancer.
- Prevention and management of sexual violence and violence against women.
- Establishment and maintenance of Reproductive Health Commodities Security.

SRHR: National Reproductive Health Policy, 2008.
In the context of Reproductive Health, all couples and individuals have the right inter alia:

- To be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.
- To decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.
- To make decisions concerning reproduction, free of discrimination, coercion and violence. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community.

The *National Reproductive Health Policy 2008* establishes these strategic priorities as the core SRHR for all citizens of Vanuatu, and sets out a framework and detail for delivering these. In consideration of significant changes to SRH and more general population health priorities, funding conditions and practices since the formulation of the Policy in 2007-8, a review and revision has been scheduled for early 2015. This process will include a number of planned, evidence-based reviews and consultations to measure the Ministry of Health's progress in meeting its SRH targets within the Policy and Strategy, and to identify implementation bottlenecks to be considered in the development of the revised Policy. The first such review is this detailed, consultative needs assessment of SRHR, conducted in November and December, 2014.

[6] Ministry of Health, 2009; *Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010*; Port Vila, Government of Vanuatu.

1.3: Country Context.

Vanuatu is an extensive archipelago comprising 80 islands (of which 68 are inhabited) situated along a northwest – southeast axis between Solomon Islands and New Caledonia. Vanuatu is ranked 131 out of 187 countries under the UNDP Human Development Index (HDI), which is calculated based on life expectancy at birth, access to education and information, and standards of living as a reflection of Gross National Income per capita[7]. The country's middle-developing economy (positioned in the lowest economic quartile in the region) is driven predominantly by urban-based service delivery (including a strong tourism industry), and significantly smaller primary/agricultural (predominantly farming and fisheries for subsistence and local markets) and manufacturing sectors. The economic urban bias is at odds with the estimated 75.6% of the population[8] which dwell in rural areas.

High fertility: During its most recent National Population and Household Census in 2009, Vanuatu recorded a total population of 234,023 comprising 114,932 females and 119,091 males[9] (although more recent estimates vary between 271,100[10] and 275,734[11]).

The estimated population growth rate of 2.4% is the highest in the Pacific region[12], and is driven largely by a 2009 Total Fertility Rate (TFR) of 4.1 children per woman entering the period of child bearing age. Data from the 2013 Vanuatu Demographic and Health Survey suggests TFR is on the rise (4.2)[13], and there is concern that Vanuatu may be entering into a phase of reversed fertility transition, in which the decline in fertility that commenced in the early 1980s has troughed, and begun to increase. High fertility, particularly amongst Vanuatu's rural households, places a considerable economic and development burden on this large proportion of the population.

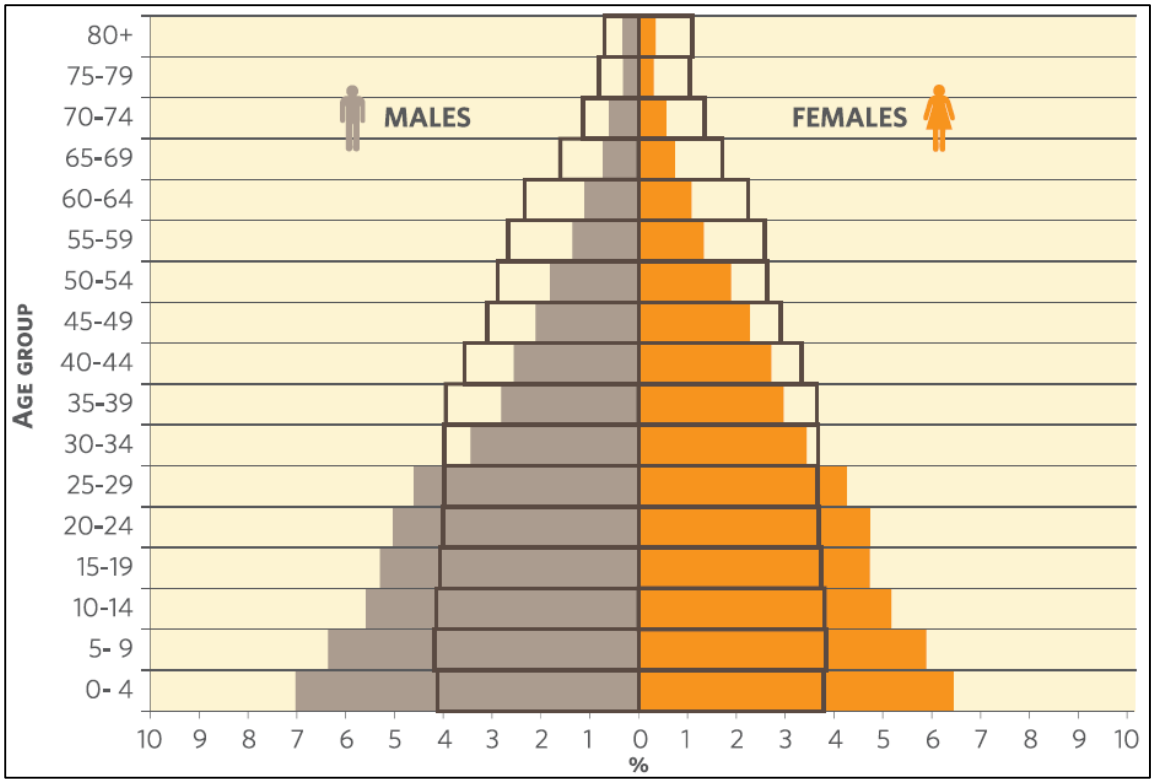
Young, dispersed population: The trend for population growth has the potential to continue in Vanuatu due to the relatively young population, unless effective interventions to promote and deliver family planning are increased. In 2009, 57.8% of the country's female population was under the age of 25 years, and under current trends (see Figure 1.1), it is estimated that the proportion of the population made up of women of child bearing age (15-49 years) will increase significantly by 2050. Improved development outcomes for households, and especially for individual females, will be heavily influenced by the effectiveness of reproductive health and family planning services.

A formidable challenge facing the Ministry of Health in terms of meeting this increased need for reproductive health and family planning services will be ensuring these reach the significant proportion of the population dwelling in dispersed, isolated rural areas. The 2009 *National Population and Household Census* identifies a rural/urban population distribution of 75.6%/24.4% respectively, of which

[7] UNDP, 2014; *Human Development Reports*, Vanuatu; http://hdr.undp.org/en; accessed 7th January 2015.
[8] UNFPA, 2014; *Population and Development Profiles: Pacific Island Countries*; Suva, Fiji; UNFPA Pacific Sub-Regional Office.
[9] VNSO, 2009; *National Population and Housing Census: Basic Tables Report, Volume 1*; Port Vila, Government of Vanuatu.
[10] UNFPA, 2014 op. cit.
[11] VNSO, 2014a; *Live Population of Vanuatu*; www.vnso.gov.vu; accessed 7th January 2015.
[12] UNFPA, 2014 op. cit.
[13] VNSO & SPC, 2014; *Vanuatu Demographic and Health Survey 2013*; Port Vila, Government of Vanuatu.

the former demonstrated higher fertility rates and significantly higher teenage (15-19 years) fertility than their urban counterparts[14].

Figure 1.1: Vanuatu Population by age and sex: 2015 (shaded area) and 2050 (outlined). Source UNFPA[15].



1.4: Health Priorities and Status in Vanuatu.

The identified health outcome indicators within the *Vanuatu Health Sector Strategy 2010-16* (HSS) reflect substantial prioritisation of maternal, child and newborn health, namely:

- Under five mortality rate by main cause of death (MDG4).
- Infant mortality rate (MDG4).
- Ratio and cause of maternal deaths by population by province (MDG5).
- Proportion of deliveries assisted by Skilled Birth Attendant (doctor, midwife or registered nurse) by province[16].

Given that each of these health priorities have relevance for, and are addressed within the SRHR priorities of the *National Reproductive Health Policy 2008* (see Table 1.2), it is necessary to review and consider available data as the basis for this evidence-based SRHR Needs Assessment.

[14] VNSO, 2009 op. cit.
[15] UNFPA, 2014 op. cit.
[16] Government of Vanuatu, 2010; *Health Sector Strategy 2010-2016: Moving Health Forward*; Port Vila; Government of Vanuatu.

Table 1.2: Relationship between the National Reproductive Health Policy 2008's SRHR strategic priorities and the priority indicators within the HSS.

SRHR Strategic Priorities	Links with HSS Indicators	Impact of SRHR on HSS Indicators
Safe motherhood: improved delivery of quality antenatal, perinatal, postpartum and newborn care.	Infant mortality rate (MDG4).	Improved antenatal and delivery services with skilled birth attendants aims to identify, prepare for and respond to complications, thereby increasing the chances of survival of both mother and baby. Postnatal and newborn care supports mother and child to ensure infant survival for the first year of life.
	Ratio and cause of maternal deaths by population by province (MDG5).	
	Proportion of deliveries assisted by Skilled Birth Attendant (doctor, midwife or registered nurse) by province.	
Promotion and delivery of quality family planning services. Establishment and maintenance of Reproductive Health Commodities Security.	Infant mortality rate (MDG4).	Providing women and their partners with information and access to quality family planning services and commodities facilitates their right to make informed choices about the number, spacing and timing of their children. Planned, well-spaced birthing increases chances of survival for the mother and infant, and can increase development opportunities and access to health care for young children.
	Ratio and cause of maternal deaths by population by province (MDG5).	
	Under five mortality rate by main cause of death (MDG4).	
Improved delivery and access to SRH services for adolescents	Infant mortality rate (MDG4)	Information and access to family planning services facilitates young peoples' right to choose number, spacing and timing of pregnancy. Planned pregnancy increases survival of mother and infant, and increases development opportunities for young women.
	Ratio and cause of maternal deaths by population by province (MDG5)	
Addressing of gynaecological morbidities, including abortions, cancer, infertility and menopause. Prevention and management of STIs, including HIV	Infant mortality rate (MDG4)	Addressing infertility supports individuals and couples to realise their SRHR. Limiting and responding to unsafe abortions reduced maternal mortality. Managing gynaecological morbidities (and STIs) can reduce birthing complications, increase infant survival and/or decrease infant morbidity (and increases child survival). Preventing HIV transmission from mother to child increases child survival.
	Ratio and cause of maternal deaths by population by province (MDG5)	
	Under five mortality rate by main cause of death (MDG4).	
Prevention and management of sexual violence and violence against women	Infant mortality rate (MDG4)	Sexual violence and rape can impact on maternal and infant mortality by denying women their right to make informed choices about the number, spacing and timing of pregnancies. Unplanned pregnancies pose a mortality risk to mother and newborn, and limit development opportunities for mother, baby and children.
	Ratio and cause of maternal deaths by population by province (MDG5)	
	Under five mortality rate by main cause of death (MDG4).	

The Infant Mortality Rate (IMR) in Vanuatu, at 15/1,000 live births[17] has reduced significantly (from 21/1,000 live births) since the National Population and Housing Census was conducted 2009, and is well below the 2016 target of 20 as articulated within the HSS[18] (see Table 1.3). Similarly, Vanuatu's Under Five Mortality Rate, at 18/1,000 live births[19] is well below the HSS 2016 target of 25.

Reducing maternal mortality remains a significant challenge for Vanuatu's dispersed, under-resourced health system. While data sets differ across sources, the current Maternal Mortality Ratio (MMR) rest within a range of 86[2021] and 110[22] maternal deaths per 100,000 live births, which substantially exceeds the baseline and target MMR (68 and 50 respectively) articulated in the HSS[23]*.

It should be noted, however that Vanuatu's small population masks the extent to which the number of maternal deaths significantly influences the MMR. As such, the range quoted could, in reality, reflect a difference of one or two maternal deaths in a given year, and a reduction of two or three maternal deaths a year could see Vanuatu meeting its maternal mortality reduction target. Given the potential for the MMR to vary so significantly from one year to the next, a more useful approach for measuring the performance of the health system to prevent and respond to maternal deaths is to consider the actual number and causes of deaths each year, and to determine whether they are a result of related, preventable and/or predictable events (Figure 1.2). A Ministry of Health advisory group seeks to investigate and report on every maternal death each year, in order to monitor and respond to trends associated with unpreventable and preventable maternal deaths respectively.

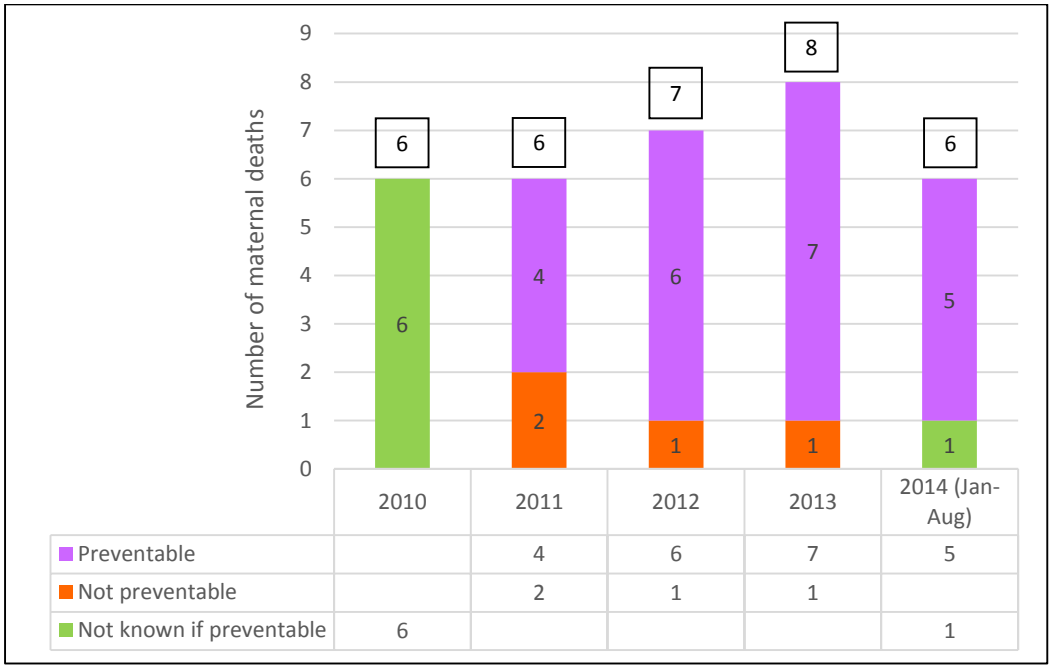
A strategic SRHR priority for Vanuatu is to facilitate increased coverage of skilled attendants at births through improved training, coverage and supervision of qualified midwives. In Vanuatu, a skilled birth attendant is a trained doctor, midwife or registered nurse, and the HSS articulates a 2016 target of 90.0% of births being attendant by one of these[24]. Current coverage estimates of skilled birth attendants at deliveries (86.8% of urban births and 71.6% of those in rural areas) remain below the strategic target[25].

While HIV prevalence in the country remains low (currently six identified cases out of a total of nine since the first case was detected in 2003)[26], there is increasing evidence to suggest that incidence of other STIs is rising, especially amongst young people under 25 years of age, who have reported high rates of unprotected sexual activity with multiple partners, whilst displaying limited awareness/knowledge of STIs and their transmission[27]. In a 2008 Second Generation Surveillance activity conducted in the capital, Port Vila, 25.1% of women attending antenatal clinics at the Vila Central Hospital tested positive for

[17] UNDP, 2014 op. cit.
[18] Government of Vanuatu, 2010 op. cit.
[19] UNDP, 2014 op. cit.
[20] Ministry of Health, 2007; *Vanuatu Multiple Indicator Cluster Survey 2007*; Port Vila; Government of Vanuatu and UNICEF.
[21] WHO, 2014; *Vanuatu statistics summary (2002 – present)*; apps.who.int/gho/data/node.country.country-VUT; accessed 8th January 2015.
[22] UNDP, 2014 op. cit.
[23] Government of Vanuatu, 2010 op. cit.
**Note: the baseline and target MMR presented in the HSS are incorrectly labelled as maternal mortality rate, not ratio.*
[24] Government of Vanuatu, 2010 op. cit.
[25] UNICEF 2013; *Vanuatu Statistics;* www.unicef.org/infobycountry/vanuatu_statistics.html; accessed 8th January 2015.
[26] Ministry of Health, 2014; *National Strategic Plan on HIV and STIs 2014-2018 (DRAFT)*; Port Vila, Ministry of Health.
[27] Ministry of Health, 2008a; *Second Generation Surveillance of Antenatal Women, STI Clinic Clients and Youth*; Vanuatu; Ministry of Health and SPC.

chlamydia, and in the 15-24 year age bracket, 30.2% tested positive[28]. Similar results for chlamydia were identified through voluntary testing in 2011 (25.6%), and Hepatitis B (with 16.5% testing positive) is also on the rise[29].

Figure 1.2: Total number of preventable and unpreventable maternal deaths by year 2010-2014[30].



Gender-related SRHR: Gender equity and equality, a key component of SRHR and a significant determinant of improved SRH, are yet to be achieved within most aspects of Vanuatu society. The female to male ratio for Vanuatu's HDI is 0.9, suggesting females have a lower life expectancy at birth, less access to education and information and generally lower standards of living (as a reflection of Gross National Income per capita) compared with males. The national labour force in Vanuatu comprises 61.5% of the female population, while 80.3% of males are employed[31].

Since achieving independence in 1980, there have been only five or six seats held by women in the National Parliament, and there is currently no female representation. This is despite a commitment made by Vanuatu to the 57th Commission on the Status of Women[32] in 2013 to establish a 30 per cent quota of women within Parliament. Female representation on most national decision-making bodies remains insufficient and unrepresentative[33].

Neglect of women's SRHR is reflected throughout the country. Violence against women, including physical, emotional and sexual violence is present across all provinces, in both urban and rural

[28] Ibid.
[29] Government of Vanuatu, 2012; *Global AIDS Response Progress Report*; Port Vila, Government of Vanuatu.
[30] Health Information Unit, 2014; *Health Information Unit Bulletin: September 2014*; Port Vila, Vanuatu Ministry of Health.
[31] UNDP, 2014 op. cit.
[32] Republic of Vanuatu, 2013; *Elimination and Prevention of Violence Against Women and Girls*; 57th Commission on the Status of Women, New York, 4-15 March, 2013.
[33] VWC, 2011; *Vanuatu National Survey on Women's Lives and Family Relationships*; Port Vila, VWC and VNSO.

communities. In a comprehensive household survey conducted by the Vanuatu Women's Centre (VWC) in 2010-11[34], 60% of women reported to have suffered from physical and/or sexual violence from their intimate partner (44% in the preceding 12 months) and 48% of women reported to have been physically and/or sexually assaulted by someone other than their intimate partner. 41% of the surveyed women's first sexual experience was forced and/or unwanted.

Physical violence during pregnancy from the father of the child takes place in 15% of pregnancies, while 14-21% of women wishing to use family planning methods, and 74-78% of women wishing to use condoms have either been subjected to, or have been fearful of resultant physical and sexual violence from their intimate partner[35].

1.5: Reproductive Health and Family Planning in Vanuatu.

Reproductive, maternal, newborn, child and adolescent health are recognised priorities within the Vanuatu HSS, and the *National Reproductive Health Policy 2008* aims to ensure that "*all people, especially women, men, youth and those living in rural areas, respectful of their individual rights, shall have access to quality reproductive health services and information*". Implicit within this statement is a national commitment to achieving MDG Target 5B (*achieve by 2015, universal access to reproductive health*), and the following section outlines Vanuatu's progress against the appropriate global indicators, namely:

- Contraceptive method mix.
- Contraceptive Prevalence Rate (CPR).
- Adolescent birth (or fertility) rate.
- Antenatal care coverage.
- Unmet need for family planning.

1.5.1: Contraceptive method mix.

A range of modern contraceptives and other family planning methods are available from various sources, including government, private and NGO-operated clinics and community-operated Aid Posts (although male condoms are the only family planning commodity available from the latter). Injectable and oral contraceptives are the most common form of modern methods used, followed by male condoms, and to a lesser extent, female condoms. Intrauterine Contraceptive Devices (IUCDs) are used throughout the country (particularly in rural areas), and female and male sterilization does take place, although less frequently than in the past (and unless medically indicated, this occurs mainly in urban and peri-urban areas with access to hospital surgical facilities)[36]. The emergency contraceptive pill is widely available at provincial hospitals and health centres, although there remains some opposition to its use within the nursing cohort (reportedly out of fear from religion-inspired community backlash).

[34] Ibid.
[35] Ibid.
[36] VNSO & SPC, 2014 op. cit.

UNFPA conducted training for reproductive health staff in November 2014 on the administration of *levonorgestrel*-releasing implants 75 mg (Jadelle). A small stock of these was introduced to Vanuatu at that time, and a larger, national stock has been ordered and is expected to arrive in-country in the first quarter of 2015. The Vanuatu Family Health Association (VFHA), which received some of the initial stock, reports that this has been well received by their clients, and demand for Jadelle is growing[37].

1.5.2: Contraceptive prevalence.

Contraceptive use is often measured and presented as the percentage of women of reproductive age (15-49 years) who are married or in a union using contraceptives at the time of the survey (known as the contraceptive prevalence rate – CPR). The 2007 Multi-Indicator Cluster Survey indicated a CPR (representing any modern or traditional method of contraception) of 38.4%[38], while the 2013 Vanuatu Demographic and Health Survey describes a CPR of 49.0%[39] for any method of contraception, or 37.1% for any modern method. This data places Vanuatu amongst those countries with the highest CPR in the region[40].

The 2013 Vanuatu Demographic and Health Survey also indicates that CPR is highest amongst women in the 25-34 year age bracket, and lowest amongst 15-24 year olds, while there is only negligible difference in contraceptive use amongst married women in urban and rural areas. There is some variation of contraceptive use amongst women who have received formal education versus those who have never attended school, however the number of respondents in the latter category are likely to be low. Little variation is demonstrated amongst differing levels of formal education (see Figure 1.3).

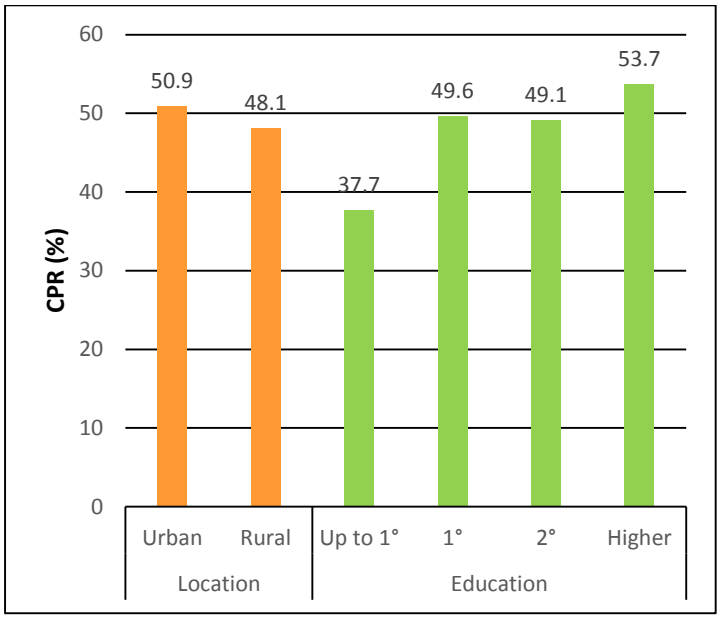
1.5.3: Adolescent birth rate.

Pregnancy during adolescence has been demonstrated to pose a higher risk than for older mothers, with teenagers being more likely to experience complications during labour, and resultant higher morbidity and mortality for themselves and their children. Socially, there is a significant, potential adverse impact on pregnant adolescent women through stigma from within communities and families, and commonly, disruption or conclusion of the mother's attainment of higher education.

The adolescent birth (or fertility) rate (ABR) is a measure of the annual number of live births to adolescent women per 1,000 women aged 15-19 years. The 2009 Vanuatu Population and Housing Census indicates an adolescent birth rate of 66 (40 urban and 77 rural)[41], - one of the highest in the region - however more recent estimates suggest this has reduced to 45[42].

[37] Personal communication; Claire Davies, VFHA; 6th January 2015.
[38] Ministry of Health, 2007 op. cit.
[39] VNSO & SPC, 2014 op. cit.
[40] UNFPA, 2014 op. cit.
[41] VNSO, 2009 op. cit.
[42] UNDP, 2014 op. cit.

Figure 1.3: CPR by Location and Education[43].



1.5.4: Antenatal care coverage.

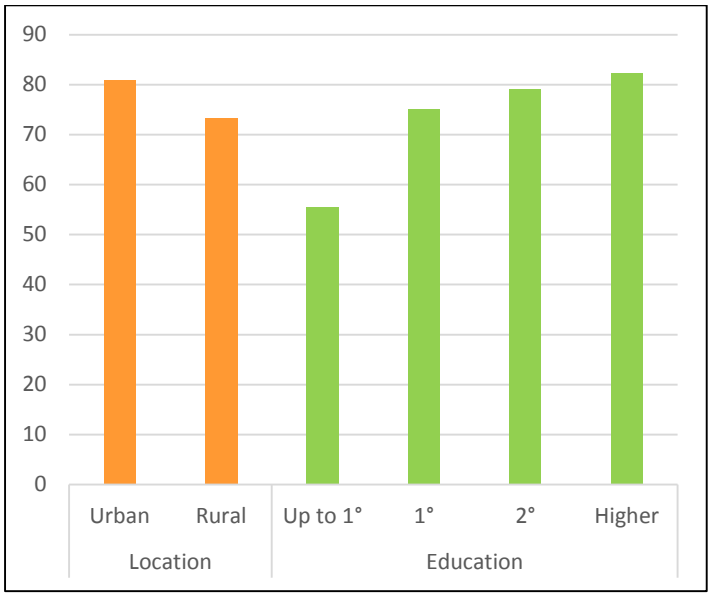
The main objectives of antenatal care are to identify and treat problems during pregnancy which threaten the development of the baby and/or the health of the mother, and to identify complications and make preparations for safe birthing. Indeed, there is a strong correlation between a safer, healthier birth and baby, and both the timing of a pregnant woman's initial antenatal care visit, and the number of subsequent visits. A further, indirect benefit of antenatal care is its capacity to assist health services to reach a larger cohort of women and their partners with post-birth, child spacing messages and options, and to sensitise them to the health service environment which encourages their return for contraceptives and further family planning information in the future.

UNICEF reports that in 2012, 84.3% of women attended at least one antenatal care clinic visit with a qualified doctor, midwife, registered nurse or nurse aide during their most recent pregnancy[44]. This correlates with the 2013 Vanuatu Demographic and Health Survey (75.6%)[45], which also demonstrates considerable variation between women who have and have not received formal education (although only minimal variation is evident across levels of formal education – see Figure 1.4).

WHO recommends that women should receive at least four antenatal care visits during pregnancy. The Vanuatu Demographic and Health Survey was able to present data on the number of antenatal care visits for approximately 81.0% of female respondents who had had a baby in the five years preceding the survey, and found that 51.8% (comprising 46.4% urban and 54.1% rural) of responding women received at least four antenatal care visits during their most recent pregnancy[46].

[43] VNSO & SPC, 2014 op. cit.
[44] UNICEF 2013 op. cit.
[45] VNSO & SPC, 2014 op. cit.
[46] Ibid.

Figure 1.4: Antenatal Care Coverage (at least one visit) by Location and Education[47].



1.5.5: Unmet need for family planning.

A significant indicator used to measure performance towards universal access to reproductive health is the extent to which women of child bearing age (who are married or in a union) either do not want, or wish to delay child bearing, and yet are currently not using contraceptives. This is referred to as the unmet need for family planning, and in 1998, it was estimated that 30.0% of women aged 15-49 in Vanuatu were experiencing this unmet need[48]. The 2013 Vanuatu Demographic and Health Survey calculates a reduction of this figure to approximately 24.2%[49].

1.6: Summary of Reproductive Health Status in Vanuatu.

Vanuatu has established a suitable framework of policies and strategies to guide service planners and providers in the delivery of the minimum suite of services and commodities to meet the nation's SRHR commitments to its citizens, however there remains some fundamental gaps in the establishment of realistic and achievable targets, and insufficient systems and processes for ongoing and systematic measuring, recording and reporting of progress.

Vanuatu has made excellent gains in reducing infant and child (under five years) mortality, although achieving its MDG4 targets remains elusive. Maternal mortality is reducing, however the use of MMR to establish targets and measure performance is inappropriate for the relatively small population, and makes monitoring progress difficult. It is recommended that more realistic targets be established, articulating actual numbers of preventable and unpreventable deaths, and used to monitor progress towards reduced maternal mortality.

[47] Ibid.
[48] Kennedy E, Mackesy-Buckley S, Subramaniam S. 2013; *The case for investing in family planning in Vanuatu: a cost-benefit analysis;* Melbourne; Burnet Institute and Family Planning International on behalf of Compass: the Women's and Children's Health Knowledge Hub.
[49] VNSO & SPC, 2014 op. cit.

Progress is certainly being made in terms of increasing demand for, and access to reproductive health and family planning, however MDG Target 5B, *universal access to reproductive health*, will remain elusive unless significantly more is done to lift CPR and reduce the unmet need for family planning, particularly amongst younger people, which in turn will contribute to a reduced ABR. Greater emphasis must be placed on accurately measuring progress in accordance with these global indicators.

Recommendation: Establishment of realistic and achievable national SRHR targets, and systems of data collection and reporting at the service-delivery, provincial and national levels which can be easily used and collated.
Recommendation: Establishment of realistic and achievable national maternal mortality targets, using actual number of deaths (not MMR) to monitor and report progress.

Table 1.3: Summary of indicators for SRH status in Vanuatu.

Indicator	HSS Baseline	HSS 2016 Target	Interim figures (year)	Updated figures (year)
IMR (per 1,000 live births)	25	20	21 (2009)[1]	15 (2014)[2]
>5 mortality rate (per 1,000 live births)	30	25		18 (2014)[2]
MMR (per 100,000 live births)	68*	50*		86-110 (2012-14)[2,3,4]
TFR (total/urban/rural)			4.1 / 3.2 / 4.4 (2009) [1]	4.2 / 3.3 / 4.7 (2013)[5]
CPR (%)			38.4 (2007)[6]	49.0 (2014)[5]
ABR (per 1,000 live births) (total/urban/rural)			66 / 40 / 77 (2009)[1]	45 (2014)[2]
Skilled attendants at birth (%) (total/urban/rural)	74 (2007)	90		74.0 / 86.8 / 71.6 (2012)[4]
Antenatal care coverage (%)			84.3 (2012)[4]	76.0 (2014)[5]
Unmet need for family planning (%)			30.0 (1998)[7]	24.2 (2014)[5]

Source: [1]VNSO, 2009: *Population and Housing Census*: [2]UNDP, 2014; *Human Development Reports*: [3]WHO, 2014; *Vanuatu statistics summary (2002 – present)*; apps.who.int/gho/data/…: [4]UNICEF 2013; *Vanuatu Statistics*; www.unicef.org/infobycountry/...: [5]VNSO, 2014; *Vanuatu Demographic and Health Survey 2013*: [6]Ministry of Health, 2007; *Vanuatu Multiple Indicator Cluster Survey 2007*: [7]Kennedy et al., 2013; *The case for investing in family planning in Vanuatu*.
** Note: the baseline and target MMR presented in the HSS are incorrectly labelled as maternal mortality rate, not ratio*

2: Purpose and Methodology.

2.1: Purpose.

The purpose of this SRHR Needs Assessment was to review progress on Vanuatu's ICPD and MDG commitments to achieving universal access to reproductive health (MDG Target 5B), with particular focus on ensuring Vanuatu citizens' SRHR are prioritised and maintained through all aspects of service planning and delivery.

Areas of focus included access to family planning information and services, and to a range of appropriate commodities to meet the needs of all groups within communities. The Needs Assessment also explored the extent to which HIV prevention, counselling and management services are integrated with wider reproductive health services, and the availability and composition of services and processes within the formal health system for preventing and responding to gender-based physical and sexual violence.

The consultative review and needs analysis sought to identify the extent to which SRHR are prioritised within the delivery of reproductive health, family planning and more general primary health care services, and to document gaps in SRHR service delivery (by location and intervention type) with a view to informing the consultative review and development of a National Reproductive Health Policy scheduled for early 2015.

2.2: Desk review.

A comprehensive desk review of the reproductive health and family planning environment in Vanuatu was conducted by Chris Hagarty, Vanuatu Reproductive Health Consultant (Ministry of Health, funded by UNDP) to ascertain the current status of the national program, and to measure progress against national SRHR and service delivery commitments, articulated within ICPD, the PAA, the HSS and the *National Reproductive Health Policy 2008*.

This desk review explored available data from demographic and household surveys and the national health information system on reproductive health status, service provision and utilisation, fertility, awareness and utilisation of family planning services, barriers to accessing services, preferences for reproductive health commodities and the extent to which services are meeting the population's reproductive health needs.

National census and household demographic and health survey data for the past 10 years were reviewed and analysed to identify reproductive health and family planning trends. Findings were collated against existing reports and data form a range of sources, including the Ministry of Health and regional technical reports and reviews, so as to verify individual data sets and to limit sampling bias where only a small number of reliable data sources were available.

Gender equity and equality, and the prevalence of gender-based physical and sexual violence in the country were also explored as a basis for determining whether available health services and interventions are of sufficient scale to facilitate the rights of Vanuatu's women.

For a comprehensive list of resources used to complete the desk review, see *Appendix 1: References*.

2.3: Consultative Needs Assessment.

The consultative needs assessment was conducted by Chris Hagarty, Vanuatu Reproductive Health Consultant, with support from the MAF Program Coordinator, over three weeks in November and December 2014, and included two consultative meetings with provincial health managers and personnel, and a number of key informant interviews with non-government providers/facilitators of reproductive health services.

Site selection: Due to limitations associated with resourcing and time available to conduct the SRHR Needs Assessment, it was not possible for the reviewers to visit every formal health facility in the country. A subsequent plan to prioritise two provinces based on direction from the National Reproductive Health Program (namely TORBA and SHEFA Provinces) also had to be abandoned due to limited flight availability during the busy, pre-Christmas period.

After consultation with Ministry of Health managers at the national and provincial levels, it was agreed to hold consultation meetings attended by Provincial Health Managers, Provincial Reproductive Health Supervisors and Provincial HIV/STI Focal Points, with a view to capturing data from every facility in the country. Two consultation meetings were conducted in Luganville (Espiritu Santo) for the Northern Provinces (incorporating MALAMPA, PENAMA, SANMA, and TORBA Provinces) and in Port Vila for the Southern Provinces (incorporating SHEFA and TAFEA Provinces). Data collected during the consultation would be verified through a review of a sample of facilities, either via a direct visit (the Pharmacy and Antenatal clinic of the Northern Provincial Hospital, Luganville, and Port Olry Health Centre in SANMA and Kampusumhed Clinic at Wan Smol Bag, Port Vila), or through consulting facility reviews recently conducted by UNFPA in Port Vila[50].

Tools development and provincial consultation: Prior to the provincial consultation meetings, the Vanuatu Reproductive Health Consultant extracted from a variety of sources a complete, up-to-date list of all currently-operating health facilities in the country, inclusive of Ministry of Health, Municipal Government, NGO and community-owned clinics. This information was obtained through the Ministry of Health's health facility mapping released in 2011[51], a more recent, up-dated list of Ministry of Health-owned facilities[52] and from the national Village Health Worker Program, managed on behalf of the Ministry of Health by Save the Children[53]. This list (see *Appendix 2: Complete list of operating clinics in Vanuatu*)

[50] Provided through a personal communication, Lorna Rolls, UNFPA Pacific Sub-Regional Office; received 31st October 2014.
[51] Ministry of Health, 2011; *Health Facility Location and Population Catchment Maps (all provinces)*; Port Vila; Ministry of Health.
[52] Email communication, Scott Monteiro, Procurement Manager/Team Leader, Vanuatu Health Resource Mechanism; received 21st November 2014.
[53] Email communication, Kristina Mitchell, Health Program Manager, Save the Children; received 28th November 2014

would be verified during the forth-coming provincial consultations, and used to map SRHR and service delivery.

Consultation meetings utilised a participative process to facilitate understanding amongst the provincial health representatives regarding SRHR and Vanuatu's associated reproductive health commitments, and to review the services provided at each facility. The abridged consultation process and tools were adapted from the *Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV*, which were sourced from UNFPA's Pacific Sub Regional Office (see Appendix 3). These explored the national policy and legislative environment, health system structure and function and service delivery as it relates to SRHR (inclusive of family planning commodities and information, treatment and management of STIs, response and management of gender-based violence, HIV prevention and response services and the extent to which the latter are integrated with more general SRH services).

The consultative review of service availability at each facility was designed to identify SRHR and service gaps, and where indicated, guided discussion sought to establish the reasons for these gaps. This was followed by an exploration of other, non-Ministry of Health service providers/facilitators within each province, which informed the cohort of organisations engaged during subsequent key informant interviews.

Key informant interviews: Key informant interviews with service and program managers/implementers from NGOs were conducted with VFHA, Wan Smol Bag, CARE International and the VWC, and with the National HIV Program Coordinator within the Ministry of Health in the first weeks of December 2014. These discussions were used to explore, clarify and verify issues raised and statements made during the provincial consultations, and to finalise a comprehensive picture of SRH service provision and SRHR promotion in the country.

For a full list of consultation participants and key informants, see *Appendix 4: List of Participants and Key Informants*.

2.4: Analysis and Limitations.

Section 3 of this report provides the summary and analysis of data collected through the consultative needs assessment. Information is presented in the order established by UNFPA's Pacific Sub Regional Office, within the *Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV* (see Appendix 3). Data, discussion and summary tables are presented in the following subsections:

- ***Policy:*** HIV and STI strategies and policies; gaps and factors which prevent or enable service integration; clinical protocols and service guidelines; stakeholder participation; legislative and legal frameworks which enable/inhibit service development/delivery.
- ***System:*** Development partners, funding and coordination mechanisms; civil society and stakeholder engagement; planning and management of programs; human resourcing; capacity development processes and needs; reproductive health commodities; laboratory and program support services; data management, monitoring and reporting.

- ***Service Delivery:*** availability of essential SRH and HIV services; current status of service integration; prevention and management of abortion; response to gender-based violence and sexual assault; peer education and outreach services; condom programming.

Limitations: Although there are numerous, internationally-tested resources and guidelines available to assist national reproductive health programs to conduct effective, comprehensive SRH needs assessments[54], many of these require a long-term commitment of dedicated survey managers and field assessment teams. For the Vanuatu SRHR Needs Assessment, there was limited time available during which to conduct the activity as a result of a combination of factors, and only a single, dedicated personnel resource.

The limited time to conduct the needs assessment was associated with a donor-driven deadline for completion of the activity (31st December 2014), and the delayed recruitment of the Vanuatu Reproductive Health Consultant (in November 2014). With the annual end of year shut down (unofficially) commencing in Vanuatu from mid-December, this left only a three-four week period in which to complete the consultation and data collection.

To further compound the resource and time challenges, the National Reproductive Health Coordinator was on scheduled annual leave during that period, leaving only the newly-recruited Vanuatu Reproductive Health Consultant, with some field support from the MAF Program Coordinator, to plan and deliver the activity. The model of provincial consultation meetings and key informant interviews was thus devised to provide the most comprehensive review of facility service data possible given the narrow time frame, and a number of data verification visits to facilities was conducted to validate the data collected. While every effort was made to consult widely with provincial staff and to verify information, the data cannot be considered as comprehensive and reflective of the true SRHR needs in the country as would be gained from visiting all facilities.

In terms of assessing SRHR, a further limitation of this assessment is that it sources data from service providers and facilities only, and neglects to consult with service users and other key target groups to ascertain if and how their SRHR are being met or neglected. Insufficient time and resources limited the opportunity to consult widely during this activity, however consultation for the forth-coming revision of the *National Reproductive Health Policy* should seek to engage with such informants to ensure the revised policy adequately reflects SRHR.

Recommendation: Consultation for the forth-coming revision of the *National Reproductive Health Policy* should seek to engage with service users and other key target groups to ascertain if and how their SRHR are being met or neglected to ensure the revised policy adequately reflects SRHR.

Information collected during the desk review, provincial consultations and key informant interviews has informed the findings of this needs assessment. In accordance with the articulated tools and report format provided by UNFPA's Pacific Sub-Regional Office, the findings are presented in terms of their relevance

[54] UNFPA, 2010; *A Guide to Tools for Assessments in SRH*; www.unfpa.org/webdav/.../publications/2010/srh_guide/index.html; accessed 18th November 2014.

to reproductive health and family planning programs and services, particularly in relation to SRHR as articulated within Government of Vanuatu and Ministry of Health policies and strategies.

Identified within the findings are a number of service gaps and the barriers/challenges which impact on effective delivery of comprehensive, rights-based reproductive health and family planning services in Vanuatu, and where appropriate, recommendations have been made to address these.

3: Findings.

3.1: Policy.

The prioritisation of SRH within the Vanuatu HSS has been described in significant detail earlier in this report (see *Section 1.4: Health Priorities and Status in Vanuatu*), and the link between the key progress indicators of the HSS and the SRHR priorities of the *National Reproductive Health Policy 2008* has been clearly demonstrated.

The *Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010*[55] is the guiding document for the delivery of reproductive health (inclusive of STI and HIV testing and management, and family planning) in Vanuatu. The Policy component of the document, which is comprehensively grounded in SRHR and gender-based approaches to SRH service delivery, was informed by the limited regional and national data available at the time of its devising, and articulates the minimum requirements for all providers of SRH and family planning services in the country, regardless of whether they are government or non-government agencies. The eight priority thematic areas of the Policy are:

- Safe motherhood: improved delivery of quality antenatal, perinatal, postpartum and newborn care.
- Promotion and delivery of quality family planning services.
- Improved delivery and access to SRH services for adolescents.
- Prevention and management of STIs, including HIV.
- Addressing of gynaecological morbidities, including abortions, cancer, infertility and menopause.
- Prevention and management of cervical cancer.
- Prevention and management of sexual violence and violence against women.
- Establishment and maintenance of Reproductive Health Commodities Security.

The second component of the document, the Strategy, articulates the program goals, objectives and activities to be carried out by predominantly government service providers (although there is reference to some activities being delivered with support from non-government service providers and multi-lateral technical agencies). The Policy and Strategy do not set quantitative targets and measurable indicators for monitoring progress, however this was addressed in a revised, three year Strategy drafted in 2011. Due to significant disruption to management and personnel within the Ministry of Health at that time, however, the draft was never finalised and endorsed.

Recommendation: Revision of a comprehensive, evidence-based *National Reproductive Health Policy* informed through quantitative data analysis and wide consultation with national and provincial program managers, service providers and users, partner agencies and provincial and community stakeholders.
Recommendation: Development of a suite of comprehensive, evidence-based national and province-specific reproductive health strategies with measurable outcomes linked to monitoring and evaluation plans and indicators, informed through stakeholder consultation.

The extent to which the *National Reproductive Health Policy 2008* incorporates prevention and management of STIs and HIV is evident in thematic areas *III. Adolescent Sexual and Reproductive*

[55] Ministry of Health, 2009 op. cit.

Health, which advocates for integrated prevention and treatment of STIs and HIV, reproductive health and family planning as part of comprehensive delivery of youth-friendly health services; and *IV. STIs including HIV, Reproductive Tract Infections*, which promotes integrated primary health care services which include prevention of mother to child transmission of HIV (PMTCT), provision of voluntary confidential counselling and testing (VCCT), provider-initiated confidential counselling and testing (PICCT) and provision of antiretroviral therapy.

Vanuatu has a comprehensive, Government-endorsed *National Strategic Plan for HIV and STIs 2008-2012*, which has guided the national response for the past six years[56]. A revised *National Strategic Plan on HIV and STIs 2014-2018* has been drafted for the next phase of national implementation, however this is yet to be finalised and endorsed[57].

Both the endorsed and draft National Strategic Plans link the HIV response with prevention and management of STIs, especially as these relate to vulnerable youth. Both articulate integration with reproductive health services to ensure HIV positive women have access to family planning and antenatal care through which to make informed decisions about birth-spacing and support for PMTCT of HIV. Antenatal clinics are the recognised, health system entry point for HIV awareness and prevention messages, and provincial HIV/STI Focal Points are tasked with working through public health programs and the primary health care system to increase reach of HIV and STI prevention messages.

In addition to the Ministry of Health's financial and resourcing commitment to integrated reproductive health and HIV services as articulated within the afore mentioned Policy and Strategy documents, UNDP is promoting implementation of integrated SRHR programming in Vanuatu through the MAF. Technical assistance and resourcing support multi-sectoral, rights-based initiatives targeting identified vulnerable groups across three components:

- Improved delivery of quality, evidence-based reproductive health services (including family planning).
- Incorporation of FLE into the national school curriculum.
- Establishment and maintenance of quality, comprehensive youth-friendly SRH services[58].

SRH and HIV/STI prevention and management are also clearly linked within the *Evidence-Based Guidelines in Family Planning for Health Workers*[59], which articulates protocols for the delivery of rights-based, voluntary reproductive health and family planning services from trained and qualified health personnel working within government and non-government health facilities. These guidelines, compiled in 2006, require immediate review and updating to reflect improvements in service delivery protocols and practice, and the introduction of new family planning commodities such as Jadelle.

Recommendation: *Evidence-Based Guidelines in Family Planning for Health Workers* to be revised, reproduced and disseminated to all relevant health workers delivering reproductive health and family planning services throughout Vanuatu.

[56] Ministry of Health, 2008b; *National Strategic Plan for HIV and STIs 2008-2012*; Port Vila; Government of Vanuatu.
[57] Personal communication, Caleb Garae, National HIV/STI Program Coordinator, Ministry of Health, 28th November 2014.
[58] Government of Vanuatu, 2013 op. cit.
[59] Ministry of Health, 2006; *Evidence-Based Guidelines in Family Planning for Health Workers: Essential Policies and Standards of Practice for Family Planning Services in Vanuatu*; Suva; Government of Vanuatu, UNFPA, WHO.

While Vanuatu's Constitution and associated legislative and legal frameworks prioritise the upholding of individuals' human rights, there is ambiguity within the law regarding the rights of some individuals and groups who are particularly vulnerable to HIV and STIs. The draft *National Strategic Plan on HIV and STIs 2014-2018* articulates an intention to review and revise legislation that fuels stigma and discrimination relating to HIV. Legislation which criminalizes certain behaviours of key vulnerable groups such as men who have sex with men and sex workers can impact on an individual's motivation to get tested, and to access vital treatment and services.

Table 3.1: Summary of SRHR Needs Assessment Findings for Section A: Policy.

Summary Table for Policy Environment	Yes/No (or details)
1. Is there a national HIV strategy/policy	✓
2. What is the title of strategy and timeframe	National Strategic Plan for HIV and STIs 2008-2012 National Strategic Plan on HIV and STIs 2014-2018 (DRAFT)
3. Is there a national SRH strategy/policy?	✓ Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010
4. Does the country also have an evidence based National Health Sector policy that Incorporates RH and HIV?	✓ Implicit, pp 3,10
5. What is the title of strategy and timeframe	Vanuatu Health Sector Strategy 2010-16 (HSS)
6. Are there any direct policy relevance to linkages between SRH and HIV in the country?	✓
7. Does SRH policy include HIV prevention, treatment, care and support issues? (eg: VCCT, BCC on HIV-SRH)	✓
8. Has SRH policy been made a priority in term of – Funding, legislation, or health sector strategy	✓
9. - Does the country have a protocol for family planning services in place? - Which stakeholders are responsible for carrying out the protocol? List. - Are the procedures in line with human rights standards? - Are the procedures for delivering FP services free from discrimination, coercion and violence?	✓ Evidence-Based Guidelines in Family Planning for Health Workers: based on, and promotes SRHR (see main text).
10. List any service protocols, policy guidelines, manuals, etc, that are specifically geared towards increasing SRH and HIV link	National Strategic Plan on HIV and STIs 2014-2018 (DRAFT) Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010
11. Is there a participatory platform that advocate for increased investments in marginalized adolescents and youth, within development and health policies and programmes? Y/N .If so, describe.	✓ MAF (see text)
12. Determine whether there is a legislative framework to supports (or does not support) the implementation of SRH and HIV linkages.	✓
13. What are the laws affecting key groups (SWs, IDUs, MSM, other) and what is their impact?	Sex work and male-male sex remains illegal; this impacts on

	key groups accessing health (incl. SRH) and legal services. National legal reform underway; no explicit commitment to addressing these issues.
14. What are the main of funding source for SRH and HIV. If possible, give a break down *Donors provide a combination of funding for activities, commodities and staffing, and technical assistance for agreed interventions.*	MOH (Government of Vanuatu and Government of Australia) UNDP UNICEF/UNFPA/WHO (mechanism pending) GFATM (pending)
15. Are there specific cases of donors putting restrictions on HIV programmes regarding SRH components or vice versa	✗
16. Within the budgets for specific SRH services, what is the proportion allocated to HIV prevention and care?	Unknown

3.2: System.

Development partners: A number of development partners support the SRHR sector in Vanuatu, through a variety of funding mechanisms and technical assistance interventions. The Government of Vanuatu, through the Ministry of Health, leads policy development and oversight, and coordination of national and provincial SRH programs. This includes training and remuneration of program and service implementing staff at all levels. Funding for the Government's support to SRH comes from its own recurrent revenue, and from Australian Government bilateral aid.

Multi-lateral agencies provide a mix of financial revenue (such as UNDP's support through MAF and UNICEF's support of maternal, newborn and child health), and significant technical assistance to programming, protocol and policy development, data analysis and training through UNICEF, UNFPA, WHO and SPC. UNAIDS also provides technical assistance to the development of HIV programming and monitoring systems, global AIDS reporting and strategic planning.

To date the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been the major funding body supporting implementation of the National HIV/STI Program, however this funding is due for completion in 2015, and processes are underway to apply for a further round of GFATM support.

Coordinating mechanisms: The RMNCAH Committee is the multi-sectoral body endorsed by Government and tasked with progressing targets for MDG4 and 5 through the establishment and maintenance of guidelines and protocols for delivery of reproductive, maternal, newborn, child and adolescent health services and interventions throughout the country. The Committee is comprised of both Ministry of Health personnel (Chair) and representatives from United Nations agencies.

The MAF Expert Working Group has been established to oversee and guide the delivery of this Program, which is working to progress MDG Target 5B. The Working Group is comprised of representatives of the Ministries of Health (Chair), Youth and Education, UNDP, UNFPA and civil society organisations, all of whom have a role to play in the delivery of the articulated SRH interventions under MAF.

While implementation of the national response to HIV and AIDS remains the responsibility of the Ministry of Health, the National AIDS Committee provides both strategic and multi-sectoral, stakeholder-reflective oversight of plans and interventions. Its 17 members comprise representatives of government ministries/departments, development partners (including WHO), the legal sector, people living with HIV, civil society (including NGOs, community- and faith-based organisations, youth and chiefs) and two ex-officio members from the National HIV/STI Program as the Secretariat.

A multi-sectoral working group known as the Vanuatu Country Coordinating Mechanism has been established to prepare funding submissions to the GFATM. This body is made up of many of the Ministry of Health, civil society and other government representatives of the National AIDS Committee.

While the above committees/groups are working to promote and progress the directives of the National Reproductive Health and HIV Policies and Strategies, which in themselves advocate for integrated approaches, there is not currently a strong working link between them to ensure coordination, other than through the participation and leadership of Ministry of Health representatives.

Civil Society engagement: In addition to civil society representation on the MAF Expert Working Group, the National AIDS Committee and the Vanuatu Country Coordinating Mechanism, civil society organisations are engaged in advocacy, planning, implementation and monitoring of SRH (including HIV and STI) interventions. This is clearly evident for the development of MAF, which was established as a result of civil society advocacy, and planned with full engagement from relevant groups, and for the running of the Vanuatu Country Coordinating Mechanism, which saw civil society organisations directly involved in the collection of data upon which to establish an evidence-based funding submission to GFATM.

The main civil society implementing partners for SRH services in Vanuatu comprise VFHA and Wan Smol Bag, while Save the Children, CARE International and Youth Challenge provide support to government for promotion of awareness of SRH issues amongst young people in communities. The national response to supporting people living with HIV has been a direct result of strong advocacy from the Irene and Zara Foundation (IZA), which is the only organisation in Vanuatu working exclusively to advocate for the rights of people living with HIV.

Planning, Management and Administration: Youth-focused HIV and STI prevention is a priority of the National HIV/STI and Reproductive Health Programs, and is well reflected amongst the strategic priorities and activities of each. The MAF is working through the Ministry of Health, VFHA and Wan Smol Bag to promote, equip and support youth-friendly health services, which include youth-targeted VCCT, prevention and management of STIs and promotion of condoms.

In 2014, steps were taken to formally integrate the HIV/STI and Reproductive Health Programs at the national and provincial levels, however re-structuring within the Ministry of Health in early 2015 has determined that the former will remain under the remit of the Director of Disease Control, and aligned more closely with the Tuberculosis Program. While this decision impacts on management resourcing, the HIV/STI and Reproductive Health Programs will continue to be tasked with coordination and integrated implementation of activities, as currently takes place through engagement with young women

attending antenatal clinics, and through the integrated planning and outreach work of the Provincial HIV/STI Focal Points with other public health programs.

Vanuatu's submission and presentation to the 57th Commission on the Status of Women[60] refers to a forthcoming *National Gender and Women's Empowerment Policy 2013-2023*, however no such policy has been released to date. The *Family Protection Act* of 2008 criminalizes domestic violence and obligates police and the law to formally act on complaints within 48 hours[6162]. The Public Prosecutor's Office and Family Protection Unit of the Vanuatu Police Force have internal 'no drop' policies to ensure domestic and sexual violence cases are brought to trial (and not withdrawn)[63], however the extent to which they proceed through the courts is subject to the complainant's willingness to appear and provide evidence; the long wait for such cases to reach trial, and pressure from families and communities commonly influence complainants not to testify in Vanuatu's courts[64].

A number of local and international NGOs such as the VWC, Wan Smol Bag and CARE International run youth-targeted programs to raise community awareness of the legal ramifications of, and appropriate community responses to gender based violence and violence against women. Each of these organisations run specific interventions targeting men and/or boys.

Human Resources and Capacity Development: SRH (including family planning) services in Vanuatu are delivered by registered nurses, midwives and doctors (although while the latter are qualified to do so, most family planning services are not delivered by doctors). Midwives are registered nurses who have undergone an additional twelve months training program, which is delivered by a nationally-accredited training institute such as the Vanuatu College of Nursing Education on an 'as needs' basis (that is, not every year, but when required to increase the cohort of trained midwives and where funding allows)[65].

There is currently a significant shortage of trained midwives in Vanuatu. Most rural clinics are staffed by only a single, trained midwife or registered nurse, making it difficult for them to leave clinics unattended while they undertake supervisory and outreach visits to lower level clinics and communities.

Ongoing refresher training is provided to midwives and reproductive health nurses in their provinces on an annual basis, either from the Vanuatu College of Nursing Education, or from a New Caledonia-based non-government organisation (*Association Partage Sante Pacifique* - APSP), which coordinates with the Ministry of Health to avoid duplication. Reproductive health nurses also receive ongoing field supervision and support both from their Zone Supervisors (usually an Advanced Nurse Practitioner) and the Provincial Reproductive Health Supervisor.

The formal midwifery training curriculum draws upon multiple, WHO technical resources and in accordance with key competencies established by the International Confederation of Midwifery, and its

[60] Republic of Vanuatu, 2013; op. cit.
[61] Republic of Vanuatu, 2009; *Family Protection Act No. 28 of 2008*; Port Vila, Republic of Vanuatu.
[62] UNIFEM, 2010; *Ending Violence Against Women and Girls: Literature Review and Annotated Bibliography*; Suva, UNIFEM.
[63]Human Rights Council, 2013; *National Report submitted in accordance with paragraph 5 of the annex to Human Rights Council Resolution 16/21: Vanuatu*; New York, United Nations General Assembly.
[64] UNIFEM, 2010; op. cit.
[65] Personal communication, Christine Jackson, Vanuatu College of Nursing Education, 26th November 2014.

delivery is subject to accreditation with the Vanuatu Qualifications Authority. Revised *Evidence-Based Guidelines in Family Planning for Health Workers* will need to be incorporated into future midwifery training upon completion in 2015.

Recommendation: Updated *Evidence-Based Guidelines in Family Planning for Health Workers* to be incorporated into midwifery training curricula (both for pre-service and refresher training) upon completion.

Reproductive Health Commodities Security: A detailed review was undertaken in 2014[66] in which it was determined that there are suitable national reproductive health commodities procurement systems in place, but that supply to provincial and clinic levels is regularly hampered by limited resources with which to meet the high costs of transport, and the latter's unreliability.

Ordering from clinics to the provincial pharmacy, and from the provincial pharmacies to the Central Medical Stores in Port Vila reflects varying quality and accuracy, and it is commonly reported that commodities are not delivered according to the quantities ordered. Many of the clinics visited during this needs assessment had expired stocks of family planning commodities (although in most cases these were removed from the utilised stocks).

Laboratory Services: While all provincial hospitals have STI and HIV testing facilities, the reality for the majority of the population living in rural areas is that they are unlikely to receive laboratory confirmation for their STIs; in most cases, syndromic management is employed for STIs, even when tests are taken and sent to the lab (it was reported that in such cases the individual rarely returns for their test results, and this was assumed to indicate successful syndromic management).

For HIV, 30 VCCT centres (across 25 sites) have been established in hospitals and health centres throughout the country however only 16 of these (16/30) are considered active at present (ie: written monthly reports of counselling and testing outputs are being submitted)[67]. Of the 30 VCCT centres, 17 are accredited to regional standards, however only 10 of these (10/17) are fully functioning[68].

Monitoring and Evaluation (M&E): M&E remains a challenge for the National HIV/STI and Reproductive Health Programs. The national Health Information System collects output data on a range of service delivery fields, but these are not gender- and age-disaggregated, and do not provide sufficient detail to support Program reporting against strategic indictors and targets. In response to this, both Programs have devised additional monthly reporting systems which either require clinic staff to complete and send to the provincial HIV/STI Focal Points and Reproductive Health Supervisors respectively, or which can be collected during supervisory visits a number of times each year. Once sent/collected, the data is compiled at the provincial level and returned to the National Program Coordinators. There are numerous steps along these processes in which the systems can break down - national reports are often delayed and generally reflect data gaps.

[66] Bailey M, Middleton J, 2014; *Family Planning and Reproductive Health Commodity Assessment (DRAFT)*; Port Vila; Ministry of Health and UNFPA.
[67] Personal communication, Caleb Garae, National HIV/STI Program Coordinator, Ministry of Health, 9th December 2014.
[68] Personal communication, Caleb Garae, National HIV/STI Program Coordinator, Ministry of Health, 23rd January 2015.

As an example, the HIV/STI Program's data collection form features twenty-eight fields, including details of the client's age, education, marital status, their source of referral, counselling and testing services provided, dates and outcomes of follow-up, partner tracing and outcomes and HIV treatment. It is acknowledged by the National Program team that collection of this data at each clinic is time consuming, and collation is often delayed.

Currently there are no integrated data collection systems and processes for the HIV/STI and Reproductive Health Programs, and no specific indicators for capturing integrated services, however antenatal care clinics are required to report reproductive health, family planning and HIV awareness and prevention activities, and these could be cross-correlated with an appropriate system by skilled information officers.

Recommendation: A simplified reporting form/system to be developed which both complement data collected within the HIS, and which reflect indicators articulated within an integrated Reproductive Health and HIV/STI Policy and Strategy.

Table 3.2: Summary of SRHR Needs Assessment Findings for Section B: System.

Summary Table of System Support Elements	Yes/No (or details)
1. Who are the major development partners for SRH?	MOH (with funding from Government of Vanuatu and Government of Australia), UNDP, UNICEF, UNFPA, WHO
2. Who are the major development partners for HIV	MOH (with funding from Government of Vanuatu and Government of Australia), UNAIDS, UNFPA GFATM (pending)
3. If any, who are the major champions supporting (policy, financial and/or technical) SRH and HIV linkages?	MOH, UNFPA
4. Is there any multi-sectoral technical group working on linkages issues?	✓
5. What is the role of civil society in SRH programming e.g. Advocacy, planning, implementation, and monitoring	(See text)
6. Are the following elements of civil society involved in the SRH and/or HIV responses? PLHIV, Young people, key populations,	✓
7. What programmes (national/donor funded) are in place to prevent STI's and HIV among young people? List.	National HIV/STI and Reproductive Health Programs (donors as above). MAF (UNDP).
8. Is there a joint planning of HIV and SRH programmes?	(Informal; by association on coordinating committees)
9. To what extent have SRH services integrated HIV and have HIV services integrated SRH	(See text)
10. Are three any CSOs supporting the institutionalization of programmes to engage men and boys on gender equality (including GBV), SRH and RR? If so describe status and list CSOs.	VWC: engage men/boys in reducing violence against women.

	Male Advocates program engages male leaders (chiefs, police etc) Wan Smol Bag: youth-targeted theatre, multi-media, workshops on gender and violence.
11. What institutions are providing integrated services for HIV and SRH? (ex. government facilities? NGOs, FBO, private sector..)	MOH, VFHA, Wan Smol Bag
12. Is there a policy on GBV or VAW? Is the health sector referred to in national Domestic Violence legislation?	✗
13. What are the highest priority training needs in the health sector, i.e. who needs to be trained on what subjects or skills?	Pre-service training for midwives. Refresher training for SRH staff.
14. Where is SRH training offered (pre service, post service)	Pre-service: Port Vila. Refresher: Provinces (annual).
15. Does capacity building on SRH and HIV integrate guiding principles and values? (ex. Stigma, gender, male involvement, attitude with key population…etc)	✓
16. Are there training materials and curricula on SRH which include HIV prevention, treatment and care at programme and service-delivery levels and as part of pre-service training?	✓
17. Are curricula and training materials revised and updated regularly	✓
18. In relation to staff for SRH and HIV programmes, what are the biggest challenges?	High workload/difficulty covering for rural outreach/supervision.
19. How do the monitoring and evaluation structures capture results of SRH programmes? (Access to services, uptake of services, Quality, client satisfaction, client profile)	Poorly (see text)
20. What indicators are being used to capture integration between SRH and HIV (e.g. HIV clients receiving SRH services, SRH clients receiving HIV services)	✗
21. Is the data collected on SRH and HIV disaggregated by sex, age and HIV status?	✓ Additional reporting systems only.
22. Does the current HIS capture all essential information on SRHR	✗
23. Describe the information flow	(see text)
24. Does the essential SRH indicator are capture in the clinic report form	✗
25. Are client registers for use of SRHR/GBV/ YFHSs services established in the various health clinical outlets, SDPs, and community centres? List places having this data collection register for clients.	✗ (see Section 3.3 below)

3.3: Service Delivery.

Essential SRH Services: Provincial consultations were used to confirm the minimum required SRH (including family planning) services which were to be offered at each clinic level (see Table 3.3).

According to this criteria, all six provincial hospitals (inclusive of the national referral hospital –Vila Central Hospital, and the Northern Provincial Hospital in Luganville) provided the minimum suite of SRH services,

as did all bar one Health Centre (in SANMA Province). Table 3.5 provides a detailed summary of the number of health facilities offering these minimum SRH services.

68.4% of Dispensaries across the country provided the minimum SRH services. Many of the defaulting clinics do not provide emergency contraceptives, reportedly due to under-staffing in which no permanent Registered Nurses are in place. These clinics are staffed by Nurse Aides only, who are not qualified to dispense/administer family planning commodities.

Table 3.3: Agreed minimum requirements for SRH (including family planning) at each clinic level.

Minimum requirements for SRH and Family Planning		Hospital, Health Centre, Dispensary	Aid Post
Family Planning	• Info to plan families and referral • Means – contraceptives	✓ ✓	✓
STI Prevention and Management	• Awareness & prevention, incl condoms • Pharmachological Treatment	✓ ✓	✓
Antenatal and newborn care	• Referral • Info: b'feeding and parenting • Pregnancy checks (1-12) • Post birth: 2 & 6 weeks	✓ ✓ ✓ ✓	✓ ✓
GBV: Prevention and Management	• Awareness/referral/reporting • Examination/response/reporting	✓ ✓	✓
Emergency oral contraceptive pill	• Referral for… • Available when needed • Without judgement • Confidential	 ✓ ✓ ✓	✓

While only 44.3% of Aid Posts were reported to be providing the minimum required SRH services, it is suggested that reported figures reflect a lack of awareness amongst provincial health managers of the activities of many Village Health Workers (who operate from Aid Posts), particularly in relation to their community awareness, health information and referral practices. This is partly due to poor reporting rates from Aid Posts to the provincial level, and partly due to insufficient supervisory visits from provincial managers in recent years. Aid Post reporting figures for SRH (including family planning) should be further verified with the national Village Health Worker Program.

In accordance with national essential medicines lists all Hospitals in the country have access to the seven priority life-saving medicines for women[69] (see Table 3.4), while Health Centres and Dispensaries can access most of these, as long as they are staffed by qualified midwives and/or specifically trained registered nurses. Aid Posts and some Dispensaries which are not currently staffed by a registered nurse do not have access to most of the life-saving medicines. Provincial consultations were unable to elicit

[69] WHO, 2012; *Priority Life-Saving Medicines for Women and Children 2012*; WHO.

the extent to which health facilities had all seven priority life-saving medicines for women in stock; a limitation of the methodology which could only be addressed through visiting every clinic in the country.

Recommendation: Improved coordination, linkage and both management and exchange of data between the national Village Health Worker Program and provincial health managers to determine the actual SRH (including family planning) activities and outputs from Aid Posts.

Table 3.4: Health facilities in Vanuatu with potential to stock the seven priority life-saving medicines for women.

Life saving maternal/ RH medicines	Availability			Comments/Details
	Hospital	Health Centre	Dispensary	
Oxytocin Inj	✓	✓*	✓*	* Only where a trained midwife (or registered nurse with obstetric training) is located.
Misoprostil tabs	✓	✓*	✓*	Note: Injections to be administered by registered nurses only, therefore not available in understaffed Dispensaries
Magnesium Sulphate Inj	✓	✓	✓	
Antibiotics				
Gentamicin Inj	✓	✓*	✓*	
Metronidazole inj	✓	Oral only	Oral only	Health Centre and Dispensary to refer to Hospital for maternal sepsis.
Cystalline Peniclin Inj	✓	✓	✓	
Ante-natal cortico-steroids:				
Hydrocortisone inj	✓	✗	✗	
Prednisolone inj	✓	✓*	✗	
Chlorhexidine	✓	✓	✓	Not actually chlorhexidine, however chlorine sachets and povidone iodine solution available.
Resuscitation devices	✓	✓#	✓#	# May only be manual devices if no power.

Essential HIV Services: Provincial consultations sought to establish the extent to which health facilities are providing VCCT, PICCT, treatment of opportunistic infections, post-exposure prophylaxis, the means for maintaining client privacy and confidentiality and basic or advanced PMTCT. Due to the low prevalence of HIV in the country, it is not surprising that treatment of opportunistic infections was not offered from any clinics other than the Vila Central Hospital and the Northern Provincial Hospital, however it was confirmed that all facilities could be suitably equipped should they have clients requiring this in future (and similarly, post-exposure prophylaxis could be made available if the prevalence of HIV increased in provincial areas). It is important to note that treatment of opportunistic infections and post-exposure prophylaxis were not identified for Tafea Provincial Hospital, despite confirmed HIV cases in the province.

It was evident that few health facilities in the country had the full range of HIV services, unless they had been designated as VCCT Centres, and provided with resourcing to ensure suitable, clean, confidential and private consulting with clients. Amongst the 25 designated VCCT sites across the country, 18 (72.0%) were offering suitable services (with the exception of treatment of opportunistic infections and post-exposure prophylaxis). This information contrasts with the National HIV/STI Program, which

indicates that up to 12 sites are not currently active[70], and that only 10 of the 17 regionally accredited VCCT centres are fully functioning[71].

It is promising to note that almost all health facilities in the country have male condoms available and are providing these for STI and HIV prevention.

Most health facilities which offer antenatal and newborn care reported to provide the basic level of PMTCT, namely prevention of HIV among women of child bearing age. Due to the low HIV prevalence across the country, few clinics offer (or have capacity to offer) interventions for prevention of unintended pregnancy amongst HIV positive women, or prevention of HIV from a mother to her child. Care and support for HIV positive mothers and their families is offered in Port Vila, but is not currently available outside the capital (however this has been available in TAFEA in the past, and established HIV/STI Program systems ensure availability of support where and when need is identified).

Only the Kampusumhed Clinic in Tagabe, Port Vila (operated by Wan Smol Bag) provides any targeted information and promotion of services to specific, vulnerable groups, such as men who have sex with men and sex workers. These groups are supported to attend the clinic, however no special clinic sessions or times other than the regular operating hours are offered.

Prevention and management of unsafe abortion: Abortion remains illegal in Vanuatu, unless medically indicated to save the life of the mother. There are therefore few reported cases of women presenting to government medical facilities requesting abortion, however VFHA has experienced these requests on a number of occasions.

Women who present to clinics with prolonged bleeding post abortion from private providers are generally referred to provincial hospitals for management. There have been few cases in recent years where the woman has faced legal action after presenting to a clinic post-abortion.

VFHA will release a report on abortion practices and estimated prevalence in early 2015[72].

Responding to gender-based violence and sexual assault: It was reported that neither the Ministry of Health nor provincial and health facility managers have established forensic protocols, guidelines or systematic processes for receiving, examining and reporting presenting cases of gender-based violence and sexual assault (including rape), however draft protocols are reportedly being developed for the Vila Central Hospital. In practice, it was suggested that these cases do not regularly present to the rural health facilities, and often they present to hospitals for medical examination only after some time has lapsed, when the survivor is pursuing legal action and is directed to do so by police.

[70] Personal communication, Caleb Garae, National HIV/STI Program Coordinator, Ministry of Health, 9th December 2014.
[71] Personal communication, Caleb Garae, National HIV/STI Program Coordinator, Ministry of Health, 23rd January 2015.
[72] Personal communication; Julias Ssenabulya, Program Strengthening Adviser, VFHA; 12th December 2014.

Table 3.5: Summary of SRHR Needs Assessment Findings for Section C: Mapping facilities and services available.

Province	Hospital	FP	Health Centre	FP	Dispensary	FP	Aid Post	FP	VCCT Centres	VCCT Service	Comments.
MALAMPA	1	1	8	8	20	9	38	0	4	4	FP: All Dispensaries offer FP and STI prevention and management, while less than half did not offer emergency oral contraceptive. Others also did not offer antenatal clinics. All Aid Posts reported to be providing information and referral for FP, but none were identified as providing referral for emergency contraception. VCCT: All clinics providing condoms, and all designated VCCT Centres reported to be providing VCCT and PMTCT services.
PENAMA	1	1	6	6	23	20	37	15	1	1	FP: 2 Dispensaries not offering emergency contraceptives and 1 has incomplete information. Amongst 9 Aid Posts, it was not known if awareness and referral for FP was being delivered, while 22 were either not (or it was unknown whether they were) offering awareness and referral for antenatal and newborn care.
SANMA	1	1	9	8	23 (+2 Prv clinics	13	40	2	6	6	FP: 1 Health Centre not offering antenatal care, GBV services or emergency contraceptives. 12 Dispensaries not offering full range of services due to under-staffing. 38 Aid Posts reported to be providing no FP services.
SHEFA	1	1	4	4	20 (+4 Prv clinics)	24	43	38	6	4	FP: All Aid Posts offering info and referral for FP, but only 5 referring regularly for emergency contraceptives.
TAFEA	1	1	4	4	12	7	35	19	6	1	FP: 5 Dispensaries not offering neither emergency contraceptives, nor 1 other minimum requirement. 3 Aid Posts reported to be not delivering any FP services, while a further 11 were either not (or not known to be) providing basic FP info or referral. VCCT: Treatment of opportunistic infections only in 1 Centre. 3 Centres not offering VCCT.
TORBA	1	1	3	3	6	5	21	21	2	2	FP: 1 Dispensary not offering emergency contraception.
Total	6	6	36	33	114 (+/-6)	78	214	95	25	18	
Percentage	100%		91.7%		68.4%		44.3%		72.0%		

Note: 'FP' refers to the agreed, minimum requirement for SRH (including family planning) services from each clinic level – see Table 3.2)

Sexual assault examination and testing kits ('Rape Kits') are not available in provincial hospitals or clinics, but are available within some units of the Vila Central Hospital (children's and general Outpatients Departments, Integrated Women's Health Clinic). Post-exposure prophylaxis for HIV and STIs is available from these facilities.

Recommendation: Establishment of (and training for) national guidelines for systematic forensic assessment and reporting of sexual assault cases within health facilities.
Recommendation: Equipping of all designated health facilities with sexual assault examination and testing kits, inclusive of post-exposure prophylaxis for HIV and STIs, and protocols developed and disseminated for their use and regular re-stocking.

Vila Central Hospital also has a private and confidential waiting room for women who have experienced gender-based, domestic or sexual violence, and a dedicated nurse for arranging referrals to a select list of trained doctors and counsellors from the VWC (with whom this initiative was enacted).

Peer Education: Both Wan Smol Bag and VFHA have programs in which dedicated peer educators are employed to reach target populations with SRH messages. CARE International also has a Lifeskills training program which utilises a peer education approach.

Wan Smol Bag's 15 peer educators (with an equal gender split, and ages ranging from 20-35) are supported by an administration structure, overseen by an employed Coordinator, and operate in Port Vila, Luganville and from the Haulua Youth Centre, North Pentecost. They receive a minimum wage and benefits, and training each year. They produce records of their activities, including figures of how many people they reach, disaggregated by age and gender. Wan Smol Bag's peer educators distribute condoms and provide statistics to the Ministry of Health. Activities specifically target young people, men who have sex with men and people who are transgender.

VFHA's peer education program is similarly resourced and operates on the islands of Epi, Espiritu Santo, Gaua, Pentecost, Malekula, Ambae, Tanna, Paama, Aneityum and in Port Vila. Peer educators receive an allowance, although this differs depending on the funding source, and they are overseen/supported by a manager/coordinator. They receive refresher training each year, and keep records of their activities (including condom distribution) disaggregated by gender and age.

CARE International is conducting Lifeskills training with young people as an entry point for engaging with women and girls in TAFEA Province over the next two years. This training utilises a peer education approach, and contains elements of relationship development and SRHR, with emphasis on negotiation skills (to assist young people – girls, in particular – to negotiate unwanted sexual advances, arranged marriages, and their SRHRs).

Community outreach: In addition to the peer education activities promoting SRHR awareness and STI and HIV prevention through condom distribution, a number of regular outreach clinical services take place across the country. Wan Smol Bag's Kampusumhed Clinic and peer educators deliver basic clinical, VCCT and awareness services via mobile visits to communities on Efate (Etas, Teouma and Rentapau)

each month. The Haulua Youth Centre on Pentecost also receives outreach services from Wan Smol Bag's team in Santo each month.

VFHA's Youth Friendly Services Project works with and through government health services, through a service strengthening model. VFHA staff accompany government staff on outreach and supervisory visits. Outside Port Vila, these visits reach Ekipe, Erakor, Eratap, Takara and Pangpang communities, and a number of communities in South Santo.

Government provincial health services also conduct outreach from high-level rural clinics (Hospitals and Health Centres) to Dispensaries and Aid Posts. These Maternal and Child Health outreach visits take place regularly (subject to funding) and comprise the usual SRH and family planning aspects of antenatal and newborn care delivery.

Table 3.6: Summary of SRHR Needs Assessment Findings for Section C: Service Delivery.

Summary Table of Service Delivery Findings	Yes/No (or details)
Peer Education	
15. Which Organizations are involved in Peer Education Programs?	Wan Smol Bag, VFHA CARE Int'l (Lifeskills only)
16. Are Peer educators supported by an administrative structure? If so, what is the structure?	✓
17. Do peer educators receive financial support for their work?	✓
18. Do Peer educators cover the entire country? If not, which parts?	✗ MALAMPA: Malekula, Paama. PENAMA: Ambae, Pentecost. SANMA: Luganville, South Santo. SHEFA: Port Vila, Efate, Epi. TAFEA: Tanna, Aniwa, Futuna, Erromango, Ambrym. TORBA: Gaua.
19. Do the peer educators keep a record/register of the above people that they educate? If so, how many of the people from the above groups have peer educators reached or provided services to over the last two years? What is the target number of young people to be reached by peer educators per annum?	✓ (Data not made available)
20. Do Peer educators work with: Young people Sex workers LGBT	✓
21. Are materials available on SRH issues for peer educators to use and distribute?	✓
22. Do the peer educators distribute condoms (male/female) and/or lubricant?	✓
23. How many peer educators have been trained in SRHR over the last two years? How many more needs to be trained per annum?	27-40 trained. Multiple communities in other locations not serviced with peer educators (suggest 4/area = 32; 16 per annum).

24. Are peer educators offered regular training? If so how often and by whom?	✓ Annual refresher by their programs, and CARE Int'l
25. Are there trained trainers in country?	✓
26. How many peer education trainers are there? how many of them are female? How much more trained trainers does the country need?	12-16 trained (50/50 gender split). These are not all active and require refresher training and resourcing. This complete number would be adequate.
Community Outreach	
28. List the organizations/ institutions provide outreach on SRH to communities. And list the target groups	MOH, VFHA, Wan Smol Bag (see text for targets)
29. List the organizations/ institutions provide outreach on HIV to communities. And list the target groups	MOH, VFHA, Wan Smol Bag (see text for targets)
30. Are there existing SRH committees in the communities consisting of community members and religious leaders? Y/N Explain and list. How many community leaders, gatekeepers and religious leaders have been trained on SRHR?	✗ No Committees for SRH. Save the Children, CARE and VFHA have conducted informal training with leaders in all provinces (records not maintained/ available).
31. Do the community outreach reach out to the key population (SWs, MSM and transgender)	✓
32. Does the country have a SBCC (Social Behavioural change Communication) Strategy for adolescents, youth and those from key populations? Y/N	✗ No Strategy exists. Various interventions proposed under MAF.
33. Are there any IEC materials on SRHR available in the country	✗ Not specifically SRHR; SRH only
34. Any available IEC materiel focus on linkages (SRHR and HIV)	✗
35. Is the national CSE/FLE education curriculum aligned with international standards? Y/N	✓ FLE forth-coming in 2015
36. Do the outreach program provide Comprehensive sexuality education at primary and secondary	✓ FLE forth-coming in 2015
Youth Leadership	
37. Does the country have a strategy/policy/guidelines/national standard on YFHS? If so, describe	✓ Under MAF
38. How many facilities offer some form of youth friendly health services? List them	14 Port Vila, Santo (incl. Luganville), Aneityum, Paama, Tanna, Gaua, Epi, Malekula, Ambae, Pentecost, Santo, Ambrym
39. Have YFHS facility assessments been done? If so, in which facilities?	Unknown
40. How are organizations of young people involved in responses to HIV and in SRH programming (part of situation analysis, planning, budgeting, implementing, evaluation, youth engagement)	Unknown

41. Is there a youth advisory committee on SRH, HIV in the country?	✗
42. Does the national youth council deal with SRH issues? If so, how?	✓ Engaged in FLE development and YFS planning under MAF
43. Are young people consulted in health sector policy development, planning and/or reporting?	✗
Condom Programming	
44. Where are condoms (male and female) available?	Stores, all health centres, bars/nightclubs, peer educators, tertiary colleges, nakamals.
45. Are condoms for sale in the country?	✓
46. Is lubricant available in the country? Where?	✓ (as with Q44)
47. Are there community-based distributors in the country?	✓
48. Are condoms available equally in rural areas as in urban areas?	✗

4: Conclusion and Recommendations.

Vanuatu remains committed to upholding the human rights of its citizens, and particularly those most vulnerable, such as females, children and young people, through its Constitution, ratifying international conventions and treaties, and through development of gender- and rights-based sectoral policies. However significant structural, economic, cultural, attitudinal, geographical and fiscal challenges act as barriers to the development and implementation of services and processes which uphold SRHR and contribute to improved sexual and reproductive health, particularly for women and young people.

Within the health system, major challenges to improved SRH, and to the delivery of services which meet basic SRHR include: under-staffing; outdated policies, strategies and clinical guidelines; inadequate reporting mechanisms, systems and processes; and under-resourced commodities distribution systems. Many of these can be addressed through strong, national-level leadership from within the Ministry of Health's Department of Public Health (from the National Reproductive Health Program in particular), and through informed, consultative planning and program implementation at the provincial level.

Strategic priorities must be established based on available evidence and through consultation with key affected populations and other stakeholders to ensure services meet actual needs, and are likely to be acceptable and utilised.

Coordination and consultative planning with program partners and donors will ensure resources are directed to identified SRHR interventions of strategic importance. Leadership and coordinated, strategic planning will identify and meet resourcing gaps and avoid duplication of interventions.

Significantly improved legislation, policy and political and social commitment to gender equality and equity at all levels must be established before real gains in SRHR can be made. While this must remain a priority for the health system, gender equality and equity is a larger, multi-sectoral responsibility, and must be more adequately addressed throughout government, with lead from the Office of the Prime Minister and the Ministry of Justice.

4.1: Summary of Recommendations.

Integrated Policy, Strategy and Protocol Development:

- Consultation for the forth-coming revision of the *National Reproductive Health Policy* should seek to engage with service users and other key target groups to ascertain if and how their SRHR are being met or neglected to ensure the revised policy adequately reflects SRHR.
- Revision of a comprehensive, evidence-based *National Reproductive Health Policy* informed through quantitative data analysis and wide consultation with national and provincial program managers, service providers and users, partner agencies and provincial and community stakeholders.
- *Evidence-Based Guidelines in Family Planning for Health Workers* to be revised, reproduced and disseminated to all relevant health workers delivering reproductive health and family planning services throughout Vanuatu.
- Updated *Evidence-Based Guidelines in Family Planning for Health Workers* to be incorporated into midwifery training curricula (both for pre-service and refresher training) upon completion.

Prevention and response to gender-based violence:

- Establishment of (and training for) national guidelines for systematic forensic assessment and reporting of sexual assault cases within health facilities.
- Equipping of all designated health facilities with sexual assault examination and testing kits, inclusive of post-exposure prophylaxis for HIV and STIs, and protocols developed and disseminated for their use and regular re-stocking.

M&E:

- Establishment of realistic and achievable national SRHR targets, and systems of data collection and reporting at the service-delivery, provincial and national levels which can be easily used and collated.
- Establishment of realistic and achievable national maternal mortality targets, using actual number of deaths (not MMR) to monitor and report progress.
- A simplified reporting form/system to be developed which both complement data collected within the HIS, and which reflect indicators articulated within an integrated Reproductive Health and HIV/STI Policy and Strategy.
- Development of a suite of comprehensive, evidence-based national and province-specific reproductive health strategies with measurable outcomes linked to monitoring and evaluation plans and indicators, informed through stakeholder consultation.

Coordination for integrated SRH and HIV/STI programming:

- Improved coordination, linkage and both management and exchange of data between the national Village Health Worker Program and provincial health managers to determine the actual SRH (including family planning) activities and outputs from Aid Posts.

Appendix 1: References.

Bailey M, Middleton J, 2014; *Family Planning and Reproductive Health Commodity Assessment (DRAFT)*; Port Vila; Ministry of Health and UNFPA.

Government of Vanuatu, 2013; *Vanuatu MDG Acceleration Framework: Improving Access to Reproductive Health Services*; Port Vila; Government of Vanuatu and UNDP.

Government of Vanuatu, 2012; *Global AIDS Response Progress Report*; Port Vila, Government of Vanuatu.

Government of Vanuatu, 2010; *Health Sector Strategy 2010-2016: Moving Health Forward*; Port Vila; Government of Vanuatu.

Health Information Unit, 2014; *Health Information Unit Bulletin: September 2014*; Port Vila, Vanuatu Ministry of Health.

Human Rights Council, 2013; *National Report submitted in accordance with paragraph 5 of the annex to Human Rights Council Resolution 16/21: Vanuatu*; New York, United Nations General Assembly.

Kennedy E, Mackesy-Buckley S, Subramaniam S. 2013; *The case for investing in family planning in Vanuatu: a cost-benefit analysis*; Melbourne; Burnet Institute and Family Planning International on behalf of Compass: the Women's and Children's Health Knowledge Hub.

Ministry of Health, 2014; *National Strategic Plan on HIV and STIs 2014-2018 (DRAFT)*; Port Vila, Ministry of Health.

Ministry of Health, 2011; *Health Facility Location and Population Catchment Maps (all provinces)*; Port Vila; Ministry of Health.

Ministry of Health, 2009; *Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010*; Port Vila, Government of Vanuatu.

Ministry of Health, 2008a; *Second Generation Surveillance of Antenatal Women, STI Clinic Clients and Youth*; Vanuatu; Ministry of Health and SPC.

Ministry of Health, 2008b; *National Strategic Plan for HIV and STIs 2008-2012*; Port Vila; Government of Vanuatu.

Ministry of Health, 2007; *Vanuatu Multiple Indicator Cluster Survey 2007*; Port Vila; Government of Vanuatu and UNICEF.

Ministry of Health, 2006; *Evidence-Based Guidelines in Family Planning for Health Workers: Essential Policies and Standards of Practice for Family Planning Services in Vanuatu*; Suva; Government of Vanuatu, UNFPA, WHO.

Pacific Conference of Parliamentarians for Advocacy on ICPD beyond 2014, 2013; *Moana Declaration: Outcome Statement of Pacific Parliamentarians for Population and Development*; Suva; UNFPA, AFPPD and IPPF.

Parliament of the Republic of Vanuatu, 2012; *Constitution of the Republic of Vanuatu*; source: parliament.gov.vu/Constitution.html, accessed 6/1/15.

Republic of Vanuatu, 2013; *Elimination and Prevention of Violence Against Women and Girls*; 57th Commission on the Status of Women, New York, 4-15 March, 2013.

Republic of Vanuatu, 2009; *Family Protection Act No. 28 of 2008*; Port Vila, Republic of Vanuatu.

SPC, 2014; *Pacific Sexual Health and Well-being Shared Agenda 2015-2019*; Suva; SPC

UNDP, 2014; *Human Development Reports, Vanuatu*; http://hdr.undp.org/en; accessed 7th January 2015.

UNFPA, 2014; *Population and Development Profiles: Pacific Island Countries*; Suva, Fiji; UNFPA Pacific Sub-Regional Office.

UNFPA, 2010; A Guide to Tools for Assessments in SRH; www.unfpa.org/webdav/.../publications/2010/srh_guide/index.html; accessed 18th November 2014.

UNICEF 2013; Vanuatu Statistics; www.unicef.org/infobycountry/vanuatu_statistics.html; accessed 8th January 2015.

UNIFEM, 2010; *Ending Violence Against Women and Girls: Literature Review and Annotated Bibliography*; Suva, UNIFEM.

VWC, 2011; *Vanuatu National Survey on Women's Lives and Family Relationships*; Port Vila, VWC and VNSO.

VNSO, 2014a; *Live Population of Vanuatu*; www.vnso.gov.vu; accessed 7th January 2015.

VNSO & SPC, 2014; *Vanuatu Demographic and Health Survey 2013*; Port Vila, Government of Vanuatu.

VNSO, 2009; *National Population and Housing Census: Basic Tables Report, Volume 1*; Port Vila, Government of Vanuatu.

WHO, 2014; Vanuatu statistics summary (2002 – present); apps.who.int/gho/data/node.country.country-VUT; accessed 8th January 2015.

WHO, 2012; *Priority Life-Saving Medicines for Women and Children 2012*; WHO.

Appendix 2: Complete list of operating clinics in Vanuatu.

MALAMPA Province.

Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type
Malekula	Norsup Hospital	Provincial Hosp	Malekula	Lawa	Aid Post	Ambrym	Utas	Health Centre
	Uripiv	Dispensary		Dixon	Aid Post		Endu	Dispensary
	Amelatin	Dispensary		Melip	Aid Post		Toak	Aid Post
	Vinmavis	Dispensary		Veningaibus	Aid Post		Sameou	Dispensary
	Lambubu	Dispensary		Unmet	Dispensary		Nebul	Health Centre
	Tisvel	Aid Post		Leviam	Dispensary		Olal	Dispensary
	Lakatoro	Aid Post		Wiaru	Aid Post		Fire Mountain	Aid Post
	Mae	Aid Post		Anuatuk	Aid Post		Ranvetlam	Aid Post
	Eresfa (Louni)	Aid Post		Palu	Aid Post		Willit	Aid Post
	Rensarie	Dispensary		Espikal Bay	Health Centre		Baiop	Health Centre
	Limap	Aid Post		Tontar	Dispensary		Melumlum (Pt Vato)	Dispensary
	Tisman	Dispensary		Tenmaru	Dispensary		Lolibulo	Aid Post
	Melken	Aid Post		Win	Aid Post		Malvert	Aid Post
	Aulua	Dispensary		Pikair	Aid Post	Paama	Liro	Health Centre
	Asuruk	Aid Post		Metkun	Aid Post		Lehili	Dispensary
	Repaksivir	Aid Post		Womul	Aid Post		Luvil	Aid Post
	Burbar	Aid Post		Atchin (Mainland)	Health Centre		Selusa (Tahi)	Aid Post
	Lamap	Health Centre		Wallarano	Dispensary			
	Maskelyne	Dispensary		Vao (Island)	Dispensary			
	Akamb Island	Dispensary		Vao (Mainland)	Aid Post			
	Avock Island	Aid Post		Walla Island	Aid Post			
	Bonvor	Aid Post		Orap	Aid Post			
	SW Bay (Wintua)	Health Centre		Galilee	Aid Post			
	Malvakal	Aid Post		Atchin (Island)	Aid Post			
	Carolyne Bay	Dispensary		Botovro	Aid Post			
	Lembinwen	Aid Post						

PENAMA Province.

Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type
Ambae	Lolowai	Provincial Hosp	Maewo	Kerepei	Health Centre	Pentecost	Zuru	Aid Post
	Naleoleo	Dispensary		Naviso	Dispensary		Ila / Kumreut	Aid Post
	Qatuneala	Aid Post		Leleveia	Dispensary		Lewamemeh	Aid Post
	Vurease	Aid Post		Titiro	Aid Post		Melsisi	Health Centre
	Ambaebulu	Aid Post		Nasawa	Dispensary		Tsimbwege	Dispensary
	MCH	Aid Post		Asanvari	Dispensary		Ranmawot	Dispensary
	Nduindui	Health Centre		Baitora	Aid Post		Ubigu / Hubikuh	Aid Post
	Mann/Walaha	Dispensary	Pentecost	Abwatuntora (Mauna)	Health Centre		Neilebati	Aid Post
	Navuturiki	Aid Post		Angoro	Dispensary		Noda	Aid Post
	Lotasana	Aid Post		Aute	Dispensary		Ranwadie	Aid Post
	Volovuho	Aid Post		Latano	Dispensary		Ransrek	Aid Post
	Lonata	Aid Post		Tari Ilo	Dispensary		Onlaba	Aid Post
	Nambangaleo/Ala Memorial	Aid Post		Aligu	Dispensary		Rasen	Aid Post
	Loone	Aid Post		Rahuana	Aid Post		Baie Barrier	Health Centre
	Vuigalato	Aid Post		Namaram	Dispensary		Pangi	Health Centre
	Vandue	Dispensary		Bwatnapni	Dispensary		Point Cross	Dispensary
	Lolovange	Dispensary		Ledungsivi	Dispensary		Saint Hendry	Aid Post
	Lolopuepue	Dispensary		Enkul	Dispensary		St Anne Londar	Aid Post
	Ambanga	Aid Post		Tanbok	Aid Post		Wanur	Aid Post
	Vuiberugu	Aid Post		Narua	Aid Post		St Joseph	Aid Post
	Vanuamarama	Aid Post		Vanmamla (Lesasa)	Dispensary			
	Sakau	Dispensary						
	Lolovoli	Aid Post						
	Makemu	Aid Post						
	Redcliff	Aid Post						
	Lolovele	Aid Post						

SANMA Province.

Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type
Santo	Northern PH	Provincial Hosp	Santo	Sulemauri	Dispensary	Santo	Port Olry	Health Centre
	Matevulu (Sch)	Dispensary		Tasiriki	Dispensary		Hog Harbour	Dispensary
	Sunflower (CLS Church)	Dispensary		Valape	Aid Post		Natawa	Aid Post
	Capricorne (M)	Dispensary		Jungle Mountain	Aid Post		Bonjo / Lantakar	Aid Post
	Nabulvaravara (M)	Dispensary		Wusi	Dispensary		Lorevilko (Lolosa)	Aid Post
	Sarakata (M)	Dispensary		Kerepua	Aid Post		Sara	Dispensary
	Nambauk	Aid Post		Nogugu / Nokoku	Health Centre		Kole	Dispensary
	Ngerger	Aid Post		Wunpuko	Dispensary		Wunavai	Dispensary
	NTM	Aid Post		Tasmate	Dispensary		Vaturei	Dispensary
	VFHA	Urban Clinic		Valapei	Aid Post		Butmus	Aid Post
	NCYC	Urban Clinic		Olboe	Aid Post		Mavea	Aid Post
	Fanafo	Health Centre		Lelesvare	Aid Post		Nalailan	Aid Post
	Stone Hill	Aid Post		Vunavai	Aid Post		Buama	Aid Post
	Palon	Aid Post		Malau	Health Centre		Solway	Aid Post
	Vules Epe	Health Centre		Pesena	Dispensary	Malo	Avunatari	Health Centre
	Tasmalum	Health Centre		Bethel	Aid Post		Atariboe	Dispensary
	Tataikala	Dispensary		Pealulup	Aid Post		Tabunveresake	Aid Post
	Isu/Wailapa	Dispensary		Jereviu	Aid Post		Abangaura	Aid Post
	Forijinal	Aid Post		Vusiroro	Aid Post		Rustron	Aid Post
	Punuas / Jarailen	Aid Post		Jerove	Aid Post		Banavity	Aid Post
	St Daniel (Okoro)	Aid Post		Saramauri	Health Centre		Tawi/Tahi Field	Aid Post
	Kokonae (Urepo)	Aid Post		Paparama	Dispensary		Avorani	Aid Post
	Ipaiato	Aid Post		Vatia/Vatelulu	Aid Post		Sao	Aid Post
	Vavasanaur	Aid Post		Woramauri	Dispensary		Tutuba	Dispensary
	Araki	Aid Post		Bene	Health Centre	Aore	Aore	Dispensary

SHEFA Province.

Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type
Efate	Vila Central Hospital	Nat'l Ref Hosp	Efate	Ewekau (Teouma)	Aid Post	Pele	Pele	Aid Post
	Rufare Mauri (Ifara)	Dispensary		Saupia/Paunagisu	Health Centre		Mangarisu	Aid Post
	Erakor (Village)	Dispensary		Epau	Aid Post	Tongariki	Amboh	Dispensary
	Imere (Mele)	Health Centre		Ekipe	Aid Post		Buninga	Aid Post
	Toroa Kalpuas (Tagabe - M)	Dispensary		Onesua	Aid Post	Emae	Vaemauri	Dispensary
	Laknapora (Ohlen - M)	Dispensary		Saama	Aid Post		Marae	Aid Post
	Tewaikara (Freswota 1 - M)	Dispensary		Siviri	Aid Post	Makira	Makira	Aid Post
	Nambatri (M)	Dispensary		Malafau (Tanoliu)	Aid Post	Mataso	Mataso	Aid Post
	Welu (Centrepoint - M)	Dispensary		Mangaliliu	Aid Post	Epi	Vaemali	Health Centre
	Alamburu (Catholic)	Dispensary		Surossa	Aid Post		Burumba	Dispensary
	Monmarte (Catholic sch)	Aid Post	Lelepa	Amauri	Dispensary		Ngala	Dispensary
	USP (Emalus)	Aid Post	Moso	Leimarowia/Supiariki	Dispensary		Port Quimi	Dispensary
	Eton	Aid Post	Nguna	Silimoli	Dispensary		Nalema	Aid Post
	Erakor Bridge (Anne P - Prv)	Urban Clinic		Taloa	Aid Post		Filakara	Aid Post
	Notamasen (Freswota 1 - Prv)	Dispensary		Vatu-Au/Utanlangi	Aid Post		Penopo/Nulnessa	Aid Post
	Kampusumhed (WSB)	Urban Clinic	Emao	Marowia	Dispensary		Taliko/Votlo	Aid Post
	VFHA	Urban Clinic		Mapua	Aid Post		Saventer/Sarah	Aid Post
	NTM (Agathis)	Urban Clinic		Lausake	Aid Post		Maleba (Mabfilau)	Aid Post
	INTV (sch)	Aid Post		Epule	Aid Post		Mate	Aid Post
	VMF	Aid Post	Tongoa	Silimauri	Health Centre		Bonkoviu	Aid Post
	Emetrar (Club Hipique)	Aid Post		Nimair/Bongabonga	Dispensary		Esake/Malvisi	Aid Post
	Eretap	Aid Post		Tavalapa	Dispensary		Lamen Island	Aid Post
	Lycee (French Sch)	Aid Post		Lakalaka (Lupalea)	Aid Post		Lamen Bay	Aid Post
	Kiemkepip (Ohlen Freswin)	Aid Post		Mangamena (Mangarisu)	Aid Post		Nikaura	Aid Post

M = Municipal Clinic; Prv = Provate Clinic; Sch = school clinic.

TAFEA Province.

Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type
Tanna	Lenakel Hospital	Provincial Hosp	Tanna	Louwital	Aid Post	Tanna	Kwamera	Aid Post
	Iouananen	Dispensary		Lavis	Aid Post		Ieruareng	Aid Post
	Lousula	Aid Post		Lenus (Launahuru)	Aid Post		Port Resolution	Aid Post
	Tan Yapa	Aid Post		Kitau (Nagus Kasaru)	Health Centre	Erromango	Ipota	Dispensary
	Loanatom	Dispensary		Lohatan	Aid Post		Dillon's Bay	Dispensary
	Ipai	Aid Post		Lewangi	Aid Post		Port Narvin	Dispensary
	Loutaliko (Latakren)	Aid Post		Namilo	Aid Post		Cook's Bay	Aid Post
	Lenawawa	Aid Post		Imarapu	Aid Post		Happy Land	Aid Post
	Isla	Aid Post		Loutapanga	Aid Post		South River	Aid Post
	Enapkasu	Aid Post		Louanuialu Kapalpal	Aid Post		Warvis	Aid Post
	Ikiti	Dispensary		Iatalakei (Whitesand)	Health Centre	Aniwa	Rotebeka	Dispensary
	Nimatane	Aid Post		Ikwarmanu (Nafe)	Dispensary	Futuna	Naukero	Dispensary
	Tafea College	Aid Post		Isaka	Aid Post		Matangi	Aid Post
	Green Hill	Health Centre		Imaio	Aid Post		Initi (Harold Bay)	Aid Post
	Louieru (Jet)	Dispensary		Iatukuai	Aid Post	Aneityum	Yorien	Dispensary
	Lamlu St Raphael	Dispensary		Imaki	Health Centre		Umez	Aid Post
	Lounatke	Aid Post		Kwaraka	Aid Post		Port Patrick	Aid Post
	Lounipina	Aid Post						

TORBA Province.

Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type	Island	Clinic name	Clinic Type
Torres Group	Lou	Health Centre	Ureparapara	Lehali	Dispensary	Gaua	Mataka	Health Centre
	Tegua	Aid Post		Lemaily	Aid Post		Womal (Dolap)	Dispensary
	Tormeryau (Hiu)	Aid Post		Diver's Bay	Aid Post		Beam	Aid Post
	Lequel (Toga)	Dispensary	Vanualava	Qatveas	Hospital		Dorig	Aid Post
Motalava	Pemisas	Health Centre		Vetuboso (Hanington)	Dispensary		Masliliu (Saika)	Aid Post
	Rah	Aid Post		Vatrata	Aid Post		Siriti	Aid Post
	Vateil	Aid Post		Kerepeta	Aid Post		Vaget (Aworor), school	Aid Post
Mota	Sarawia	Dispensary		Ambeck	Aid Post		Santa maria, school	Aid Post
	Gamalna	Aid Post		Letel wood (Vatop)	Aid Post	Mere Lava	Lequel (Robul)	Dispensary
				Amon Mansel (Lalnatak)	Aid Post		Tasmat	Aid Post
				Wasaga	Aid Post		Aota	Aid Post

Appendix 3: Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV.

Source: Draft tools provided by UNFPA, Pacific Sub-Regional Office, November 2014

Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV

Purpose

This Needs Assessment Tools is looking at the broad range of linkages issues, such as policy, systems and services.

Assessment components

Components	Key areas of assessment
1. Policy	- Political Positions--National Policies/Guidelines - Funding/Budgetary Support - Policy: Leadership (Champions)/Political Will
2. System	- Partnerships - Planning, Management and Administration - Staffing, Human Resources and Capacity Development - Logistics/Supplies - Laboratory Support - Monitoring and Evaluation - Health information system
3. Service delivery	- HIV integrated into SRH - Overall Perspective on Linkages in SRH and HIV Services - Peer education program - Community engagement/outreach/ youth leadership and engagement - Family planning services - YFHS and - Condom programming - VAW survivor services and support

4. Humanitarian	- Availability of the policy - System to support SRHR - Guideline and protocol

Methodology

- Stakeholder consultation
- Conduct desk review
- Conduct interviews: formal, informal, or group discussion
- Data collection/information

Target Audiences

1. Policy: Coordinator, Program managers, director for health services
2. System: Coordinator, Program managers
3. Service delivery: target for any type of health care workers working at the clinical level, youths, and communities (clients)

Guidance documents:

- SARA and EMONC
- A Guide to Tools for Assessments in Sexual and Reproductive Health
- Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages, A Generic Guide
- Responding to Intimate Partner Violence and Sexual Violence against Women, WHO clinical and policy guidelines

Measurable:

Components	**Information collection**
Service Availability: look at the physical presence of services	- Facility density - health worker density - service utilization
Service readiness: Look at Capacity to deliver services	- Basic amenities - equipment & supplies - diagnostics - essential medicines & commodities - Human resource Capacity: capacity at facility level, Training need (RH, FP), and training curriculum
Specific service readiness areas	Family planning, antenatal care, Obstetric care, Neonatal care and child health (curative, immuni zation)

	HIV, PMTCT, TB, Malaria, YFHS and Chronic Diseases, VAW
EmOC indicators	Availability and distribution of facilities fully functioning at EmONC levels: - Institutional delivery rate - Met need - Population-based cesarean rate - Direct obstetric case fatality rate - Intrapartum stillbirth and early neonatal death rate - % maternal deaths due to indirect causes

Assessment Questionnaire

A. Policy

Section 1: Political Positions National Policies/Guidelines				
			Comments	**Source of information**
1. Is there a national HIV strategy/policy	Yes ☐	No ☐	Add colum for countries	
2. What is the title of strategy and timeframe				
3. Is there a national SRH strategy/policy?	Yes ☐	No ☐		
4. **Probe question for Q5** Does the country also have an evidence based National Health Sector policy that Incorporates RH and HIV? *(For SRHR Results matrix indicator 3.2a)*				
5. What is the title of strategy and timeframe				
6. Are there any direct policy relevance to linkages between SRH and HIV in the country?	Yes ☐	No ☐		

7. Does SRH policy include HIV prevention, treatment, care and support issues? (VCCT-FP, BCC on HIV-SRH)				
8. Has SRH policy been made a priority in term of – Funding, legislation, or health sector strategy				
9. Probe question for Q10 - Does the country have a protocol for family planning services in place? - Which stakeholders are responsible for carrying out the protocol? List. - Are the procedures in line with human rights standards? - Are the procedures for delivering FP services free from discrimination, coercion and violence? *(For SRHR Results framework indicator 1.4a)*				
10. List any service protocols, policy guidelines, manuals, etc, that are specifically geared towards increasing SRH and HIV link				
11. Is there a participatory platform that advocate for increased investments in marginalized adolescents and youth,				

within development and health policies and programmes? Y/N .If so, describe. *(For SP/MCP5 Output 3.1 Indicator 4)*				
12. Determine whether there is a legislative framework to supports (or does not support) the implementation of SRH and HIV linkages.				
13. What are the laws affecting key groups (SWs, IDUs, MSM, other) and what is their impact?				
Section 2: Funding/Budgetary Support				
14. What are the main of funding source for SRH and HIV. If possible, give a break down				
15. Are there specific cases of donors putting restrictions on HIV programmes regarding SRH components or vice versa				
16. Within the budgets for specific SRH services, what is the proportion allocated to HIV prevention and care?				

B. System

Section 1: Partnership				
			Comments	**Source of information**
1. Who are the major development partners for SRH				
2. Who are the major development partners for HIV				
3. If any, who are the major champions supporting (policy, financial and/or technical) SRH and HIV linkages?				
4. Is there any multi-sectoral technical group working on linkages issues?	Yes ☐	No ☐		
5. What is the role of civil society <u>in SRH programming</u> e.g. Advocacy, planning, implementation, and monitoring				
6. Are the following elements of civil society involved in the SRH and/or HIV responses? PLHIV, Young people, key populations,				
Section 2: Planning, Management and Administration				
7. Probe question for Q8	Yes ☐	No ☐		

What programmes (national/donor funded) are in place to prevent STI's and HIV among young people? List. *(For SP/MCP5 output 3.1 indicator 3)*				
8. Is there a joint planning of HIV and SRH programmes?				
9. To what extent have SRH services integrated HIV and have HIV services integrated SRH				
10. Probe question for Q11 - Are thre any CSOs supporting the institutionalization of programmes to engagemen and boys on gender equality 9including GBV), SRH and RR? If so describe status and list CSOs. *(For SP/MCP5 output 2.1 indicator 6)*				
11. What institutions are providing integrated services for HIV and SRH? (ex. government facilities? NGOs, FBO, private sector..)				
12. Is there a policy on GBV or VAW? Is the health sector referred to in national Domestic Violence legislation?				
Section 3: Staffing, Human Resources and Capacity Development				
13. What are the highest priority training needs in the health sector, i.e. who				

needs to be trained on what subjects or skills?				
14. Where is SRH training offered (pre service, post service)				
15. What is the enrolment for the training				
16. Does capacity building on SRH and HIV integrate guiding principles and values? (ex. Stigma, gender, male involvement, attitude with key population…etc)	Yes ☐	No ☐		
17. Are there training materials and curricula on SRH which include HIV prevention, treatment and care at programme and service-delivery levels and as part of pre-service training?	Yes ☐	No ☐		
18. Are curricula and training materials revised and updated regularly	Yes ☐	No ☐		
19. In relation to staff for SRH and HIV programmes, what are the biggest challenges? (retention, recruitment, task shifting, Workload and burnout, Quality)				
20. What solutions have you found to those challenges?				

Section 4: Logistic and Supply (Summary of RHCS Assessment)				
21. To what extent do logistics systems support service-delivery integration? (separate supply, planning, recording and monitoring)				
Section 5: Laboratory Support				
22. Do laboratory facilities serve the needs for both SRH and HIV services? (Haemoglobin, Blood grouping and typing,, STI diagnosis, HIV diagnosis, including rapid tests, CD4 count? HIV viral load, liver function tests, urinalysis, random blood sugar, and pregnancy testing)	Yes ☐	No ☐		
Section 6: Monitoring and Evaluation				
23. How do the monitoring and evaluation structures capture results of SRH programmes? (Access to services, uptake of services, Quality, client satisfaction, client profile)				

24. What indicators are being used to capture integration between SRH and HIV (e.g. HIV clients receiving SRH services, SRH clients receiving HIV services)				
25. To what extent does supportive supervision at the health service-delivery level support effective SRH Services				
26. Is the data collected on SRH and HIV disaggregated by sex, age and HIV status?	Yes ☐	No ☐		
27. Is the current HIS captured all essential information on SRHR				
28. Describe the information flow				
29. Does the essential SRH indicator are capture in the clinic report form				
30. Are client registers for use of SRHR/GBV/ YFHSs services established in the various health clinical outlets, SDPs, and community centres? List places having this data collection register for clients.				

C. Service delivery

Section 1: Mapping facilities and service available	
1. Which of the following essential SRH services are offered at this facility?	1. Family planning ☐ 2. Prevention and management of STI ☐ *(For SRHR results matrix indicator 3c)* 3. Maternal (ANC) and newborn care ☐ (For SRHR results matrix indicator 3c) 4. Prevention and management of gender-based violence ☐ 5. Prevention of unsafe abortion and management of post-abortion care ☐ 6. Other (specify):…… 7. None ☐ 8. Unsure, don't know 9. 7 life saving maternal/ RH medicines from the WHO list. ☐ *(For SRHR results matrix indicator 1.2a)*
2. Which of the following essential HIV services are integrated with SRH services at this facility?	1. HIV counselling and testing ☐ (if yes) a. VCT ☐ b. PICT ☐ 2. Treatment for OIs and HIV ☐ 3. Home-based care ☐ 4. Psycho-social support ☐ 5. HIV prevention information and services for general population ☐

	6. Condom provision ☐ 7. PMTCT(four prongs) ☐ a. prong 1: prevention of HIV among women of childbearing age and partners ☐ b. prong 2: prevention of unintended pregnancies in HIV+ women ☐ c. prong 3: prevention of HIV transmission from an HIV+ woman to her child ☐ d. prong 4: care & support for the HIV+ mother and her family ☐ 8. Specific HIV information and services for key populations a. IDUs (e.g. Harm Reduction) ☐ b. MSM ☐ c. SWs ☐ d. Other key populations (specify) :…… 9. Other services (specify):……. 10. No integration ☐ 11. unsure, don't know ☐
3. How does your facility offer HIV services within:	1. Prevention and management of STI services ☐ 2. Maternal and newborn care services ☐ 3. Prevention and management of gender-based violence ☐ 4. Prevention of unsafe abortion and management of post-abortion care ☐

	5. Family planning? ☐	
4. Are the privacy and confidentiality of clients maintain at services delivery	Yes☐ No☐ Please clarify: ……	
5. Are the following equipment available Nationally	a. Sanitary towels in the examination room	Yes☐ No☐
	b. Consent forms	Yes☐ No☐
	c. Sexual assault evidence collection kits	Yes☐ No☐
	d. Clean clothes for survival use if they have to leave clothes for the forensics/evidence	Yes☐ No☐
6. Is the emergency contraceptive available at the clinic	Yes☐ No☐	
7. Problem experienced with the sexual assault evidence collection kits	a. Keep evidence locked away	Yes☐ No☐
	b. Share the rape kits and see if medical staff have comments on the contents	Yes☐ No☐
	c. Availability of treatment in examination room	Yes☐ No☐
8. Available of tests and treatment		
a. Where people who have been raped first present (OB/GYN, ER, other)		
b. Triage or reason of delays in examination of patient		
c. Where do patient normally wait		
d. Who examine the patients		
e. How the patient information normally collected and stored		
f. Do you have forensics training or protocol	Yes☐ No☐	

g. Has staff been involved in giving evidence in court? What was the experienced?		
9. What was the comment reaction of the staff toward rape cases		
10. Where does the victims normally refer to:	a. Legal	Yes☐ No☐
	b. Psychological	Yes☐ No☐
	c. Shelter	Yes☐ No☐
11. Are the following testing and treatment are available for the victims	a. Pregnancy test	Yes☐ No☐
	b. PEP for HIV	Yes☐ No☐
	c. PEP for STI	Yes☐ No☐
12. Do the staff have undergo training on	a. Sexual violence (adult)	Yes☐ No☐
	b. Sexual assault (children)	Yes☐ No☐
	c. Physical assault	Yes☐ No☐
13. Is VAW integrated in ANC care	Yes☐ No☐	
14. Is VAW integrated in family planning services	Yes☐ No☐	

Section 2: Peer Education program

	Comments	**Source of information**
15. Which Organizations are involved in Peer Education Programs?		
16. Are Peer educators supported by an administrative structure? If so, what is the structure?		
17. Do peer educators receive financial support for their work?		
18. Do Peer educators cover the entire country? If not, which parts?		
19. **Probe question for Q20**		

Do the peer educators keep a record/register of the above people that they educate? If so, how many of the people from the above groups have peer educators reached or provided services to over the last two years? What is the target number of young people to be reached by peer educators per annum? *(For SRHR results matrix indicator 2.2a)*		
20. Do Peer educators work with: • Young people • Sex workers • LGBT		
21. Are materials available on SRH issues for peer educators to use and distribute?		
22. Do the peer educators distribute condoms (male/female) and/or lubricant?		
23. Probe question for Q24 How many peer educators have been trained in SRHR over the last two years? How many more needs to be trained per annum? *(For SRHR results matrix indicator 8a)*		
24. Are peer educators offered regular training? If so how often and by whom?		
25. Are there trained trainers in country?		
26. How many peer education trainers are there? how many of them are female? How much more trained trainers does the country need? *(For SRHR results matrix indicator 8b and 8c)*		
27. If available get list of all peer educators in the country, their location, age, and gender.		

Section 3: Community outreach		
28. List the organizations/ institutions provide outreach on SRH to communities. And list the target groups		
29. List the organizations/ institutions provide outreach on HIV to communities. And list the target groups		
30. Are there existing SRH committees in the communities consisting of community members and religious leaders? Y/N Explain and list. How many community leaders, gatekeepers and religious leaders have been trained on SRHR? *(For SRHR results matrix indicators 10b and 10d)*		
27. Do the community outreach reach out to the key population (SWs, MSM and transgender)		
28. Probe question for Q29 Does the country have a SBCC (Social Behavioural change Communication) Strategy for adolescents, youth and those from key populations? Y/N *(For SP/MCP5 Output 1.1 Indicator 11)*		
29. 28. Are there any IEC materials on SRHR available in the country		
30. Any available IEC materiel focus on linkages (SRHR and HIV)		
31. Probe question for Q32 Is the national CSE/FLE education curriculum aligned with international standards? Y/N *(For SP/MCP5 Output 3.1 indicator 5)*		

32. Do the outreach program provide Comprehensive sexuality education at primary and secondary		
Section 4: Youth leadership		
33. Does the country have a strategy/policy/guidelines/national standard on YFHS? If so, describe		
34. How many facilities offer some form of youth friendly health services? List them		
35. Have YFHS facility assessments been done? If so, in which facilities?		
36. How are organizations of young people involved in responses to HIV and in SRH programming (part of situation analysis, planning, budgeting, implementing, evaluation, youth engagement)		
Youth Involvement		
35. Is there a youth advisory committee on SRH, HIV in the country?		
36. Does the national youth council deal with SRH issues? If so, how?		
37. Are young people consulted in health sector policy development, planning and/or reporting?		
Section 5: Condom programming		
38. Where are condoms (male and female) available?	_____health centres _____bars and nightclubs _____shops Other: _____	

39. Are condoms for sale in the country?	
40. Is lubricant available in the country? Where?	
41. Are there community-based distributors in the country?	
42. Are condoms available equally in rural areas as in urban areas?	

D. Humanitarian

1. Does the policy reflect some kind of needed response in times of crisis/disaster?	
2. Does the system enable or support SRHR in times of crisis?	
3. Are there service delivery guidelines for SRHR during humanitarian crisis	
4. Does the country have a humanitarian contingency plan that include elements for addressing SRH needs of women, adolescents and youth including services for survivors of sexual violence in crises? Y/N. If possible obtain contingency plan document. *(For SP/MCP5 indicator 12 output 1.1)*	

Appendix 4: List of Participants and Key Informants.

Name	Title	Organisation
Henry Wetul	Acting Provincial Health Manager, Torba	MOH (Torba)
Nerry Isom	Provincial Reproductive Health Supervisor	MOH (Torba)
Colenso Silas	Provincial HIV/STI Focal Point	MOH (Torba)
Joseph Mape	Manager, Sanma Rural Health	MOH (Sanma)
Valma Banga	Provincial Reproductive Health Supervisor	MOH (Sanma)
Jeffrey Vutilolo	Lab Technician, NDH + Provincial HIV/STI Focal Point	MOH (Sanma)
Kepoue Andrew	Acting Provincial Health Manager, Malampa	MOH (Malampa)
Sophie Morris	Provincial Reproductive Health Supervisor	MOH (Malampa)
Melody Wai	Acting Provincial Health Manager, Penama	MOH (Penama)
Rosita Aru	Provincial Reproductive Health Supervisor	MOH (Penama)
Lester Dingley	HIS Officer, Northern Provincial Hospital (NPH)	MOH (NPH)
Suzanne	RN Saramauri Health Centre	MOH (Sanma)
Robert Moise	Acting Provincial Health Manager, Tafea	MOH (Tafea)
Ruth Moise	Provincial Reproductive Health Supervisor	MOH (Tafea)
Andrew Williams	Provincial HIV/STI Focal Point	MOH (Tafea)
Morris Amos	Provincial Health Manager, Shefa	MOH (Shefa)
Janet Eric	MCH Nurse EPI focal	MOH (Shefa)
Robson Joe	Provincial HIV/STI Focal Point	MOH (Shefa)
Caleb Garae	National HIV/STI Coordinator	MOH
Lollyn Jeremiah	Assistant Coordinator, National HIV/STI Program	MOH
Anita Vocor	2nd Pharmacist, Northern Provincial Hospital	MOH (NPH)
Dr Thomas Sala Vurobaravu	Obstetrics and Gynaecology Surgeon	MOH (NPH)
Marie-Michelle Manwo	Midwife, ANC Northern Provincial Hospital	MOH (NPH)
Sara Timbati	Midwife, ANC Northern Provincial Hospital	MOH (NPH)
Radiant Stanley	RN, Port Olry Health Centre	MOH (Sanma)
Rose Nirambath	Midwife, Kampusimhed Clinic, Wan Smol Bag (WSB)	WSB
Norley Jack	Midwife, Kampusimhed Clinic, Wan Smol Bag	WSB
Jayline Malverus	Peer Education Coordinator	WSB
Julie Aru	Program Manager, Vanuatu Family Health Assoc	VFHA
Julius Ssenabulya	Program Strengthening Adviser, VFHA	VFHA
Michael Buttsworth	HIS Technical Officer	WHO
Scott Monteiro	Procurement Manager/Team Leader	MOH, DFAT
Inga Mepham	Country Director	CARE International
Merilyn Talu	Coordinator	VWC
Christine Jackson	MNCH Consultant / Midwifery Technical Adviser	DFAT / VCNE