Kiribati Healthy Families Project:
End of project evaluation

FINAL REPORT

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Acknowledgements

This report is the result of learning from committed and passionate people working on improving health in communities in Kiribati. In particular the staff from Kiribati Family Health Association and Family Planning New Zealand provided excellent support throughout and spent much time in the planning and execution of this evaluation process. Many individuals in South Tarawa and Abaiang and staff from the MHMS, MWYSSA, MOE, MIA, UNFPA, BIMBA, Te Toamatoa were generous with their time, open in sharing their views and experiences, and helpful in providing access to relevant materials. Their support is greatly appreciated. In addition, MFAT staff in Tarawa, in particular the Deputy High Commissioner and the Development Programme Coordinator provided many valuable insights that have contributed to the analysis presented in this report.

To all, my thanks, as this review would not have been completed without your commitment to your work and communities.

Professor Anna Klinken Whelan

Executive Summary

The overall goal of Kiribati Healthy Families Project (HFP) phase two was, over five years 2015-2020, to increase access to sexual and reproductive health information, skills and services on South Tarawa and six outer islands, resulting in a reduction in sexually transmissible infections (STIs) and unplanned pregnancies. The beneficiaries of the project are men, women and adolescents in South Tarawa and the six outer islands. The project also aims to work with three key identified groups: youth, people living with disabilities and commercial and transactional sex workers.

The end-of-project review focused on assessing the three strategies identified in the Theory of Change: capacity development, service delivery and enabling environment for SRHR. Nearly 40 relevant documents were reviewed; 29 key informant interviews, 14 informal dialogues and four focus group discussions with 35 leaders, women and young people, were conducted as part of the evaluation in Kiribati. The static clinic was visited and a client-staff interaction was observed. The results framework data and KFHA service statistics were reviewed.

Findings indicate that the Healthy Families Project is highly **relevant** to the Government of Kiribati's concern with population growth in the *Kiribati Vision 2020* and *Kiribati Development Plan 2016-2019* and the *Ministry of Health Strategic Plan 2016-2019*; in particular, the contraceptive prevalence target of 45% of women to use modern contraception by 2019. The Project also aligns well with the New Zealand Aid Programme that includes priorities of progressing health and education outcomes in the Pacific reset. Providing women with choice about when and if to have a child, and reducing teenage pregnancies and STIs is empowering. Most stakeholders reported that KFHA is considered a trusted clinical and training partner; in particular key informants said that they valued and benefitted from various trainings offered by KFHA.

Capacity development training in clinical care and SRHR health promotion has been conducted by FPNZ for 100 KFHA and MHMS staff over the five years. Topics included updates on contraception, history taking, IUD and vasectomy counselling. Health promotion trainings on SRHR topics have been conducted for 75 youth, Healthy Families Taskforce and other stakeholders.

Service delivery increased over phase 2 with additional staff funded by the HFP. Client and service numbers have grown with the increase in mobile clinics and outreach. In year 5, 2019, over 9,000 clients received over 47,000 SRH services in the static, mobile and outer island clinics, however contraceptive services comprised only 10% of all SRH services. There are more youth volunteers and about 2,000 young people (under 25) accessed services. People with disabilities and diverse sexual orientations access KFHA services and trainings.

Outreach activities have increased significantly and more clients in remote villages in the outer islands are able to access SRH services through this outreach. Clinical staff conduct annual visits and work with MHMS staff including providing training and mentoring; an efficient and effective mode to meet client needs while reducing costs for more frequent visits. Nearly 8,000 clients received over 37,000 SRH services through outreach in outer islands in year 5.

Data collection and reporting systems are improving and, by developing a unique client identification number, KFHA are now able to report numbers of clients seen– which is a major achievement that many SRH service providers are unable to report on. KFHA developed a transparent integrated work plan and budget that can report on various funding sources (UNFPA, IPPF Core, DFAT regional Pacific, and MFAT bilateral), ensuring that funding contributes to achieving key outcomes. Financial organizational culture shows accountability and transparency and financial management systems and reporting improved over phase 2.

In terms of **policy and enabling environment**, KFHA have been consulted and contributed to numerous policies, reviews and surveys participated in key meetings; included SRHR in Public Health

bylaws in TUC and BTC; and the Executive Director has received recognition globally for her contribution to SRHR and island development.

Although there is in-kind contribution, KFHA currently receive no government funding and, given limited funds for primary health care, this is unlikely to change much in the future. The relationship between KFHA and FPNZ is positive and valued by both organisations.

The general political, religious and traditional culture and values towards SRHR remain a major challenge in Kiribati and will require **evidence-based communication for change strategies** to shift.

A number of other challenges were identified. **The current KFHA static clinic requires urgent renovation in order to meet IPPF accreditation standards for infection control.** There is no youth drop-in centre or **youth-friendly space** in South Tarawa. Coordination and planning with government Ministries needs attention; and **joint planning** with MHMS to develop future sustainable strategies.

What has worked well is the focus on Island Development Plans and integration of NCDs into mobile and outreach clinics. This service delivery model should continue into phase 3 and if KFHA have the capacity, to continue the expansion to a further three islands, and cover nine islands.

Table 8 details recommendations for phase 3. Below is a summary of key areas to focus on, based on the findings and analysis:

1. Focus on youth and increasing contraceptive services

- If the Healthy Families Project is to reduce key stagnant indicators, then the focus on contraceptive services must step up considerably in the next phase, including awareness of emergency contraception, especially when there are FP stock-outs in outer island clinics. KFHA should develop an island specific plan to increase contraceptive services and client numbers.
- A clear youth engagement strategy should be a key focus for the next phase, and to ensure that there is a youth drop-in centre in South Tarawa where youth feel comfortable to seek advice and counseling on health and SRH issues. If a venue is confirmed, this activity may be negotiated in collaboration with the MHMS.
- More youth-friendly information material and messaging could be developed using social media platforms, however this would benefit from some technical support (possibly through the New Zealand Volunteer Service Abroad scheme) working with KFHA and youth volunteers.

2. Clarify capacity development model and theory of change, including a stronger focus on student nurses (KSON) and staging curriculum from primary, junior and secondary schools (with MOE). Phase 3 should develop a joint CD plan with the MHMS, embedding it to support the RMNCAH strategy.

3. Coordination and joint planning: RMNCAH

- There are several donor partners that fund components of SRHR, gender empowerment and community approaches, which result in some overlaps and duplication, particularly at village level and in outer islands. There is a risk of perverse incentives and reduced efficiency from not coordinating and planning activities at village level. Detailed joint planning and coordination between all stakeholders (especially MHMS/RMNCAH, MWYSSA, MIA, MELAD, KFHA, KRCS, including UN agencies and MFAT) for phase 3 activities should be trialed.
- Stock-outs in village health centres need to be addressed urgently by the MHMS and UNFPA to ensure that procurement and predictive ordering systems are understood and adhered to.

KFHA/MHMS: data reporting. KFHA and MHMS Health Information Unit need to work together to understand the monthly data being reported on by KFHA so it can be included in national reports.

Other recommendations are internal to KFHA related to prioritising and considering opportunity costs of specific activities and staffing and ensuring staff development and clinical quality of care.

Contents

Acronyms

CBD	Community based distributors
CPR	Contraceptive prevalence rate
EC	Emergency Contraception
ED	Executive Director
FGD	Focus Group Discussion
FLE	Family Life Education (curriculum)
FP	Family Planning
FPNZ	Family Planning New Zealand
GoK	Government of Kiribati
HFT	Healthy Families Taskforce
HIV	Human Immunodeficiency Virus
HFP	Healthy Families Project
IDP	Island Development Plan
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
KAP	Knowledge Attitude Practices
KFHA	Kiribati Family Health Association
KDHS	Kiribati Demographic and Health Survey
KIT	Kiribati Institute of Technology
KSON	Kiribati School of Nursing
LGBTQI	Lesbian gay bisexual transgender queer and intersex
MELAD	Ministry of Environment, Land, Agriculture and Development
MFAT	Ministry of Foreign Affairs and Trade (New Zealand)
MHMS	Ministry of Health and Medical Services
MIA	Ministry of Internal Affairs
MOE	Ministry of Education
MTR	Mid Term Review
MWYSSA	Ministry of Women, Youth, Sports and Social Affairs
NCD	Non-communicable diseases
PHC	Primary Health Care
PLWD	People living with disabilities
RMNCAH	Reproductive maternal neonatal child and adolescent health
SDG	Sustainable Development Goals
SOGIE	Sexual orientation, gender identity expression
SRHR	Sexual reproductive health and rights
SROP	Sub Regional Office of the Pacific (IPPF)
STI/RTI	Sexually transmissible infections/Reproductive tract infections
TFR	Total fertility rate
UHC	Universal Health Coverage
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization

End of Project Evaluation: Kiribati Healthy Families Project

1. Background

1.1. Introduction and objectives

The New Zealand Ministry of Foreign Affairs and Trade (MFAT) funded an independent evaluation consultant to conduct an end-of-project review of the Healthy Families Project (HFP) being jointly implemented by Kiribati Family Health Association (KFHA) and Family Planning New Zealand (FPNZ). The first phase of the HFP ran from 1 February 2012 – 31 March 2015. The second phase commenced on 1 April 2015 and is due to complete on 31 March 2020. It is fully funded by the NZ Aid Programme with a total budget of NZD 2,720,427.

The purpose of this draft report is to present an independent analysis of the progress, key lessons learned from phase 2 completion and recommendations for phase 3. Comments were sought from FPNZ and KFHA that were then considered and incorporated as appropriate into the final report.

1.2. Country context relevant to SRHR

Kiribati has a population of around 113,000 with an estimated 30,000 women of reproductive age (15-49 years). Youth (15-24 years, male and female) form nearly 20% of the population (22,000)[1]. Population growth is a major concern of the Government of Kiribati (GoK) and was reported at around 1.8% to 2.1% (depending on sources), and as the third highest in the Pacific (after Solomon Islands 2.3 and PNG at 2.2)[2]. The total fertility rate (TFR) has been reported at around 4 with only a slight decline in TFR from around 4.3 to 3.9 over a 20-year period.[3] Fertility rates are highest among women aged 25–29, although rates remain elevated among women aged 20–24 and 30–34. Fertility rates among women aged 35–39 are higher than for many Pacific Island countries. Together, these higher fertility rates are what drives Kiribati's TFR close to 4.0.[4] Kiribati also has one of the highest rates of under-five mortality in the Pacific.

The Kiribati Development Plan 2016-2019 (KDP) stated that in 2010 the Contraceptive Prevalence Rate (CPR) was 18% (a decline from 32%in 2005 and 22% in 2007) and that CPR is well below the MHMS target of 57%.[5] KDP strategies relevant to SRHR include *increasing access to and use of high quality, comprehensive family planning services, particularly for women*. Targets in the KDP include:

- Declining adolescent birth rate for 10-14 years, 15-19 years per 1,000 girls in that age group.
- Increased contraceptive contacts (all forms) seen at health facilities per 1,000 population.
- Maintaining the number of maternal deaths at zero or as close as possible.

The Ministry of Health and Medical Services (MHMS) *Strategic Plan 2016-2019* also includes Strategic Objective 2 that is highly relevant to the HFP: *Increase access to and use of high quality, comprehensive family planning services, particularly for vulnerable populations including women whose health and wellbeing will be at risk if they become pregnant*[6].

The Plan also identified a number of strategic actions and targets to 2019:

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[1] Sharp M (2018) Kiribati DHS 2018 Work Plan for Pacific Community (SPC) Annex 2
[2] Ibid
[3] SDD Pacific Community and UNSW, *Fertility trends in the PICTs*, 2019; p.50.
Total fertility rates vary depending on data sources, but the KV20 (p.39) stated that TFR increased from 2.7 in 2011 to 3.7 in 2016, however this 2011 data source is considered 'implausibly low' (ref SDD/UNSW p.51).
[4] SDD Pacific Community and UNSW, *Fertility trends in the PICTs*, 2019;
[5] Kiribati Development Plan 2016-2019; p.31
[6] MHMS *Ministry Strategic Plan 2016-2019* (2015) p.16

2.1. Improve skills, quality of services and access to family planning drugs and commodities for rural and urban islands.

2.2. Reinvigorate national Reproductive Health committee to proactively monitor & evaluate the data input towards Family Planning services

2.3. Engage with development partners around support for initial implementation of the RH strategy, and initiate work to identify a sustainable funding mechanism.

2.4. Strengthen partnership with **KFHA**, FBOs, youth groups and other non-government organisations to expand Family Planning services and increase involvement of men.

2.5. Engage with other GoK ministries departments to coordinate and integrate resources and approaches to managing population growth to benefit the aspirations of all sectors.

Ambitious key performance indicators with targets to 2019 were set (see below)[7]. The Kiribati Demographic Health Survey (KDHS) 2019 will provide data on whether these were achieved.

Health Indicator	2019 Target	Baseline
SDPs offer at least three contraceptive methods	100%	85% (2010)
Contraceptive prevalence rate (population aged 15–49)	45%	36% (2000) 18% 2010
SDPs reporting stock-outs of family planning drugs and commodities in last 12 months	0%	21% (2009)
Fertility rate (women aged 15–49 years)	<3.5	4.1 (2010)
Number of teenage pregnancy	100	120 (2014)
Revised National SRH policy		2008
Number of islands	12	3
Number of communities visited for Family Planning awareness	30	8 (2015)
Increased partnership with churches	All in 2016	2

The Kiribati Demographic Health Survey (KDHS) asks women of reproductive age, their knowledge of modern family planning methods: in 2009, 93% of women could name at least one method; women named 'injectable' as the most known modern family planning method (86%) followed by the condom, implants and 'pill' (83%)[8]. Only 26% knew of emergency contraception. The ideal family size (mean) was stated to be 2.7 for women and 2.3 for men, however this number is significantly lower than the observed TFR for Kiribati women, which is around 3.8[9].

The 2009 KDHS asked all current users of modern contraceptive methods about the most recent source of their methods. Government hospitals are the most common public source (54%), followed by health centres (23%) and family planning clinics i.e. KFHA (9%)[10].

Data on Unplanned pregnancies and STIs

Results from the KDHS 2009 showed that 82% of births in the five years preceding the survey were planned (wanted then) while **17% were unplanned** — 10% were mistimed (wanted later) and 7%

[7] MHMS *Ministry Strategic Plan 2016-2019* (2015) p.19
[8] Kiribati Demographic and Health Survey, 2009; p.69
[9] Kiribati Demographic and Health Survey, 2009; p.113
[10] Kiribati Demographic and Health Survey, 2009; p.80-81

were not wanted[11]. Analysis of data showed that the proportion of unplanned births steadily increases with increasing birth order, from 10% for first-order births to 21% for fourth- or higher-order births. The proportion of births that are wanted later, peaks at birth order 3 at 14%, while those that are not wanted at all reach a maximum of 9% at fourth- or higher-order birth. The proportion of unplanned births is lowest for women aged 15–19, and steadily increases with age. This is largely a function of the proportions of women who want to postpone their births. These proportions increase from just 6% for women aged 15–19 to around 12% for women aged 30 and over. Among older women, approximately one in five births was either mistimed or unwanted altogether.

> 'The Kiribati SGS surveys have identified **high prevalence of STIs** such as chlamydia, especially in young people aged less than 25 years. Rates of teenage pregnancy are also high. Both factors indicate high levels of unprotected sex, especially in young people, resulting in the potential for rapid and extensive spread of HIV if it is introduced to the population. Gender-based violence is also a concern in Kiribati, leading to high rates of non-consensual sex for women, with associated risk of HIV infection (Secretariat of the Pacific Community 2010). Condom use rates are generally low, owing to lack of awareness, access and acceptance of condoms. Religious leaders are often unsupportive of sex education programmes for young people and HIV prevention programmes that include condom promotion'.
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> Kiribati Demographic and Health Survey, 2009; p.199

The KDHS stated that the rate of condom use in Kiribati is too low to prevent circulation of STIs such as chlamydia, which requires condom use rates to rise to around 80–90% for effective control[12]. The *Kiribati Family Health and Support Study* published in 2010 showed that violence against women is prevalent. According to the study, 68 per cent ever-partnered women aged 15–49 reported experiencing physical or sexual violence, or both, by an intimate partner[13].

The KDHS conducted in 2019 will provide valuable insights into any changes in unplanned pregnancies and reported STIs, since the Healthy Families Project started in 2012.

Non-communicable diseases (NCDs)

While Kiribati is challenged by infectious (communicable) diseases and has one of the highest under-five mortality rates in the Pacific, non-communicable diseases (NCDs) are also a major concern and leading cause of death and disability. To address NCDs, the MHMS Strategic Plan[14] included indicators and targets for prevention, detection and early treatment of diabetes, hypertension and cervical cancer as well as initiatives about healthy eating, physical activity, tobacco and alcohol.

1.3. The Healthy Families Project

The overall goal of Kiribati Healthy Families Project (HFP) phase two is to increase access to sexual and reproductive health information, skills and services on South Tarawa and six outer islands, resulting in a **reduction of sexually transmissible infections and unplanned pregnancies**. The beneficiaries of the project are men, women and adolescents in South Tarawa and the six outer

[11] Kiribati Demographic and Health Survey, 2009; p.114

[12] Kiribati Demographic and Health Survey, 2009; p.236

[13] Kiribati Development Plan 2016-2019; p.40

[14] MHMS *Ministry Strategic Plan 2016-2019* (2015)

islands. The project also aims to work with three key groups: youth, people living with disabilities and commercial and transactional sex workers. The project complements UNFPA's Transformative Agenda, IPPF's Niu Vaka strategy and MFAT funded Humanitarian project.

To achieve the HFP overarching goal, three core strategies with short, medium and long-term outcomes were identified: capacity development, service delivery and enabling environment.

Capacity Development – Family Planning New Zealand (FPNZ) and KFHA deliver training programs to nurses and health educators on South Tarawa and six outer islands; FPNZ supports KFHA through ongoing mentoring and professional development opportunities; KFHA develops a SRHR Community of Practice to continue support.

- Short-term outcome 1: Trainees have improved sexual and reproductive health and rights (SRHR) knowledge, skills and attitudes.
- Medium-term outcome 1: Trainees proactively advocate SRHR and deliver strengthened SRHR services; KFHA's capacity, profile and networks are strengthened.
- Long-term outcome 1: KFHA is recognised as a Pacific leader in SRHR and works to sustain the SRHR professional capacity of trainees.

Service Delivery – KFHA delivers mobile clinics, after-hours clinics, condom distributions, school education visits, health promotion campaigns, workshops with key groups, and IECs to South Tarawa; KFHA manages grant programs for South Tarawa health educators and outer island community based distributors (CBDs)/island councils.

- Short-term outcome 2: Access to SRHR information and services improves through increased number of delivery points.
- Medium-term outcome 2: Program beneficiaries have increased SRHR knowledge and skills, and increased access to clinical services; uptake of SRHR services increases.
- Long-term outcome 2: I-Kiribati in South Tarawa and 6 outer islands have the knowledge, skills and access required to realise their SRHR.

Enabling Environment – KFHA delivers advocacy programs to community leaders in South Tarawa; engages community leaders in outer island SRHR strategy; FPNZ carries out research projects to inform leaders on key SRHR issues.

- Short-term outcome 3: Community leaders have increased SRHR knowledge and skills and more positive attitudes to SRHR.
- Medium-term outcome 3: Community leaders become SRHR champions.
- Long-term outcome 3: The social environment and governing structures in South Tarawa and 6 outer islands enable and empower I-Kiribati to realise their SRHR.

The Healthy Families Project phase 2 builds on the strength and quality of existing partnerships with key stakeholders at the local and national level and developed memorandum of understanding (MOUs) with the Ministry of Health and Medical Services (MHMS)/Reproductive maternal neonatal child and adolescent health (RMNCAH), the Ministry of Women, Youth, Sport and Social Affairs (MWYSSA), the Ministry of Education (MOE) and Ministry of Internal Affairs (MIA), and also developed MOUs with six outer island Councils.

Working at community level is critical to generate positive behaviour change of individuals, families and communities and to successfully implement NCD/SRHR programs. MWYSSA is the focal agency for engaging at community level, in particular for youth, gender equality and social inclusion. MIA provides support grants to outer islands Councils and Clerks and has a coordination role for other Ministry visits to islands. The Ministry of Environment, Land, Agriculture Development (MELAD) also works in outer islands, promoting sustainable development and agriculture. The MOE is responsible for primary, junior and senior secondary school curriculum reform, which includes Morals and

Personal Development, Health and Physical Education and Family Life Education (FLE) curriculum.

2. Evaluation purpose and methodology

2.1. Scope and approach of the evaluation

The end of project evaluation of the Healthy Families Project focuses on the funded period 2015-2020 and builds on the lessons learned from the Mid-term Review (MTR) of 2018. The approach and principles underpinning the evaluation were participatory to ensure transparency while maintaining independence. A highly consultative approach was used and key stakeholders such as MFAT, KFHA, FPNZ were engaged from the start.

This evaluation also considered how social and cultural norms could affect project implementation especially as SRHR is a sensitive topic in the context of i-Kiribati culture and religion. It was also important to recognise the dynamics of power imbalances and understand how to empower marginalised groups and focus on behaviour change, especially for adolescents, people with disabilities and sex workers, in order to improve their SRHR outcomes. The evaluation also recognises that efforts in changing social and cultural norms and capacity building are long-term in nature and that results derived at this stage may be difficult to determine.

2.2. Primary users

The Primary users of the evaluation are:

- MFAT as the funder of the HFP and also the evaluation commissioner;
- KFHA in collaboration with FPNZ as the implementing partners.

2.3. Purpose of the evaluation

The primary purposes of the evaluation were to:

- Assess the overall impact of the project.
- Assess to what extent the project outputs were delivered and the project outcomes achieved
- Provide recommendations on a possible future phase of the project.
- In addition, the Terms of Reference (TOR) included providing qualitative data for the monitoring, evaluation, research and learning (MERL) table.

2.4. Key evaluation objectives and questions

Five key objectives were addressed in the evaluation:

- To assess the extent to which the objectives of the Kiribati Healthy Families Project are consistent with beneficiaries' requirements and country needs.
- To examine the progress made in achieving the Kiribati Healthy Families Project's outcomes.
- To assess how efficiently the Kiribati Healthy Families Project uses resources.
- To identify any changes needed to maximise the positive outcomes of the Kiribati Healthy Families Project and minimise negative outcomes.
- To identify the need for a further phase of the project and the sustainability of the project after completion.

2.5. Methodology and data collection

A wide range of information sources was used, in order to gain as comprehensive a picture as possible in the limited timeframe. The methodology entailed a combination of qualitative and quantitative methods - document review, key stakeholder interviews, field visits with structured observations, focus group discussions and informal dialogues including with end beneficiaries, such as women, people living with disabilities (PLWD), sex workers and young people. A report of actions

taken on the 2018 MTR recommendations was requested. In addition the evaluator reviewed the Healthy Families Project Indicator Results Framework. However, much of the data to assess community and individual changes are derived from Community and Stakeholder Surveys, conducted in 2015 and repeated in 2020, which were not available for analysis in this evaluation.

The methodology was primarily qualitative with open-ended/semi-structured interviews and group discussions to address the key objectives questions and to explore and gain insight into the 'why' and 'how' questions. Observations, interviews and informal discussions with KFHA staff were conducted at KFHA clinic in South Tarawa to gain insights from staff and KFHA clients (where possible) and in government offices and cafes for external stakeholders. A field trip to outer island, Abaiang provided opportunities to learn from island leaders, health staff, women and youth.

Table 1: Evaluation Method and Sample

Method	Sample	Data collection strategy
Key informant interviews	KFHA program manager, staff, ED (8); Key stakeholders: MHMS (3), MFAT (3), UNFPA (2), FPNZ (2), MIA (1), MWYSSA (2), MOE (3), MP (1), DPO (1), BIMBA (1) IPPF/SROP (2)	Semi-structured interviews Total n=29
Clinic/ outreach observations	Static clinic (South Tarawa) Static clinic (KIT)	Structured observation Total n=2
Focus group discussion (FGD)	Outer island leaders Abaiang FGD n=6 Outer island Abaiang youth volunteers n=10 Outer island Abaiang women n=10 South Tarawa women around clinic n=9	Open ended questions Total FGD n=35
Informal dialogue	Youth volunteers/clients n=3 Women clients n=6 MHMS nurses n=2 Sex worker n=1 KIT student services staff n=2	Total one to one interviews n=14

2.6. Data analysis

Data were reviewed regularly to identify areas for follow-up. Qualitative information from interviews, focus groups, clinic assessments and participant observation were analysed through thematic analysis. In-depth analysis of consolidated data was completed at the end of data collection. Findings were crosschecked with primary users and stakeholders to ensure that the information had a high degree reliability and accuracy. This process provided a valuable check of the accuracy of the findings and that recommendations were feasible, implementable and sustainable.

Quantitative data were analysed from KFHA/FPNZ Annual reports to assess progress towards outputs and outcomes, however the annual report from year 5 was not yet available, so final data for phase 2 are unable to be collated for this evaluation. Data from IPPF/DHIS2 Service Statistics and associated progress reports were reviewed and clarification was sought from IPPF SROP staff, although there remained some variations in figures. However these data provided a level of triangulation in findings. The evaluation also drew upon data and analysis from other studies and assessments, and in particular the thorough MTR in 2018.

2.7. Reporting

An Evaluation steering committee, comprised of the FPNZ chief executive, international programmes manager and programme officer and the KFHA Executive Director (ED) and program coordinator, was established to provide expert advice and feedback on the approach and review key products of the independent evaluation. The draft report was circulated to the steering group on March 2nd and the final report reflects the comments received, noting that there were no substantive variations of views or disagreements.

2.8. Ethical considerations

The evaluation adhered to ethical standards during the course of the review, namely the Australasian Evaluation Society's Guidelines for the Ethical Conduct of Evaluations. Findings were discussed in an accountable and transparent manner. Participants received an explanation of the purpose of the evaluation and how the information they provided would be used. Verbal consent was given. No participants requested anonymity, and any quotes in the findings were confirmed.

2.9. Sample and method

Fieldwork was undertaken in Kiribati from 13 to 20 February 2020. A schedule was designed to include observations of KFHA activities to learn from staff, clients, other partners and stakeholders and young people. A list of all meetings, field visits and interviewees is provided at Annex 3.

3. Findings and analysis

3.1. Relevance

The Healthy Families Project is highly relevant to the New Zealand Government as part of the Pacific reset and focus on deeper collaboration with Pacific countries; in Kiribati, the New Zealand Aid Programme supports the Government of Kiribati (GoK) vision and development priorities.

Given the country context, the Healthy Families Project is considered by all key stakeholders as highly relevant, in particular to the GoK Vision (KV20) and the *Kiribati Development Plan* (KDP). The KV20 stated an aim to reduce the fertility rate by a minimum of 0.3 every year with a target of 2.8 by 2019. This has not been achieved and the KV20 acknowledges the diversity of cultural and religious beliefs are part of the complexities that make it difficult to achieve a reduction in fertility. It states that the outcome is 'dependent on the behavioral preferences of parents' and acknowledges that the Government's role will be to ensure 'services are available along with awareness raising and advocacy' to ensure that 'appropriate preventative measures are taken'.[15] However it does not provide a clear plan for how to increase contraception, and indeed is silent on using the term.

If Kiribati is to meet the ambitious SRHR targets in the KV20 and KDP, the MHMS will need support from all SRHR partners, especially KFHA as a major SRH service provider, as noted in the National Development MTR in 2018. That MTR called for strengthened coordination and planning processes to maximise efforts and avoid duplication and overlap. KFHA was specifically mentioned in this review: MHMS *'partners with NGOs to execute a number of activities to contribute to achieving goals and targets. The Kiribati Family Health Association is an active partner of the Ministry and is mandated under its constitution to focus on Family Health and the core function of women health-check services (for cancer). KFHA operates a mobile check-up and lab service, and does community and outer island outreach programs in this area.'*[16]

The Healthy Families Project also aligns well with the needs of key beneficiaries. The majority of KFHA's clients are women and providing them with informed choices about family planning and quality counselling is empowering. KFHA have addressed disability inclusiveness and engaged with

[15] Kiribati 20-year Vision 2016-2036 KV20; p.40

[16] Kiribati Voluntary National Review and Kiribati Development Plan Mid-Term Review 2018, NY; p.44

the disabled persons organisation, Te Toamatoa. Deeper collaboration with Kiribati LGBTQI, BIMBA, could provide wider reach into more marginalised and vulnerable groups, including sex workers.

Most stakeholders reported, unprompted, that KFHA is considered a trusted clinical and training partner; in particular informants have said that they valued and benefitted from various trainings offered by KFHA. The relationship of KFHA with the MHMS is generally very positive, but there is room for improved communication and coordination, in particular with the Division of Public Health, under which RMNCAH sits.

Observations - relevance

One MHMS interviewee stated that '*Without KFHA we would have problems. We do have clinics but not enough staff…staff trained well enough to perform for family planning.*'

s9(2)(a)

3.2. Progress against outputs and outcomes

According to the Healthy Families Project work plan, quarterly and annual reports, most indicators in the Monitoring and Evaluation framework are exceeding targets, on track or close to. The MTR described HFP strategies and concluded that 'the work of the Healthy Families Project is well on track to achieving its objectives'[17]. This evaluation will not repeat the descriptions of each strategy, as they have not changed since 2018.

A Summary Table of Findings addressing each Key Evaluation Question (Table 4) shows that the HFP has directly contributed to increased numbers of KFHA and MHMS staff trained in SRHR; increased number of tests and treatment of STIs/HIV; and that reproductive health targets, including reducing teen pregnancies are included in all Island Development Plans (IDPs).

Progress against intended outputs and outcomes is described under the three strategies – capacity development, service delivery and enabling environment.

3.2.1 Capacity Development

Capacity development is one of the three pillars of the HFP, with targets set for number of nurses trained, and number of trainings held in outer islands. Clinical training is provided by FPNZ on new clinical skills (e.g. IUD insertion and removal) and refresher contraceptive updates for MHMS and KFHA nurses. In total over five years, 100 MHMS and KFHA staff have received training on STIs, contraception, history taking and counselling, and on clinical skills of IUD insertion and removal, with two staff (MHMS and KFHA) assessed as competent.

Annual trainings on SRHR health promotion were conducted for 75 KFHA staff and volunteers and other stakeholders, including for Healthy Families Taskforce (HFT) members. The training manual developed by FPNZ is valued by stakeholders and considered a useful contribution to sustainability. HFT members in the outer islands have used their $1,500 grant to organise SRHR training for volunteers, often to coincide with KFHA outer island annual visit.

Six outer islands were visited by KFHA over the 5 years (Butaritari, Marakei, Abaiang, North Tarawa, Aranuka and Abemama; as well as BTC and TUC on South Tarawa). Under the HFP, three islands were visited to conduct clinical training with MHMS staff (contraceptive updates and IUD

[17] Sonya Hogan Mid-Term Review Kiribati Healthy Families Project, Phase 2, 2018 p.6

counselling, vasectomy and PAP smear training,) along with mobile clinics and support for planning with traditional leaders and Councillors. CBDs were also trained on SRH, KFHA data collection, and SRHR health promotion and referral messages for household visiting. For the remaining three islands KFHA signed MOUs and provided support for planning with island authorities, and training of youth on SRHR and data collection as well as providing mobile services. In 2019 there was an inclusion to train 30 women on these six islands under the support of Niu Vaka Project funded by DFAT.

Assessing the short-term impact of capacity development [knowledge, attitude and practice (KAP)] relies on pre and post testing of participants, and in the longer-term on whether they are utilising their skills in the workplace. One issue that was identified in the MTR and has continued since, is the lack of women accepting IUDs as a method, which impacts on trainees who need to practice new skills on volunteer clients. **Targeted awareness leading to increased interest and acceptance of IUDs may be needed in phase 3, before more IUD training sessions are planned.**

Data on pre and post testing are reported in Annual Narrative reports[18] and provide evidence of immediate gain in knowledge. Longer-term retention and utilisation of knowledge and instances of positive changes made in their work is reported through follow-up evaluation. This is valuable information that would be useful to analyse systematically over time, and to develop targeted follow-up training or refreshers, in particular for clinicians.

It was positive to note that HFT members who had left for a range of reasons were followed up (Year 2 annual report: p.24), which reminded them to remain champions for SRHR wherever they were living and working. It is hard to assess the medium term outcome without access to systematic follow up evaluations. These only need to be done once a year and preferably face-to-face for those on outer islands with limited access to internet communication. **Community of Practice could be reconceptualised in phase 3 as SRHR champions, clearly describing attributes and expectations.**

KFHA has also provided SRHR awareness-raising and information to a range of students: at Kiribati Institute of Technology (KIT) and the Marine Training Centre (MTC), and in 2016 to nurses at Kiribati School of Nursing (KSON). These student nurses are likely to be the future MHMS workforce in health centres, hospitals and in outer islands. A **strategic Capacity Development plan for nurses in phase 3** could include staged awareness, knowledge and skills - from school curriculum to undergraduate, postgraduate and ongoing professional development for this critical SRHR workforce. Not all nurses will be skilled at all contraception methods, but at a minimum, they should understand all FP methods and be able to utilise the WHO wheel for FP counselling. Those student nurses who express interest in SRHR could then be selected for further training after graduation to be SRHR champions and equipped with more specialist clinical skills.

3.2.2 Service Delivery

With solid foundations laid in HFP phase 1, static clinic, mobile and after hour clinics and outer island outreach services and client numbers have increased in phase 2, in particular village outreach visits. Table 2 provides comparable data for three years of the HFP, and demonstrates the impact of funding outer island outreach. Each year, around 4,500 people are reached through the outer island clinics, around 2,700 through mobile clinics and around 1,800 at the static clinic. This indicates that the strategy of funding the mobile clinic (HFP fund 26 clinics in South Tarawa) is effective; rather than waiting for clients to travel to the static clinic, which is quite public and would incur travel costs for clients. About 9,000 clients in total were seen each year, mostly women with about a third under 25 years (except for the CBD program, where over 50% were males and 68% were under 25).

[18] For example, in Year 1, 80% of test questions were answered correctly or mostly correctly by clinical trainees (compared to 34% pre-training). Similarly, 81% of the health promotion trainees were able to name three or more contraceptive options (compared to 32% pre-training).

Table 2: Number of clients by Service Delivery Point

Year	Static Clinic (women)	Mobile clinic	Outer island	TOTAL (women)	CBD *
2017	1292 (1029)	3106	5040	**9,438 (7,131) (76%)**	11,203
2018	1550 (1109)	2787	4612	**8,949 (7,034) (79%)**	13,999
2019	1870 (1622)	2660	4496	**9,026 (8,269) (92%)**	10,539

Source: KFHA Performance report to Board, 2019

- The number of clients reached by CBDs varies depending on the number and capacity of volunteers. It is not a measure of KFHA/HFP staff. Although numbers are large, it is unclear how clients are actually counted, given the wide range of condom distribution methods, hence they are not included in the total clients.

Island Development Plans

The evolution of Island Development Plans in phase 2 is a real highlight that demonstrates how KFHA is able to learn, adapt and change. The fact that specific SRHR outcomes and targets have been set in Island Development Plans is impressive, given the conservative cultural-religious social norms in Kiribati. If this can be sustained as part of 'normal development,' it is likely to have a long-lasting impact. The possible downside is negative community pressure and further stigmatisation.

Highlight: Agreed SRHR and NCD targets in the IDP

- 65% women have had PAP smear test by the end of 2019
- Family planning prevalence rate to be increased 10% from the 2018 rate
- Reduced number of teenage pregnancy to 90% from the 2018 number
- By the end of November 2019, 25% of the young people aged 15-24 have been tested on STIs and HIV (islands census population 2015 for target number of young people)
- Reduced mortality rate of children under 5 years old of 3 every 100 births
- 95% of children under 1 year old have completed vaccination.
- 60% of people aged over 40 of the island's population are screened for NCD
- People over 40 years old have done 2 types of exercises to address NCDs

KFHA provide support to Island Councils on how to develop their Plan, and suggestions for targets and how to meet them. An outer island symposium was conducted in 2018 to share lessons and the major highlight was the ownership of island councils for their Island Development Plans (IDP), especially the SRHR components. For example in 2018:

- Leaders in Butaritari strongly encouraged all women to obtain a PAP smear and have allocated a maneaba (community meeting house) as a shelter for survivors of domestic violence.
- Aranuka council have observed that people are changing their attitudes around their health responsibilities and have seen a reduction in domestic violence due to a reduction in alcohol consumption on the island.
- Leaders in Abaiang feel that their people are becoming more aware of SRH and their rights around family planning. They value the clinical services provided by KFHA on their island and the support to change bylaws reducing opening hours of kava bars.
- The chairman traditional leader from the island of Marakei stated that the implementation of the IDPs has revitalised the community's spirit in understanding their common

responsibilities and roles in improving their health and general welfare.

Highlight: NCDs - beyond SRHR services

The phase 2 strategy of increasing mobile outreach in South Tarawa and to outer islands, where awareness of SRHR is low and health centres may not have adequately trained staff or commodities in stock, was sound. However there was still the stigma of being seen going to a clinic for contraception or STI/HIV testing, especially for Catholics. By broadening the focus of these clinics beyond SRHR, as essentially 'Healthy Island Expos' and including NCD screening, nutrition and other health promotion messages, KFHA have been able to reach much more people in villages.

Data from KFHA service statistics for 2019 demonstrate that many people, mostly older, in outer islands and mobile clinics have their blood pressure checked and that about 10% are referred to MHMS services for follow-up. MHMS staff in health centres also conduct such health checks and maintain a NCD register; however KFHA visits are able to mobilise large numbers in each village through youth volunteer household visits.

Table 3: KFHA NCD data by Service Delivery Point, 2019

SDP	Diabetes		Hypertension		Diabetes referral		Hypertension referral	
	<25	>25	<25	>25	<25	>25	<25	>25
Static Clinic	60	224	91	326	0	10	0	3
Outer Islands	106	2109	135	2142	0	180	4	198
Mobile clinic	51	1397	63	1429	0	148	1	153
Total	**217**	**3,730**	**289**	**3,897**	**0**	**328**	**5**	**354**

Source: KFHA Service Statistics

This primary health care (PHC) approach supports GoK concerns about rising NCDs but also quietly allows conversations about family size, timing and need for contraception, to more people. There is no stigma to having your blood pressure or blood sugar tested, and many people will attend clinics for such screening. For young people (under 25) it may be more acceptable to their families and community for them to have a 'health check' (while also being able to gain confidential advice about SRHR).

While this integrated 'Healthy Island' approach appears to be effective in increasing the number of people attending clinics, it will be important to not lose focus on FP and STI/HIV testing. **Phase 3 will need to closely monitor the quarterly data to ensure FP client numbers are increasing.**

Laboratory services

KFHA is one of the few IPPF Pacific Member Associations providing laboratory testing for PAP smears and chlamydia (high vaginal swab), rapid STI (gonorrhoea, syphilis) and HIV testing. Laboratory supplies are often a problem and FPNZ has provided a small level of support (e.g. for reagents and slides) when requested by KFHA. The HFP also provided support for professional development for the Lab Technician to attend an Australian Cytology conference in 2019. For phase 3, the MTR recommended training of a youth volunteer to prepare slides and conduct basic testing to reduce the workload of the lab technician, as part of a laboratory assistant training. The feasibility of this remains to be considered in phase 3.

Table 4: Summary table of findings, addressing evaluation questions

Objectives	Key Questions	Findings
Q1. To assess the extent to which the objectives of the Kiribati Healthy Families Project are consistent with beneficiaries' requirements and country needs.	1.1 To what extent does the project align with the priorities of the NZ Aid program, the Government of Kiribati, KFHA and island councils?	The Kiribati 20-Year Vision 2016-2036 (KV20) is a long-term development blueprint for Kiribati focused on delivering results linked to the Sustainable Development Goals (SDGs). The KV20 states an aim to reduce the fertility rate by a minimum of 0.3 every year. The fertility target rate for 2019 of 2.8 has not been met. The KV20 also includes a focus on the training of health workers as a means of improving health care. Strategic partnerships with NGOs and international partnerships are acknowledged to support government to deliver services and improve infrastructure. The MHMS 2016-2019 includes SRHR targets that are unlikely to have been met. An analysis of the 2019 KDHS will provide the data to determine this. The HFP provides resources for outreach to more islands and village awareness than the MHMS is able to budget for. The HFP also aligns with the NZ Aid Program, in line with the Pacific reset as well as alignment with KFHA's core business. Through the HFP, island councils have increasingly understood the importance of health and family planning, and value KFHA's contribution.
	1.2 To what extent does the project address the needs of the project's target groups?	Yes, SRHR strategies and clinical services and outreach to marginalised groups are relevant in meeting the needs of women, PWD and LGBTQI/SOGIE groups, **however, more focus is needed to increase the number of contraceptive services (currently only 10% of SRH services) and knowledge of emergency contraception for youth. More could be done in partnership with BIMBA and youth volunteers to reach transactional/sex workers and prevent STI/HIV.** The LGBTQI Association, BIMBA, representative knew of KFHA and had participated in awareness-raising sessions, but BIMBA focuses on MSM and transgender issues. BIMBA are concerned about STIs/HIV but he was unsure how comfortable members were to attend KFHA clinic for testing and treatment. People with disabilities can be seen in static clinic services, and a mobile clinic is conducted annually at the Nanikaai camp. Representatives said they considered KFHA to be 'disability- friendly' in terms of physical access and staff caring attitudes. Overall over one-third of KFHA clients are young people (<25), however there is low knowledge of emergency contraception (EC) in the community and few consultations for EC are reported from KFHA clinics and outreach. This needs to be addressed with KFHA clinicians and included in awareness-raising sessions, where appropriate.
	1.3 To what extent is the	The MHMS receives 15% of the total government budget, and has major challenges to address, including high under-

Objectives	Key Questions	Findings
	project supported by the Government of Kiribati and Island councils?	five mortality, low life expectancy, and double burden of disease with rising NCDs. It is unlikely that the GoK will be able to fund SRHR to the extent that is needed to meet SDG and MHMS targets. However the GoK and island councils provide in-kind support and value KFHA to provide awareness-raising and screening outreach visits.
Q2. To examine the progress made in achieving the Kiribati Healthy Families Project's outcomes.	2.1 To what extent is the program achieving the outcomes, in the short, medium and long term?	The overall goal of the HFP Phase two is to increase access to sexual and reproductive health information, skills and services on South Tarawa and six outer islands, resulting in a **reduction of sexually transmissible infections and unplanned pregnancies**. Community, religious and cultural norms around sexuality make it very difficult to achieve outcomes in the short and even medium-term; SRHR topics are often considered 'taboo' in Kiribati language. There is huge stigma associated with sex outside of marriage and unplanned pregnancies; social norms appear to be little changed over time. **Improving the enabling environment for SRHR will require different strategies in phase 3.** Data presented in this report indicate that service delivery is effective in meeting the targets set: the HFP reached more clients through mobile and outreach island services, with targets met for STI/HIV testing, however only 10% of total SRH services are for contraceptive services. Capacity development (CD) data demonstrate satisfaction and improvement in knowledge, attitudes and practices for some skills, however longer-term impacts are difficult to determine. **CD activities need regular follow-up to ensure that the learnings are being used in the workplace, in particular MHMS staff; and that staff have the materials needed to utilize new skills and knowledge. Clinical staff need ongoing professional development, and educators need to be observed in the field to ensure they are practicing what they learned. Phase 3 should review the CD strategy and the balance of budget invested.**
	2.2 What have been the changes since Family Planning's cost-benefit analysis (CBA) in 2014?	The HFP has provided a consistent investment in family planning as recommended by the CBA, however changes will take time and further consistent funding. For SRHR to make advances, there will need to be efforts made to **influence social norms through a range of media and for young people, especially through social media and radio**. While there is little evidence of changes in social norms, the KDHS 2019 data will show if more women are accessing FP and if unmet need is decreasing, which is a good indication of change in behaviour.
Q3. To assess how efficiently the Kiribati	3.1 How well does the Kiribati Healthy Families Project use resources to	As efficiently as possible in the context of Kiribati where outer island travel is very expensive. Annual reports indicate that KFHA demonstrates financial accountability and transparency but that financial management systems could be improved. Several sources of funding for SRHR (e.g. MFAT, DFAT, UNFPA) require clarity around coordination and

Objectives	Key Questions	Findings
Healthy Families Project uses resources.	achieve results?	collaboration. This is not easy as funding and targets can be seen as 'territorial'. In particular, many activities are funded to reach village level, and there is sometimes overlap and also inefficiencies; that could result in perverse incentives and inefficiencies. **A more streamlined assessment of priorities and opportunity costs could be done within KFHA and FPNZ in consultation with relevant Government Ministries and RMNCAH committee.** There may be cost-sharing opportunities. Capacity development is one of the three pillars of the HFP, with targets set for number of nurses trained, and number of trainings held in outer islands. Clinical training is provided by FPNZ on new clinical skills (e.g. IUD insertion and removal,) and refresher contraceptive updates aimed for MHMS and KFHA nurses. In total over five years, 100 MHMS and KFHA staff have received training on contraceptive history taking and SRHR updates, and on clinical skills of IUD insertion and removal, with two staff (MHMS and KFHA) assessed as competent. CD budget over the five years for FPNZ was about 22% of the total budget; and 13% for in-country CD costs. Static clinic client numbers are low (about 3-8/day on Mondays and Fridays) with four clinical staff present; many more clients attend mobile and after-hours clinics in villages. **The staffing model might need review by KFHA.** IEC materials need updating and the Facebook (FB) site is not active. All young people agreed that they had phones and used FB 'a lot', including easy access to porn. The KDHS and HFP FP Usage and Barriers study found that radio is effective to reach most of the population and could be expanded; TV is less accessible and expensive.
Q4. To identify any changes needed to maximise the positive outcomes of the Kiribati Healthy Families Project and minimise	4.1 What are the long-term positive and negative changes produced by the project?	4.1 The fact that specific SRHR outcomes and targets have been set in **Island Development Plans** is impressive, given the conservative cultural-religious social norms in Kiribati. If this can be sustained as part of 'normal development', it is likely to have a long-lasting impact. The possible downside is negative community pressure and stigma, e.g. if zero teen pregnancies were not met, could a young pregnant woman then be subjected to worse stigmatization? Regular STI/HIV, PAP smear testing through mobile and outreach commenced through the HFP and if this becomes normalized, along with condom distribution, in villages and outer islands, this will also have long-lasting positive health impact. Although a larger number of men and women have been screened and tested in outer islands because of the HFP, FP uptake remains very low. It may take more than an annual visit to gain trust and establish a relationship to talk about FP. **Phase 3 should continue activities building confidence and skills of MHMS staff who live and work in the**

Objectives	Key Questions	Findings
negative outcomes.	4.2 How can the project increase positive outcomes and decrease negative outcomes?	**outer islands.** Engaging youth is critical for future reductions in unplanned pregnancies and STIs. The more young people are aware and access contraception (including condoms and EC) the sooner CPR will increase and TFR reduce. This evaluation could not identify any specific negative changes **produced** by the project; although negative comments and restrictions, in particular from church leaders, impact on the outcomes of the HFP. Concerns were expressed by MHSM and MIA, about outer island outreach, **suggesting better coordination and approvals, as well as standardized incentives for community participation for phase 3.** 4.2 **Consulting and joint planning with MHMS and MIA on outer island outreach could maximize human resources and build positive linkages amongst KFHA and MHMS and other government staff.** Nurses are a critical workforce for SRHR and FP service provision and education. KFHA has provided awareness-raising in some years to student nurses at Kiribati School of Nursing (KSON) but not every year. These student nurses are the future MHMS workforce in health centres, hospitals and outer islands. **A strategic Capacity Development plan for nurses in phase 3** could identify staged awareness, knowledge, skills starting from school curriculum, building higher level KAP in undergraduate curriculum, onto postgraduate and ongoing professional development for this critical SRHR workforce. Not all nurses will be skilled at contraception methods, but a minimum could be expected (e.g. to understand all FP methods and be able to utilise the WHO wheel for advice). Those student nurses who express interest in SRHR could then be selected for further training after graduation as SRHR champions and provided with training for more specialist clinical skills. Using a broader PHC approach and providing screening for NCDs allows KFHA access to more people in villages and outer islands, than being known only as an SRHR provider. **This is a positive change in strategy and should continue in phase 3, along with careful monitoring of FP uptake to ensure it is not 'lost'.** 4.3 KFHA receive most of their commodities through UNFPA/MHMS systems. While KFHA do not appear to have experienced stock-outs since 2015 in phase 2, this could be because they have other suppliers if necessary (e.g. IPPF SROP, other IPPF MAs or the IPPF Regional Office). KFHA noted that they have sometimes provided MHMS with

Objectives	Key Questions	Findings
	4.3 What external factors, including the commodity chains, will impact KFHA's ability to maintain the positive outcomes	commodities and always bring supplies for outer island outreach. UNFPA have recently conducted a Health Facility Readiness Assessment and found that a high % of MHMS Health Centres do not have commodities in stock, including no depo or Jadelle. MHMS health centre staff claim that they can get commodities when needed, however if women have to return another day for their contraception, some may not return. This may also lead to a sense that the Health Clinic is not a reliable way to obtain contraception (and possibly other medications).
Q5. To identify the need for a further phase of the project and the sustainability of the project after completion	5.1 To what extent is KFHA able (financially, resourcing etc.) to maintain and expand on the reach of the services provided? 5.2 What support would be required for the Kiribati Family Health Association to maintain the positive outcomes of the project following the completion of the project?	5.1 Currently KFHA have managed to provide annual outreach to the 6 outer islands and increased the number of days on islands in order to reach more villages and spend more time with MHMS staff, mentoring their SRHR skills. KFHA are expanding to another 3 islands in 2020 with one-off UNFPA funding. This will provide a lesson-learning opportunity to see if staff have the capacity to deliver on 9 islands in a year. However this will also depend on efficient programming with little disruption caused by weather or airline/boat scheduling problems. 5.2 Essentially funding for phase 3 is required to maintain positive outcomes, in particular to continue ongoing mobile and outer island outreach service delivery. This should be planned and agreed with the MHMS and MIA (and included in new MOUs). The static clinic will need to be improved or new premises built soon. Capacity development should focus clearly on schools, jointly planned and agreed to with MOE; on student nurses, supporting KSON to map SRH in the nursing curriculum; and other educational institutions, such as KIT and MTC. Training for MHMS staff requires planning and agreement on rationale, numbers and content, with a clear strategy to cover a specified % of MHMS staff with basic FP/STI KAP that is measurable. Support is needed for rigorous social and behavior change communication (SBCC) research, in consultation with MHMS and UNFPA, possibly focusing on youth. This research could provide evidence to develop clear, segmented communication strategies, including through social media, radio and word-of-mouth. Developing systematic methods of collecting data and evidence for phase 3 will be required; with additional support for the project coordinator, and from IT/M&E staff. Support for the ED will also be required in phase 3, possibly a Deputy Director, who can assist with day-to-day management, allowing the ED to focus on advocacy and high-level

Objectives	Key Questions	Findings
		engagement. Learning dialogues (review and reflection) with external stakeholders, including GoK Ministries, MPs, MFAT, DFAT, UNFPA, DFAT should be scheduled annually and facilitated externally for phase 3.

3.3. Static Clinic services

For the five years of HFP phase 2, data for the static clinic show steadily increasing numbers (note that data for Year 1 are not comparable as IPPF definitions were changed). With the increase in staff funded by HFP, the numbers of clients and services have grown; in 2019, 2,000 clients received over 10,000 SRH services in the static clinics in the last year. Young people (under 25 years) consistently comprise over a third of total clients seen in static clinics (37%) and over 80% are women.

Table 5: Static Clinic SRH services and clients numbers

Indicator	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Number of clients – static	X	X	1,291	1,225	2,000
Number of women - static			1,029 (80%)	1,109 (90%)	1,622 (81%)
Number of young clients - static (% of total clients)	X	X	462 (35%)	460 (37%)	747 (37%)
Marginalized clients, people with disabilities and SOGIE - static	X	X	345	788	952
Number of SRH services - static	36,379	6,981	8,742	10,321	10,181
Contraceptive services - static	11,091	294	497	809	1,111
Antenatal care services - static (pregnancy test)	332	118	27	57	45
STI/RTI/HIV services - static	4,757	1,040	1,046	1,415	1,426

Source: KFHA service statistics, IPPF SROP

The majority of static clinic services provided by KFHA were for STI/RTI and HIV/AIDS counselling and testing; around 1,400 services in the final two years (14% of total SRH services). This exceeds the original target of 1,200 by the end of phase 2. Antenatal and pregnancy testing accounted for very few services, however is something that could be considered for phase 3, as KFHA employ midwives.

Of some concern is that contraceptive services comprise only 11% of all SRH static services. The HFP family planning usage and barriers research provide some reasons for this that could be explored with clinicians, health promoters and program manager, and develop strategies to increase these numbers substantially in the next phase - if TFR is to decrease and CPR increase.

In addition, the clinic itself requires urgent upgrading in order to meet IPPF infection control standards, given the upcoming accreditation process due to start in 2020.

3.4. Outreach clinical services – mobile and outer island

Outreach activities in South Tarawa have increased significantly with the addition of a new vehicle (HFP phase 1) and HFP funded staff (including a driver). More villagers are able to access SRH services through this outreach. Clinical staff (generally preceded by HFP educators and KFHA youth volunteers) conduct village outreach in South Tarawa and annually to six outer islands. This is an efficient and effective mode to meet client needs while reducing costs for more frequent visits, as long as MHMS health centre staff are able to continue SRH services. Data indicate that nearly 8,000 clients received over 37,000 SRH services through outreach in 2019, mostly women. Of note are the large numbers of STI services each year, largely for young people, and high number of contraceptive services (over 14,000), largely due to an effective Community Based Condom Distribution system.

Table 6: Mobile and Outreach SRH services and clients

Indicator	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Number of clients outreach Number women outreach (%)	X	X	6,402 6,102 (95%)	6,118 5,925 (97%)	7,981 7,721 (97%)
Number of young clients (%)	X	X	2,125 (42%)	1,137 (28%)	1,202 (21%)
Number of marginalized clients, people with disabilities/SOGIE	X	X	5,055	4,063	5,731
Number of SRH services outreach	22,389	39,984	54,965	36,104	37,533
Contraceptive services outreach	2,100	1,045	1,038	11,724 (includes condoms)	14,123 (includes condoms)
Antenatal care services outreach (pregnancy test)	X	183	23	20	25
STI/RTI/HIV services outreach	X	12,818	15,743	14,595	12,406

Source: KFHA Service Statistics, IPPF SROP

Outreach Awareness activities are conducted at a number of sites, including villages, workplaces, primary and junior secondary schools, Colleges/Universities and at church youth groups. Table 7 shows that the number of HFP awareness-raising activities, which include health promotion dramas, goal setting with young people, radio programmes, working alongside government Ministry activities, marches and providing mobile clinics to support increased demand for services. KFHA also provide health promotion activities in at least five major events a year, such as International Youth Day. The effectiveness and impact of these activities are difficult to gauge, however they generally have a wide reach (around 2,300 people) and high visibility for KFHA youth.

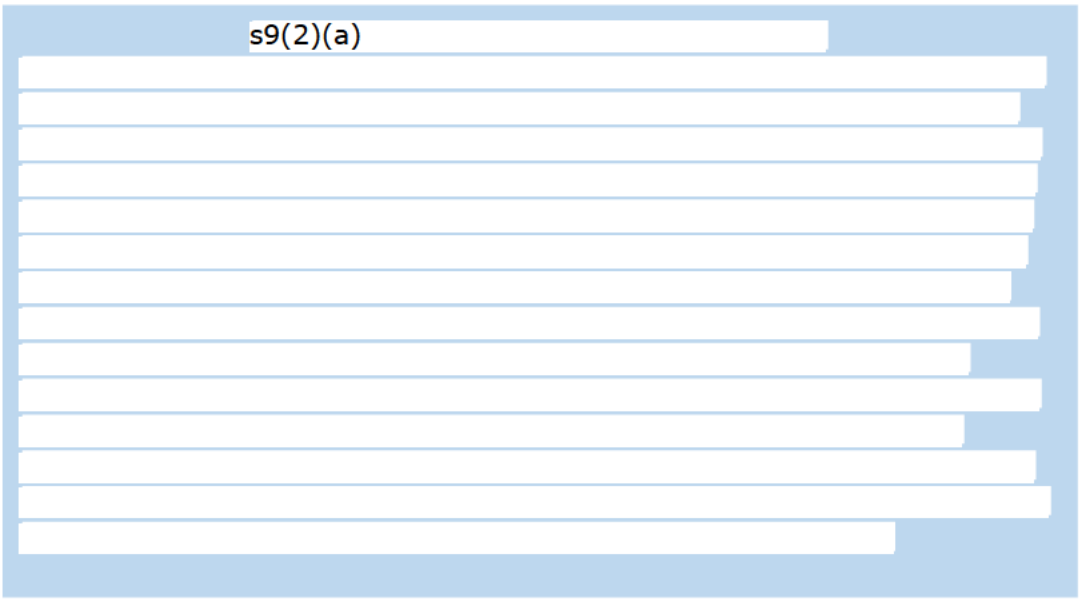
Table 7: Outreach Awareness activities

Sites	2017	2018	2019
Villages	48	51	46
University/Colleges	7	5	2
Junior/Senior secondary	3	3	N/A
Church Youth groups	1 (n=52)	1 (n=45)	1 (n=53)
Youth groups	7 (n=210)	9 (n=271)	11 (301)
Workplaces	3	4	3

3.5. Enabling environment and advocacy

The general political, religious and traditional culture and values towards SRH remain the major challenge in Kiribati and it will take concerted efforts to change social norms, however KFHA are seen as a key NGO partner by government Ministries. KFHA have been consulted and contributed to

numerous policies, reviews and surveys – such as the national RMNCAH policy and strategy; national HIV, AIDS and STI policy; Youth policy; KDHS; including SRHR in Public Health bylaws in TUC and BTC and participated in dozens of meetings. This indicates that KFHA is a key partner and consulted on a number of relevant health topics as well as Disaster and Emergency planning. In addition, KFHA staff participate on several committees – Health Sector Coordination and RMNCAH Committees. KFHA hold regular meetings with community leaders, government officials, and church leaders and present at the parliamentary health select committee.



Working to change social norms will need to be addressed systematically, based on sound social and behavioural change communication (SBCC) research, in the next five years.

3.6. Impact

The overall impact of the HFP will be clearer once the KDHS 2019 is published and will document the changes and hopefully improvements since 2009, for TFR, CPR, unplanned pregnancies and sources of contraception and incidence of STIs. These data will provide an assessment of KFHA's contribution, noting that the overall goal of the HPF was to increase access to sexual and reproductive health information, skills and services on South Tarawa and six outer islands, resulting in a **reduction of sexually transmissible infections and unplanned pregnancies**. The KDHS report was unavailable for this end of project evaluation.

Other positive impacts include steady numbers of around 20 youth volunteers[19] who are trained and provide SRHR awareness-raising and distribute condoms in South Tarawa; one youth volunteer has been employed as HFP staff. Around 2,000 young people under the age of 25 receive KFHA services each year, however there is no drop-in youth centre in the main population centre of South Tarawa. KFHA clinicians do see unmarried young people requesting contraception and provide counseling. Emergency contraception (EC) is available but numbers provided are low, with only 44 consultations in 2019. Knowledge of EC was reported as very low in the KDHS 2009; this is a major concern if young people are to be supported in their choice to prevent early or unwanted pregnancy.

[19] Numbers range as youth move in and out with their family, study and work commitments

A Youth Engagement Strategy would be useful to plan future activities for the next phase (for example joint planning and activities with Kiribati Red Cross and Youth peer educators could produce synergies and broader understanding of general adolescent health including SRHR).

Increasing numbers of people with disabilities are seen in static clinic, and KFHA run a specific mobile clinic to the Nanikaai camp that is 'disability- friendly' in terms of physical access and staff caring attitudes.

The LGBTQI Association, BIMBA, representative knew of KFHA and had participated in awareness-raising sessions, but BIMBA work focuses on MSM and transgender issues, and not on family planning. BIMBA are concerned about STIs/HIV but he was unsure how comfortable members were to attend KFHA clinic for testing and treatment. In the past, KFHA volunteers have worked with male and female 'sex workers' and provided condoms and awareness about STI/HIV prevention and testing. This is important but challenging work with a key population, that would help prevent STIs and unplanned pregnancies and possible violence, but it requires night-time activities to reach women when they are at bars and clubs. KFHA staff and volunteers, or peer educators (i.e. other sex workers) could support regular activities in phase 3 for this key and difficult to reach population.

3.7. Challenges

KFHA and other key stakeholders identified a number of challenges listed below that will need to be addressed in phase 3.

3.7.1. KFHA premises

As noted, the current KFHA premises would not meet IPPF accreditation standards for infection control and hygiene. It is also quite a public site, on the main road in South Tarawa. The GoK has allocated land in a more private area, and KFHA have a container with materials to build a new clinic, offices and youth drop-in centre. It is urgent that final approval be given to KFHA to commence building new premises. IPPF accreditation could then be delayed until the new clinic is operational.

3.7.2. Sustainability

While the MHMS is committed to improving Primary Health Care (PHC) and SRH services, there is limited GoK funding for SRH in general and the reality of shifting funding to PHC will take time. Specialist SRH services are available at the Family Health Centre located in the hospital grounds in Bikenibeu, staffed by Obstetricians, Gynaecologist, midwives and nurses - trained in maternal and child health, contraception, clinical management of rape and SGBV.

The KDHS 2009 indicates that the majority of women surveyed said that they received their contraception from government hospitals (54%), government health centres (23%) and family planning clinic (9%).[20] KDHS 2019 will provide an update on source of contraception. In Phase 3, the focus on MHMS staff should continue, with a clear plan to reach all student nurses, and continue to increase their knowledge, attitudes, skills and practice in SRHR.

The approach to promoting sustainability in phase 3 should ensure that the HFP is aligned with MHMS priorities and able to adapt when priorities change. Coordination mechanisms should be embedded in the design and all activities should have a MHMS (or other government Ministry) focal point. MHMS RMNCAH staff could jointly present data with KFHA staff at meetings, including at conferences. A transition and exit strategy for end of phase 3 should be considered, unless MFAT plan to continue funding for another ten years.

3.7.3. Coordination and planning

[20] Kiribati Demographic and Health Survey, 2009; p.80

Coordination was considered an issue of concern in Year 1 of phase 2, and FPNZ had convened a bi-annual SRHR coordination meeting between Family Planning, KFHA, MHMS and UNFPA. Several donor partners fund components of SRHR (MFAT, DFAT, UNFPA) requiring clarity around collaboration and coalition opportunities. In particular, **coordination and joint planning** around village awareness programs requires collaborative efforts from MHMS, MWYSSA, MIA and KFHA. The RMNCAH and Health Sector meetings provide opportunities for improved coordination and should be included in phase 3 planning and budgeting.

3.7.4. Social norms

Community, religious and cultural norms around sexuality makes it very difficult to discuss such topics in the Kiribati language. There is huge stigma associated with sex outside of marriage and unplanned pregnancies and social norms appear to be little changed over time. A social behavior change communication strategy (SBCC) that is appropriate for Pacific island countries and territories including in Kiribati is needed to maximize efforts at community/village level.

4. Limitations and constraints

The FPNZ Program Officer attended most meetings and also on the field trip to outer island in Abaiang. This provided a useful way to learn about the project together with the evaluator, however there were some meetings when this was not appropriate; and is something to consider for phase 3 MTR. Involving local MFAT staff in future evaluations may be considered.

KFHA youth officer and youth volunteer provided a useful overarching commentary of activities when Kiribati language was used, in particular during focus group discussions. However given the complexities of the issues discussed, a professional SRHR, independent interpreter would have been able to provide simultaneous translation, that would have added to the richness of data collected and observed.

The KFHA HFP coordinator was on family leave and was only available for an initial meeting. Observations of clinic services were not possible as no clients attended when the observation was scheduled. An observation of an after-hours clinic did not occur due to a miscommunication with KFHA staff and the community. Limited time in-country did not allow for more in-depth interviews, analysis and cross-checking of findings; this was done by email remotely.

5. Recommendations

KFHA made good progress in phase 2 and addressed many of the MTR recommendations, where feasible. Based on the findings and challenges identified in this end of project evaluation, a number of areas could be considered for the next phase. These are listed in Table 8 under the theme *issue of concern,* as defined by the evaluator, followed by a description of relevant findings and preliminary recommendations that were only briefly discussed while in-country. Further discussion and clarification around feasibility of the recommendations will be needed. Recommendations focus on what has worked well in phase 2, what continues to need to be supported and what has been less successful.

6. Proposed next steps

- MFAT/KFHA/FPNZ to review report by end-March, taking into consideration the suggestions and recommendations for phase 3.
- KFHA ED and staff to consider recommendations and develop a prioritised action plan such as:
  - Revise MOU with MHMS
  - Joint planning for outer island outreach with MIA, MHMS, MWYSSA and others

  - Agree focus for phase 3 school program with MOE
  - Plan for village outreach with MHMS and others
  - Plan for increasing contraceptive services and number of clients
  - Plan for increasing knowledge about availability of emergency contraception
  - Agree future KSON engagement and map SRHR in nursing curriculum with FPNZ
  - Ensure that the KIT clinic operates on the days and times as noted on the door
  - Review data collection and entry including client satisfaction reporting
  - Identify sex workers who could support peer health promotion
- UNFPA/MHMS to convene a meeting with relevant staff - MHMS (Pharmacy, Warehouse, RMNCAH Officer) and include KFHA ED and Clinical Manager if needed - to urgently address the MHMS health centre stock-out situation.
- FPNZ and KFHA organize a facilitated Learning Dialogue to review phase 2 and develop a clear Capacity Development strategy for phase 3 that would support the MHMS new RMNCAH policy and strategy plan.
- MFAT to consider supporting VSA positions (social media/youth engagement; SBCC/videos) in the next round of submissions.

Table 8: Recommendations for Phase 3 based on findings

Issue of concern	Findings	Recommendations
1. KFHA clinic Quality of Care (QOC) standards impacts on HFP services	The KFHA clinic is a rented 2-storey building, which has running water into a basin; it is not plumbed. This and other cleanliness issues seriously impacts on hygiene, infection control and quality of care. The KFHA Laboratory deals with blood/biological specimens that require safe handling systems and processes, including during outer island outreach. New premises for KFHA have been discussed since 2014 and KFHA has land allocated by the government in Bairiki.	KFHA will be participating in an IPPF accreditation process in 2020 and the current clinic is unlikely to gain accreditation as it is. This is a major risk to the HFP and requires urgent action from KFHA. IPPF SROP liaise with FPNZ prior to the QoC review in 2020, as this might inform future Capacity Development training needs. Plans for the Laboratory need to meet GoK standards and ensure safe handling and disposal of blood and biological materials, including during outer island outreach. The issue of land for KFHA clinic/youth centre in South Tarawa is one that MFAT High Commissioner may be able to address with the GoK. KFHA/MFAT clarify what final approval is required to start construction in Bairiki, before the election (that is likely to cause further delays).
2. Focus on youth – high numbers of young people; high youth unemployment;	There is no **Youth drop-in centre** in Kiribati. However the MHMS informed that there is building available in the Bikenibeu area. This site has a small court area that could be used for volleyball and other sports. KFHA have also been allocated land in the Bairiki area, and have plans for a building to include a youth-friendly space.	KFHA liaise with MHMS RMNCAH and confirm if the MHMS are refurbishing a youth drop-in centre in Bikenibeu; if so, then KFHA could collaborate and support forming a youth group to renovate the building. Urgent action is needed by all stakeholders to ensure that youth are involved and able to contribute to creating youth-friendly spaces. KFHA follow up on land and building approvals, including youth-friendly space.
3. IEC materials not necessarily best method to reach young people	**IEC** for youth would benefit from developing more social media content using fresh modes of communication (e.g. Facebook, YouTube, videos) while continuing the effective drama mode. Discussion with youth, ED and stakeholders indicate that this would be valued.	KFHA submit proposal, with support from FPNZ, for a **VSA/AVI** with social media and behaviour change communication skills to support this shift in communication approaches, to work with youth volunteers and communications students. In order to ensure sustainability, KFHA will identify youth counterpart/s to work with the volunteer who will help build local capacity through mentorship. Phase 3 research focus on rigorous qualitative research (social and behaviour

Issue of concern	Findings	Recommendations
	Radio has been effective in phase 2. Phase 3 could develop a regular program (possibly using drama e.g. https://www.comminit.com/global/content/sawa-shabab-together-youth-radio-drama-series).	change communication) on which to base the youth messaging and include training youth volunteers as researchers. KFHA/FPNZ to discuss feasibility of conducting this research in phase 3, and seek additional funds if required from other sources, such as the Transformative Agenda funding.
4. Focus on **Youth-friendly approaches** with partners	KFHA staff attitudes are youth client-friendly, however FPNZ could provide additional **training on youth-friendly approaches** for those who may not have participated before (e.g MHMS staff). Align youth programs with MWYSSA and UNFPA.	FPNZ to expand YFS training to more MHMS staff, possibly in collaboration with IPPF/SROP in phase 3. Peer youth educators from KFHA, YPeer and Red Cross conduct joint activities and share materials and techniques for engaging young people around adolescent health and SRHR in phase 3. Design recognition for the work of youth volunteers and CBDs in phase 3.
5. **Partner with agencies at island Sports Tournament**	The GoK encourages youth development through sports, including a major Tournament (every 2 years). This event provides an excellent opportunity to meet and engage with young people from all outer islands.	Similar to other major events such as International Youth Day, peer youth educators from KFHA, YPeer and Red Cross conduct joint awareness activities (including condom distribution if possible) and engage during sporting events with participants, especially those from outer islands, encouraging them to be Health/SRHR champions.
6. School education programs Coordination around new school Family Life Education; Health and Personal Development curriculum	The national curriculum is currently being reviewed, and KFHA engage in the evolving process by reviewing new material to ensure that what is presented by KFHA teams in schools, aligns with the changing curriculum. All SRH awareness in schools needs to be coordinated carefully with MOE teams to avoid overlap and ensure the content is appropriate and KFHA staff are trained and gender appropriate. MOE staff member on the HFTF was on maternity leave and there was no replacement; so no grant	Currently the curricula for Years 10-12 are under review; this is a critical time for more comprehensive SRHR education. UNFPA, MoE, MHMS and KFHA continue reviewing relevant curricula to ensure aligned messaging with the CSE material. KFHA to review material they present with MOE. Ensure that gender-appropriate staff present material (i.e. a male should present to boys and female to girls). KFHA educators to be supported and mentored – including direct observations of presentations in the field (e.g. by FPNZ). MoE representative on Healthy Family Taskforce submit a proposal in 2020, or hand over her duties if she is on leave/absent.

Issue of concern	Findings	Recommendations
	proposal was submitted in 2019.	
7. Multiple funding sources for components of SRHR **Stronger collaboration and coordination needed**	It is often difficult for civil society organisations to initiate coordination mechanisms as that responsibility lies with government, however this evaluation strongly recommends that **joint planning** is required to minimise overlap, duplication and inefficiencies, in particular for outer island activities. This requires more than individual organisations and departments presenting their plans to each other, but rather sitting together to develop a joint plan.	The existing Health Sector Coordination quarterly meetings, convened by the MHMS, could provide such leadership. KFHA are invited to participate in this meeting, and should ensure that appropriate staff attend and present a clear picture of KFHA progress and data. In addition, the RMNCAH committee will be revitalised and active participation from KFHA is critical for effective coordination. If joint planning through these groups is not feasible, KFHA could invite stakeholders to a joint planning day or retreat for phase 3 planning.
8. Partner Agreements or MOUs - with MHMS	KFHA currently have several MOUs, including with the MHMS. The MHMS reported instances of miscommunication with KFHA and potential overlap, particularly around outer island visits.	KFHA and MHMS review the existing MOU and revise it to include new activities and approaches, outlining expectations and anticipating any sticking points. KFHA/FPNZ review the new Reproductive Health Policy and Strategy, and discuss with MHMS how best to support GoK needs to improve SRHR in phase 3.
9. Standardise incentives with communities and individuals	The MHMS raised the issue of incentives provided to communities to attend outreach screening and awareness raising activities. If KFHA provides higher incentives, then attendance at MHMS outreach or clinic services will be impacted.	KFHA discuss issue of incentives with MHMS and seek to find a workable solution for both parties.
10. Lesson sharing HFP and building on synergies	Lesson sharing needs to be conducted throughout a project, not just at the end. It is best development practice to hold an annual reflection and learning dialogue with internal and external stakeholders, where data are presented, and any blockages identified.	FPNZ outsource external facilitation (with expertise from an M&E expert) for an annual Learning Dialogue that is highly participatory (e.g. using 'sticky walls') including key external stakeholders and government Ministries.
11. Family	Further analysis of IPPF service statistics indicate a	Given challenging cultural and religious opposition, FPNZ to support the KFHA

Issue of concern	Findings	Recommendations
Planning and Emergency Contraception (EC) consultation numbers are low	lower number of contraceptive counselling and consultation services than would be expected; accounting for around 10% of all SRH services provided by KFHA. Very few EC consultations were provided. If the Healthy Families Project is to reduce key stagnant indicators of CPR and TFR, then the focus on family planning services must step up considerably in phase 3.	team to reflect on how each staff member can contribute to increasing numbers of contraceptive clients and services; and develop a plan for phase 3. With a stronger focus on youth, KFHA clinicians and educators must inform young people that there is an option of emergency contraception available if they want to prevent unplanned and early pregnancy. Focus on social norm change to stimulate the demand side.
12. Client satisfaction reporting.	Simple client feedback is valuable to inform services on a regular basis. The current practice is that client satisfaction surveys are done as a special exercise. It is unclear how client satisfaction is measured in mobile or outreach services.	KFHA/FPNZ and IPPF/SROP to review client satisfaction reporting system. For example, the receptionist could provide a simple form to each client on arrival in the clinic. After seeing the clinician, the receptionist could ask if the form has been filled out and ask the client to place it in a box (anonymously). The forms could be analysed and entered into a spreadsheet by IT and reported on at monthly staff meetings.
13. Capacity development model	FPNZ provide training in clinical skills and health promotion. After 8 years of funding this model, it is important to clarify the approach to and theory of change for CD and review its effectiveness. Student nurses have received SRHR information in some years of HFP, but not consistently. They are a critical workforce for SRHR and FP. A list of names of MHMS and KFHA training participants is maintained. This could be further developed with the MHMS into individual professional development plans, so that SRHR champions can be identified easily and followed up.	FPNZ/KFHA conduct a review and reflection with MHMS, MFAT, IPPF SROP and other key stakeholders to develop a clear theory of change and staged strategy for phase 3 Capacity Development, in particular the opportunity for sustainability with the MHMS. What will you expect to see by 2025? FPNZ develop a strategic Capacity Development plan for phase 3 to include staged awareness, knowledge, skills (from school, undergraduate, postgraduate and ongoing professional development) for this critical SRHR workforce. Basic KAP for **all** nurses should be agreed in curriculum with KSON (e.g. understand all FP methods and be able to utilise the WHO wheel for advice). Student nurses who express interest in SRHR could then be selected for further training after graduation as SRHR champions and trained with more specialist clinical skills. FPNZ continue support for a Professional Development plan for each KFHA staff

Issue of concern	Findings	Recommendations
		member to ensure they are clinically up-to-date. Liaise with MHMS DNS on MHMS staff training needs and database. Develop a spreadsheet with data on KAP of participants, to allow more targeted follow-up and refresher training. FPNZ consider pausing IUD training, until more demand is generated (through awareness-raising and social norm changes) and review in phase 3.
14. Engagement with sex workers	Kiribati has about 50-60 sex workers who frequent night clubs and bars around the Betio area, and some also engage with seafarers. These are women (and some men) at high risk of exploitation, violence and risky sexual behaviours.	Sex workers are a clear marginalised 'target group.' KFHA has worked in this area in the past. In phase 3, KFHA/NZFP develop a clear plan and program to reach out to sex workers, promoting condom use and personal safety. Peer volunteers could be trained and supported (and already one has volunteered when we met her during the evaluation).
15. Support for KFHA ED	The ED role requires a lot of reading and attention to detail, in order to sign-off on all aspects of KFHA work. It is a very challenging role for anyone, but the ED has a sight impairment that makes it even more difficult. KFHA have developed a Senior Management Team to discuss and review work but the final accountability remains with the ED.	KFHA ED/SMT/Board consider creating a Deputy Director role to provide day-to-day support for programs and staff, with the ED focusing on high-level leadership and advocacy. FPNZ and IPPF SROP to provide support to ED/SMT on structure and roles and responsibilities in phase 3. This is an important period of transition for KFHA and the ED has much to contribute over the longer term, and a clear role needs to be developed to utilise her reputation and contacts.
16. Linkages with IPPF/SROP	KFHA currently develop a transparent annual integrated work plan and budget. This shows where funding sources overlap; and would benefit from clearer communication in phase 3.	For phase 3, FPNZ and IPPF SROP to clarify what capacity development each provides (e.g. IPPF SROP provides Quality of Care reviews and training) and agree a plan and communication strategy with each other for the next five years.
17. MIA Communication	The Ministry of Internal Affairs is responsible for support to Island Councils and there have been changes to staffing, requiring rebuilding of the relationship. GoK heads of department meeting have recently	KFHA to meet with MIA staff and ensure any changes to protocols are adhered to, and that the MIA representative on HFTF has a clear understanding to report back to MIA senior management. KFHA present at the Annual Outer Island Forum during the Health session, if they can organise this with the MHMS. In phase 3, this could be a regular scheduled

Issue of concern	Findings	Recommendations
	established new protocols for working with Island Councils and would appreciate KFHA contacting them to discuss. MIA with MELAD organise an annual 5 day meeting of Island leaders, and allow other Ministries to present.	activity and may not require an additional, separate event funded by HFP. KFHA's work supporting Island Development Plans (IDP) is innovative as it provides a less controversial entry into villages, than just a focus on SRHR. It supports the work of several GoK Ministries and should continue as a strong element of phase 3. However it will require close liaison and negotiations with MHMS Public Health, MELAD and MIA.
18. Laboratory equipment	The KFHA laboratory provides a highly valued service, including STI/RTI/HIV rapid tests, PAP smears, blood tests - in the static clinic and also rapid tests in mobile and outreach services. Training a lab assistant was recommended in the MTR, but it is unclear what skills would be needed for this, and if it is feasible.	Phase 3 could fund support for laboratory improvements such as a portable microscope, new test for chlamydia that does not require high vaginal swab. It is unclear if there is an added benefit to training a lab assistant, and would need to be carefully considered by the SMT/ED.

Annexes

Annex 1: Terms of Reference (ToR) Independent Evaluation of the Healthy Families Project

End of Project Evaluation: Terms of Reference

Kiribati Healthy Families Project

1. Background Project Information and Rationale

The 'Healthy Families Project' is a collaborative sexual and reproductive health and rights project between Kiribati Family Health Association (KFHA) and Family Planning New Zealand. The first phase of the project ran from 1 February 2012 – 31 March 2015. The second phase commenced on 1 April 2015 and is due to complete on 31 March 2020. It is fully funded by the Ministry of Foreign Affairs and Trade (MFAT).

Kiribati, particularly South Tarawa, has some of the highest need for sexual and reproductive services in the Pacific with the prevalence of modern contraception being 18% according to the most recent Demographic Health Survey. The 2010 census recorded the total population at 103,058, with around 54% of the population living in the two urban centres of South Tarawa (49%) and Kirimati (5%). The population is predicted to reach almost 200,000 by 2050.

The overall goal of Kiribati Healthy Families Project Phase two is to increase access to sexual and reproductive health information, skills and services on South Tarawa and six outer islands, resulting in a reduction in sexually transmissible infections and unplanned pregnancies. The beneficiaries of the project are men, women and adolescents in South Tarawa and the six outer islands. The project also aims to work with three key groups: youth, people living with disabilities and commercial and transactional sex workers.

To achieve the project's overarching goal, three core areas were identified. The areas are:

1. Capacity Development – Family Planning and KFHA deliver training programmes to nurses and health educators on South Tarawa and six outer islands; Family Planning supports KFHA through ongoing mentoring and professional development opportunities; KFHA develops SRHR Community of Practice.
2. Service Delivery – KFHA delivers mobile clinics, after-hours clinics, condom distributions, school visits, health promotion campaigns, workshops with key groups, and IECs to South Tarawa; KFHA manages grant programmes for South Tarawa health educators and outer island CBDs/island councils.
3. Enabling Environment – KFHA delivers advocacy programmes to community leaders in South Tarawa; KFHA engages community leaders in outer island SRHR strategy; Family Planning carries out research projects to inform leaders on key SRHR issues.

2. Purpose of the evaluation

Key evaluation objectives:

I. Assess the overall impact of the project.
II. Assess to what extent the project outputs were delivered and the project outcomes achieved.

III. Provide recommendations on a possible future phase of the project.

IV. Provide data for the project's monitoring, evaluation, research and learning (MERL) table on:

- Staff who identify themselves as Pacific leaders in SRHR
- Community members recognise KFHA as a leader in SRHR
- Community perceptions of ability to realise SRHR
- Community perceptions of the social environment and governing structures
- National and regional agencies recognise KFHA as a Pacific Leader in SRHR
- % of KFHA and MHMS reproductive health clinic clients that describe their services and information as very good or excellent

3. Key focus areas and objectives of the evaluation

This evaluation will build on from the mid-term evaluations that occurred within phase one (2013) and two (2017) and be guided by the below questions to assess the impact of the programme. It is expected other focus areas will be defined by the evaluation in consultation with KFHA and Family Planning New Zealand.

Objective 1: To assess the extent to which the objectives of the Kiribati Healthy Families Project are consistent with beneficiaries' requirements and country needs.

- To what extent does the project align with the priorities of the NZ Aide programme. the Government of Kiribati, KFHA and island councils?
- To what extent does the project address the needs of the project's target groups?
- To what extent is the project supported by the Government of Kiribati and Island councils?

Objective 2: To examine the progress made in achieving the Kiribati Healthy Families Project's outcomes.

- To what extent has the program achieving the outcomes, in the short, medium and long term?
- What have been the changes since Family Planning's cost-benefit analysis in 2014?

Objective 3: To assess how efficiently the Kiribati Healthy Families Project uses resources.

- How well does the Kiribati Healthy Families Project use resources to achieve results?

Objective 4: To identify any changes needed to maximise the positive outcomes of the Kiribati Healthy Families Project and minimise negative outcomes.

- What are the long-term positive and negative changes produced by the project?
- How can the project increase positive outcomes and decrease negative outcomes?
- What external factors, including the commodity chains, will impact KFHA's ability to maintain the positive outcomes?

Objective 5: To identify the need for a further phase of the project and the sustainability of the project after completion.

- To what extent is KFHA able (financially, resourcing etc.) to maintain and expand on the reach of the services provided
- What support would be required for the Kiribati Family Health Association to maintain the positive outcomes of the project following the completion of the project?

4. Scope of the evaluation:

Time period and location

The evaluation will be conducted over approximately 20 days, with 8 days spent on data collection in South Tarawa and one outer island in Kiribati.

Dates for the data collection period in South Tarawa will need to be coordinated with Family Planning. The evaluation must be completed by 15 March 2020.

Engagement with key stakeholders

The following individuals and groups during the evaluation. Other respondents may be identified by the consultant as necessary.

- Programme officer, Family Planning
- Clinicians and health promoters engaged in the Project, Family Planning
- Executive Director, KFHA
- HFP Programme Coordinator, KFHA
- Youth Officer, KFHA
- Clinical nurses, KFHA
- KFHA youth volunteers, KFHA
- Ministry of Health and Medical Services (MHMS), Kiribati
- RMNCAH, Kiribati
- Ministry of Education, Kiribati
- MWYSSA, Kiribati
- Island council members, mayors and unimwaane (traditional leaders)
- Participants from clinical trainings including medical assistants
- Participants from health promotion trainings
- Participants from advocacy meetings
- Community members (focus groups may be required)

Family Planning will provide support to the consultant to establish the in-country interview schedule, travel and accommodation arrangements and assist the consultant with additional background information as necessary.

5. Approach

The methodology of the evaluation will be developed by the evaluator with support and consultation from KFHA and Family Planning New Zealand. In line with past evaluations, the consultant will conduct interviews and focus groups with key stakeholder as identified above, as well as other means of data collection as deemed appropriate by the evaluator. The evaluation will be guided by the OEDC/DAC principles for evaluation. A steering committee consisting the International programme manager and programme officer from Family Planning, and Executive Director and Programme Coordinator from KFHA will provide governance of this evaluation.

6. Reviewer specifications

The review will be undertaken by an individual contractor with support from Family Planning's programmes officer and the Kiribati Family Health Association's project coordinator.

The attributes of the contractor will include:

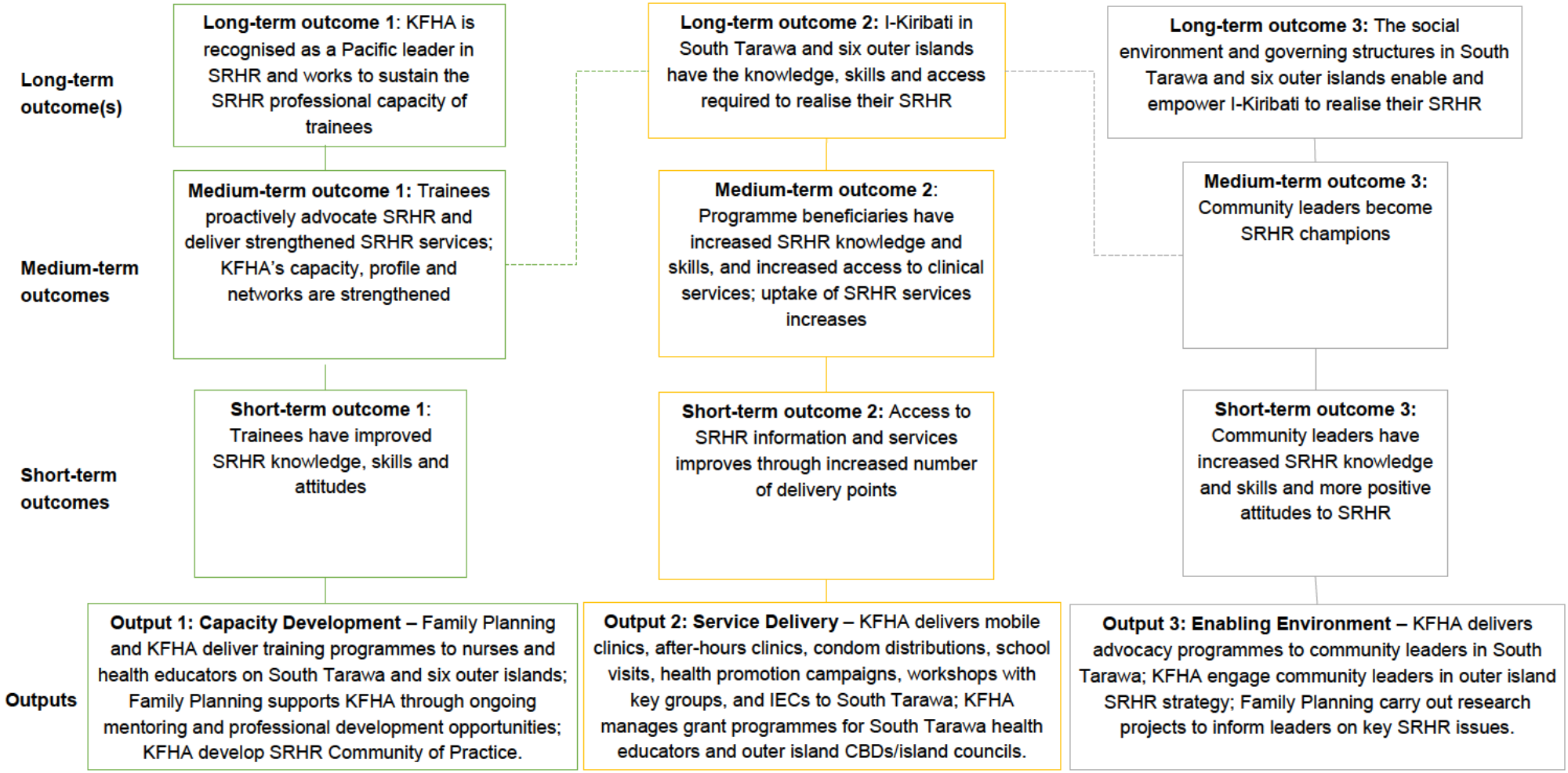
- Review expertise and experience, including undertaking development evaluations
- Appropriate research and report writing skills
- Excellent written communication skills, verbal communication skills and listening skills
- Experience working cross-culturally (Pacific experience preferred)
- An understanding of sexual and reproductive health and rights (SRHR)
- Being familiar with the MFAT MERL framework
- Being able to work to a definitive time frame. The evaluation must be completed by 15 March 2020.
- A willingness to sign Family Planning's Pledge of Confidentiality and Support of Family Planning's Sexuality Philosophy
- A willingness to undergo Police Vetting and Vulnerable Children's Act checks

7. Evaluation Deliverables

Deliverables	**Deadline**
Evaluation tools and interview schedule	1 February 2020
Evaluation and interviews in Kiribati	9 February 2020
Draft evaluation report with recommendations up to end of the project	1 March 2020
Final report incorporating Family Planning feedback	15 March 2020

Appendix 1: Results Framework

Goal of the Activity: Increased access to sexual and reproductive health information, skills and services on South Tarawa and six outer islands, resulting in a reduction in sexually transmissible infections and unplanned pregnancies.



Annex 2: Preliminary Questions

Interview questions are designed to collect experiential information from stakeholders about the impact of the Project on key outcomes (See KEQ). They will be conducted fluidly as 'conversations with purpose' in which participants are treated as expert partners in the research. Different questions will be asked depending on the role and knowledge of the informants. **PREAMBLE**: Your views will help us to assess the FHP and its continued relevance in Kiribati – in terms of activities and the progress made towards achieving its planned objectives [have ToC available to refresh].

Please consider this as an opportunity to educate us (the evaluation team) and also to educate the Ministry and KFHA so that, collectively, we can contribute to strengthened SRHR in Kiribati. There is evidence that TFR, CPR and unmet need is pretty well stagnant and that teenage pregnancy rates are high – as is the case in several countries.

Basic prompt questions for external stakeholder

I'm interested is what you think is the current political and social environment for SRHR in Kiribati… explore barriers and opportunities [esp teen pregnancy and unmet need]

How well do you think that the Healthy Families Project is able to influence the SRHR environment… explore barriers and opportunities

What is the role of your organisation in SRHR? Is it seen as an important issue or more marginal?

What impact do you think KFHA has in improving SRHR in Kiribati…explore barriers and opportunities

What are your views on how KFHA clinics operate, especially for the most marginalised (young people and those with disabilities)…explore barriers and opportunities

Have you experience with what the outreach teams are doing in the outer islands? What are your views?

How sustainable do you think the project is? Are there other options for providing SRH services through government providers?... explore barriers and opportunities

Are there other activities or approaches that could have an impact on SRHR? Is changing social norms possible in Kiribati – how might this be helped along?

Additional specific questions will need to be explored with MoH, WHO and UNFPA re MOU, medicines, integration into public health systems and training of government nurses.

Focus Group/interview mothers and women (gather demographics and ice breaker)

Talk about families and any birthing experiences [no.children/ages; NCD concerns…] – lead into other discussion ideal family size; decision making about FP

If ok to ask in a group - How many of you have used KFHA clinics? Explore experience as appropriate

What was your experience at the clinic? Describe if prepared to talk [if not then smiley face]

Where do you think young people get most of their information about sex and SRH?

Are there common myths and misconceptions that you hear?

What do you know about [list specific SRH questions to pose]? – ask to write down anonymously

What would you like to know more about [explore gaps in knowledge] - anonymous

What are views on how best to communicate with young people? Is social norm change possible in Kiribati – what are suggestions for how this might be helped along?

Focus Group KFHA youth volunteers (gather demographics and ice breaker)

Describe your role and what you do as volunteers? Explore

Where do you think young people get most of their information about sex and SRH? Are there common myths and misconceptions that you hear? How do you address those (role play?)

What are views on how best to communicate with young people? Is social norm change possible in Kiribati – what are suggestions for how this might be helped along?

What do you know about [list specific SRH questions to pose]? – ask to write down anonymously

What would you like to know more about [explore gaps in knowledge] - anonymous

Focus Group/interview KFHA young clients (gather demographics and ice breaker)

Where do you think young people get most of their information about sex and SRH?

Are there common myths and misconceptions that you hear?

What do you know about [list specific SRH questions to pose]? – ask to write down anonymously

What would you like to know more about [explore gaps in knowledge] - anonymous

What was your experience at the clinic? Describe if prepared to talk [if not then smiley face]

What are views on how best to communicate with young people? Is social norm change possible in Kiribati – what are suggestions for how this might be helped along?

ADD: How do you think that LGBTQI feel about coming to KFHA? Have any of your members acccessed services? Feedback?

ADD: How do you think that people with disabilities feel about coming to KFHA? Have any of your members acccessed services? Feedback?

KFHA staff

Clarify M&E framework and indicators – describe their views on inception, progress; data collection; barriers and opportunities.

What would help implementation of Project?

Explore issues/ views relating to providing services for unmarried young people.

Most significant change from Project? Stories from clients?

Any suggestions for efficiencies?

Any suggestions for increasing uptake of SRHR services?

What are views on how best to communicate with young people? Is social norm change possible in Kiribati – what are suggestions for how this might be helped along?

Clinical staff – explore training provided; explore how well remembered; whether used etc.

Annex 3: Schedule of meetings for Healthy Families Project Evaluation, February 13-20

Date/Time	Schedule Programme Groups	Venue
Thursday 13/02/2020	10.45am Arrival at Airport and check-in	Travel to Fema Lodge
1.00pm-3.00pm	Meeting with ED	KFHA
3.00pm-4.00pm	Meeting s9(2)(a)	KFHA
4.00pm-5pm	Meeting s9(2)(a)	KFHA
6.00-9.00pm	Dinner with the KFHA team	Koakoa
Friday 14/02/2020		
8.30am-11.30am	Senior Youth Officer and Youth Officer Travel by boat to Abaiang	Betio wharf
	Lunch Break	
1.00-2.00pm	Informal discussion with women Council representative	Abaiang
2.00-4.00pm	FGD with Leaders – Unimwane, Council Chairman, Medical Assistant, Women Council leader, Catholic church cathecist, KUC church representative	Abaiang Maneaba
4.30pm-5.30pm	Debrief and clarify discussions	
Saturday 15/02/2020		
09.00-11.30am	FGD – 10 women (including women's Council leader)	Abaiang Maneaba
	Debrief	
12.00-2.00pm	FGD – 10 youth	Abaiang Maneaba
2.00pm-3.00pm	***Lunch***	
4.00-6.00pm	Travel back to South Tarawa	
Sunday 16/02/2020		
2.30-4.30pm	Discussion with youth	Betio causeway
	Debrief	
Monday 17/02/2020		
08.00-09.00am	NZHC – s9(2)(a)	Bairiki
09.15-10.30am	Clinic Observation at KFHA. Discussion with nurses s9(2)(a)	Teaoraereke/KFHA
10.30-11.30.00pm	s9(2)(a)	KFHA Lab
11.30-12.30pm	MHMS health centre nurses (2 nurses)	Koakoa
12.30pm-3.00pm	**Lunch**/HFT (6)	Bairiki

04.00pm-05.30pm	South Tarawa Focus Group- women	KFHA
Tuesday 18/02/2020		
09.00-10.30am	MP - s9(2)(a)	Koakoa
10.30-11.30am	IT/M&E	KFHA
11.30-12.30pm	Informal discussion Sex worker	Betio
12.30am-2.00pm	Meeting with Senior Youth Officer Observation at KFHA clinic at KIT Informal discussio with KIT student services (2 staff)	KIT Student Services Betio
2.30-3.30pm	Te Toamatoa	Nanikaai Camp
	Informal discussion KFHA staff – IT, ED	KFHA
7.00-7.30pm	BIMBA	Fema Lodge
Wednesday 19/02/2020		
9-00-10.30am	MHMS Director of Public Health RMNCAH s9(2)(a)	Bikenibeu
10.30-11.00am	MHMS - DNS	Bikenibeu
12.00-1.00pm	UNFPA – SRH Specialist s9(2)(a) and Program Analyst	Bikenibeu
1.30-02.30pm	MOE-s9(2)(a) Curriculum Development unit staff (2)	Ministry of Education, Bikenibeu
03.15pm-04.15pm	Ministry of Internal Affairs – Deputy Secretary	Bairiki
	Informal discussion KFHA staff – IT, ED After-hours clinic did not take place	
5.00-9.00pm	Screening of movie – BIMBA s9(2)(a)	NZ High Commission
Thursday 20/02/2020		
08.00-10.00	Debrief with ED	Airport
	Departure for Nadi – Sydney flights	

Annex 4: List of documents reviewed for Healthy Families Project

1. Activity Design Document Phase 2, Kiribati Healthy Families Project, 2015-2020
2. HFP Year One Narrative Report, 1 April 2015 – 31st March 2016
3. HFP Year Two Narrative Report, 1 April 2016 – 31st March 2017
4. HFP Year Three Narrative Report, 1 April 2017 – 31st March 2018
5. HFP Year Four Narrative Report, 1 April 2018– 31st March 2016 2019
6. KFHA Quarterly reports for quarters 1-4 Year Five 2019
7. KFHA – FPNZ MOU (and variation)
8. KFHA Annual Work Plan and Budget, 2020
9. FPNZ 2016. Family Planning in South Tarawa, Kiribati: Usage and Barriers
10. FPNZ 2014. Investment in Family Planning in Kiribati: A cost-benefit analysis.
11. FPNZ 2020. Healthy Families Taskforce Training Manual
12. Government of Kiribati. 2015 Population and Housing Census: Management Report and Basic Tables, National Statistics Office, 2016
13. Kiribati Key DHS Facts 2009
14. Kiribati National Statistics Office and SPC 2010. Kiribati Demographic and Health Survey 2009
15. UN Kiribati Country Implementation Profile, 2012
16. SPC 2010. Kiribati Family Health and Support Study : A study on violence against women and children
17. MHMS Ministry Strategic Plan 2016-2019
18. MHMS Standard Operating Procedures for the treatment of survivors of gender based violence, undated
19. UNFPA/MHMS Kiribati National Evidence-based Family Planning Guidelines: Towards a healthy family 2015
20. MHMS DRAFT Kiribati Reproductive Maternal Newborn Child Adolescent Health Policy 2018, Strategy Plan 2018-2022
21. Kiribati Voluntary National Review and Kiribati Development Plan Mid-Term Review 2018
22. UNFPA 2018. Kiribati DHS 2018 Work Plan for Pacific Community (SPC)
23. Kiribati 20 Year Vision: 2016-2036. KV20
24. Kiribati Development Plan 2016-2019
25. Government of Kiribati 2012. National Disaster Risk Management Plan
26. UNSW 2012. Risky Business: HIV prevention among women who board foreign fishing vessels to sell sex
27. Government of New Zealand, MFAT Our Development Cooperation with Kiribati
28. WHO WPRO, UHC and SDG Country Profile, Kiribati 2018
29. UNFPA PSRO, A Transformative Agenda for Women, Adolescents and Youth in the Pacific: Towards Zero Unmet Need for Family Planning 2018- 2022

30. CHOICE for Youth & Sexuality, Investing in youth Healthy Families: a toolkit on youth-friendly funding, 2019
31. Evaluating family planning programs, Bertrand, Magnani, Rutenberg, 1996
32. WHO Developing sexual health programmes: a framework for action, 2010
33. WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries, 2011
34. Guttmacher, Costs and benefits of investing in contraceptive services in the developing world, 2012
35. Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission, 2018 https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30293-9.pdf
36. Neha S. Singh, James Smith, Sarindi Aryasinghe, Rajat Khosla, Lale Say, Karl Blanchet, Evaluating the effectiveness of sexual and reproductive health services during humanitarian crises: A systematic review, PLOS ONE, 2018
37. Engenderhealth, Reality Check: A planning and advocacy tool for strengthening family planning programs, User's Guide version 2, USAID Project Respond 2010